Whittington Health
NHS Trust

TRUST BOARD
IN PUBLIC

14:00-17:00
Wednesday
29 May 2019

Whittington Education Centre
Room 7

Meeting	**Trust Board – Public meeting**
Date & time	**29 May 2019: From 1400hrs**
Venue	**Whittington Education Centre, Room 7**

Non-Executive Director members:
Steve Hitchins, Chair
Deborah Harris-Ugbomah
David Holt
Professor Naomi Fulop
Tony Rice
Anu Singh
Yua Haw Yoe

Executive Director members:
Siobhan Harrington, Chief Executive
Dr Julie Andrews, Acting Medical Director
Stephen Bloomer, Chief Finance Officer
Carol Gillen, Chief Operating Officer Michelle Johnson, Chief Nurse & Director of Patient Experience

Attendees:
Councillor Janet Burgess MBE, Islington Council
Kevin Curnow, Operational Director of Finance
Norma French, Director of Workforce
Jonathan Gardner, Director of Strategy, Development & Corporate Affairs
Kate Green, Personal Assistant to Director of Workforce
Dr Sarah Humphery, Medical Director, Integrated Care
Councillor Sarah James, Haringey Council
Swarnjit Singh, Trust Corporate Secretary

Contact for this meeting: jonathan.gardner@nhs.net

AGENDA

Item	Timing	Title and lead	Action
Standing items			
1	1400	**Patient story** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Presentation
2	1425	**Congratulation for London Marathon runners** *Steve Hitchins, Chair*	Verbal
3	1435	**Welcome and apologies** *Steve Hitchins, Chair*	Verbal
4	1437	**Declaration of conflicts of Interest** *Steve Hitchins, Chair*	Verbal
5	1439	**24 April 2019 public meeting draft minutes, action log, matters arising** *Steve Hitchins, Chair*	Approve
6	1445	**Chairman's report** *Steve Hitchins, Chair*	Review verbal update
7	1455	**Chief Executive's report** *Siobhan Harrington, Chief Executive*	Review

Item	Timing	Title and lead	Action
Quality & patient safety			
8	1505	**Trust Wellbeing Guardian** *Norma French, Director of Workforce*	Approve
9	1510	**Quality Assurance (Care Quality Commission compliance update)** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Review
10	1520	**Serious Incidents – April 2019** *Dr Julie Andrews, Acting Medical Director*	Review
11	1525	**2018/19 Quality Account** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Approve
12	1535	**Quarterly learning from mortality report** *Dr Julie Andrews, Acting Medical Director*	Review
Performance			
13	1545	**Performance dashboard – April 2019** *Carol Gillen, Chief Operating Officer*	Review
14	1555	**Financial performance – April 2019** *Stephen Bloomer, Chief Finance Officer*	Review
Governance			
15	1620	**Provider licence self-certification** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Approve
16	1630	**Board Committees' terms of reference** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Approve
17	1640	**Standing orders, Standing financial instructions and Scheme of reservation and delegation of powers** *Stephen Bloomer, Chief Finance Officer*	Approve
18	1650	**Quality Committee, May 2019 meeting minutes** *Naomi Fulop, Committee Chair*	Review
19	1655	**Workforce Assurance Committee, April 2019 meeting minutes** *Anu Singh, Committee Chair*	Review
20	1700	**Charitable Funds' Committee, March 2019 meeting minutes** *Tony Rice, Committee Chair*	Review

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21	1705	**Questions from the public on meeting items** *Steve Hitchins, Chair*	Review
22	1710	**Any other business** *Steve Hitchins, Chair*	Review

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Minutes of the meeting of the Trust Board of Whittington Health held in public on Wednesday, 24 April 2019

Present:

Steve Hitchins	Chair
Julie Andrews	Acting Medical Director (items 1-14 and 16-20)
Stephen Bloomer	Chief Finance Officer
Norma French	Director of Workforce (items 1-8 and 10-20)
Jonathan Gardner	Director, Strategy, Development & Corporate Affairs
Carol Gillen	Chief Operating Officer
Siobhan Harrington	Chief Executive
Sarah Humphery	Medical Director, Integrated Care
Michelle Johnson	Chief Nurse & Director of Patient Experience
Tony Rice	Non-Executive Director (items 1 to 7)
Anu Singh	Non-Executive Director
Yua Haw Yoe	Non-Executive Director

In attendance:

Kate Green	PA to Director of Workforce (minutes)
Swarnjit Singh	Trust Corporate Secretary

1. Patient story

1.1 Michelle Johnson informed the Board that the patient referred to in this month's story was unable to attend. Casey Gallagher, Patient Experience Officer, introduced the team who were to present that afternoon, namely Dr Tanya Knight, Co-Team Leader and Senior Cognitive Behavioural Therapist (CBT), Elizabeth Thomas, CBT, and Sarah Murphy, Employment Lead and Assistant Psychologist, from the Haringey Improving Access to Psychological Therapies (IAPT) team and David Harper from the Shaw Trust.

1.2 David Harper, Senior Individual Placement & Support (IPS) Lead at the Shaw Trust, gave an overview of the Aim4Work programme. This started in March 2017, and European Union and matched National Lottery Social funding had recently been extended until June 2022. The programme supported people with mental health needs gaining employment opportunities and also improved and maintained participant's wellbeing. Trials had shown that participation in the IPS model resulted in people being twice as likely to gain competitive employment, earn more, and experience fewer admissions to hospital. The model was now being tested for other people, such as those with a history of drug or alcohol misuse and people who had a physical disability.

1.3 David Harper took the Board through the principles of the programme, and explained that much work had been carried out over the previous year to bring employment advisors into the IAPT setting. He was pleased to inform the Board that Haringey IAPT had been their first success and reported statistics which showed

how successful this had been: out of 68 referrals, 57 people had gone into 'programme starts' and 18 had gained employment. Of those successful in gaining employment, 79% had sustained their role after six months.

1.4 An independent review by the Centre for Mental Health took place in January 2019, and resulted in them being recognised as an IPS Centre of Excellence – the first in the country based at an IAPT service to achieve this.

1.5 Liz and Tanya described the IAPT service, a Department of Health & Social Care initiative which started in 2008, predominantly to treat those suffering from anxiety and/or depression. The Haringey service, 'Let's Talk Haringey', celebrated its 10th anniversary in October 2019, and had seen a 300% increase in referrals and a rise in recovery rates and 'reliable improvement' rates. The team provided a range of therapy from various settings including community centres and libraries. The number of people who have started or returned to work has also greatly increased since the IPS leads have joined the team.

1.6 Sarah reported that she let people know what support was available to help people back into employment and worked closely with the Shaw Trust. She introduced the story of MJ, a 35 year old woman who had self-referred to the IAPT team suffering from low moods and anxiety. MJ had been a long-term victim of domestic violence and experienced a range of other difficulties: she had been signed off work and suffered from low self-esteem. She had also been diagnosed with Type 1 diabetes while a teenager, and consequently, it was felt appropriate to offer her cognitive behavioural therapy in the team's long-term conditions' unit. As well as attending sixteen sessions there, MJ attended the employment workshops run by Sarah and Thomas from the Shaw Trust covering topics ranging from practical skills to anxiety management.

1.7 Following completion of all five workshops, MJ was offered some individual sessions with Thomas, including mock interviews. Often these would take place in community settings, and as a result of this MJ made friends in a local café where the proprietor offered her a part-time job. After this, her confidence increased and she was able to gain full-time employment, which she has now been settled in for around six months. This was the reason she had been unable to attend to present her story in person, and the Board wished her well.

1.8 Looking to the future, the team hoped to further expand its employment advice and support service. They would be conducting workshops for local employers (initially conducted through the Shaw Trust) in order both to discuss employment opportunities and to brief them on how best to support staff employed through the scheme.

1.9 In answer to a question from Tony Rice about whether people were helped to navigate their way through the complex benefits system, David Harper said that close links were maintained with the Citizens' Advice Bureau, and staff had also received specialist training. Siobhan Harrington asked whether there was an opportunity to give feedback on the service, and Sarah replied that this was available in a number of ways including at the end of a course of treatment and through feedback forms at workshops; the Shaw Trust also had a customer care team. Siobhan Harrington also asked what support the Board could offer and, in

response, the team members were clear that their most pressing need was for additional space. Staffing was also an issue – the team had volunteers and trainees - but needed more supervisors. Carol Gillen noted that an operational meeting was to be held imminently.

1.10 **The Board thanked the Haringey Improving Access to Psychological Therapies team and David Harper from the Shaw Trust for their presentation and talk into the invaluable service they provided through the individual placement and support initiative to help local people back into work.**

2. Welcome and apologies

2.1 Steve Hitchins welcomed everyone to the meeting.

2.2 Apologies for absence were received from Naomi Fulop, Non-Executive Director, David Holt, Non-Executive Director, Deborah Harris-Ugbomah, Non-Executive Director, and Janet Burgess, London Borough of Islington. Tony Rice apologised in advance for having to leave the meeting early.

3. Declaration of conflicts of interest

3.1 No-one declared any conflict of interest pertaining to any of the items on the agenda for that afternoon's meeting.

4. Minutes, matters arising & action log

4.1 The minutes of the public Board meeting held on 27 March 2019 were approved as a correct record.

4.2 There were no matters arising other than those already scheduled for discussion.

4.3 It was reported that the terms of reference for Board committees would be brought to the May Board meeting, and Steve Hitchins asked that Standing Orders also be brought to the same meeting. It was agreed that the Accountability Framework should be discussed at a Board seminar, and noted that one Board seminar would be replaced by a Remuneration Committee meeting. All other items listed on the action log were either on track for discussion at future Board meetings/seminars or had already been completed.

5. Chairman's report

5.1 This was the first Board meeting of the 2019/20 financial year, and Steve Hitchins congratulated everyone for their achievements during 2018/19, particularly in the financial outturn and asked for his thanks to be cascaded to all staff. He went on to pay tribute to former Whittington Hospital Trust Chairman, Narendra Makanji, who had died recently, saying that a book of condolences was available to be signed in the chapel.

5.2 Since the last meeting Steve Hithcins had meet with the Chairs of University College London Hospital NHSFT, North Middlesex University Hospital NHS Trust and Camden & Islington NHSFT. He had also attended the following meetings and/or events:

- the very successful Ambitious about Autism day
- a visit to Charing Cross Hospital to view their pathology department

- a fundraising quiz in aid of the Ifor Ward play area
- the distribution of the Queen's annual gift of daffodils
- meetings of district nurses, community matrons and Deborah Clatworthy's 'box of frogs' awards.

5.3 Steve Hitchins reported that he had also sat on the selection panel which appointed Mike Cook as the new Chair of the North Central London Sustainability & Transformation Plan (STP) footprint's Advisory Board. In addition, he had also been approached by NHS England to help shape their report on Non-Executive Directors and disability. Steve Hitchins also told Board members that, on the following Saturday there was to be a midwifery event, sponsored by American Airlines.

5.5 **Board members welcomed the Chairman's verbal update and agreed that congratulations and thanks be communicated to all teams and staff for their hard work in helping deliver the 2018/19 financial outturn.**

6. Chief Executive's report

6.1 Siobhan Harrington began her report by talking about the creation of the NHS Assembly, which was to be co-chaired by Professor Chris Ham (also recently appointed Non-Executive Director at the Royal Free NHST).

6.2 Moving to Quality and Safety, Siobhan Harrington reported that Emergency Department (ED) performance reached 86.6% during March, however, this was set against a background of significantly-increased attendances, with yesterday's at 385, the highest ever recorded at the Trust. The ED service continued to receive support from NHS Improvement's Emergency Care Intensive Support Team (ECIST) who were looking particularly at the front of house aspect of the service. The maternity service had again performed well on the FFT survey, and the service's video was well-received. Complaints performance has been good, and staff turnover had reduced to 10.83%, the lowest recorded. The vacancy level had also reduced. Siobhan was pleased to report that the Trust had met its control total at year-end, although there was much to do on the run rate and associated plans for 2019/20.

6.3 Siobhan Harrington also reported that progress continued to be made on the culture improvement work. A change group of around 15 colleagues met on 1 April to discuss the agenda moving forward, and there would be a reference group of around 50 people to support and guide this work. There was currently a survey seeking views on the branding for this change group, and Siobhan Harrington was clear on the importance of ensuring adequate resources were in place to support the group's important work. She explained that the focus for this year was to be on bullying and harassment and staff engagement. Another priority was the improvement of the environment and, to this end, there was ongoing planning work which would involve consultation with staff and other key stakeholders.

6.4 **Board members received and reviewed the Chief Executive's report.**

7. 2018/19 Patient stories – actions taken and learning shared

7.1 Michelle Johnson introduced a report which highlighted the range of patients' stories considered by the Board and the actions taken over the past year. The Board had listened to a mixture of face-to-face and videoed stories, with recent emphasis on the latter whilst a library was put together. Michelle was proud of what had been achieved, and mentioned that one of the first videos had been used by NHS Improvement as part of a training session for professional staff. She also stressed the importance of staff joining the presentations in the interests of shared learning.

7.2 The Trust's 2019/21 Patient Experience strategy, formally approved at the March 2019 Board meeting, was now being implemented. Michelle Johnson confirmed that she aimed to have more people attending the Board in person to recount their stories, and would like to see a balance between positive and challenging experiences. She also explained that staff stories would be considered by the Board on a quarterly basis. The webpage was also being developed, and Michelle Johnson explained that one of her ambitions was to have a patient experience lead for each Integrated Clinical Service Unit (ICSU).

7.3 Anu Singh felt that a great deal had been achieved as a result of some of the issues identified in patient stories during 2018/19 and this was evident from the combined incidents, complaints and legal reports considered by the Quality Committee. She also acknowledged the need to be clearer about how the patients themselves received feedback; whilst this was a routine part of the process it is perhaps not so well evidenced in the report.

7.4 **The Board received and welcomed the presentation on actions taken and learning identified from patient stories considered during 2018/19.**

8. Serious Incident (SI) report

8.1 Julie Andrews informed the Board that the Trust had declared a total of 32 SIs during 2018/19. The report also summarised the learning from four recent investigations, and included a summary table of the 38 investigations from the previous year. Overall, Julie believed that the Trust was moving in the right direction in terms of seeing less harm, though she would like to see an increase in reporting in some areas. She was also pleased to note that the Commissioning Support Unit (CSU) appeared increasingly satisfied with the quality of the Trust's reports.

8.2 Julie Andrews provided assurance to Steve Hitchins that the Trust had lower SI cases and numbers of moderate harm cases compared with three years ago. In response to a query about the benchmarking of this data against other NHS organisations, Julie Andrews confirmed that the Trust had comparable harm outcomes when compared with other NHS providers, but and had less benchmarking information on the length of time taken to complete SI investigations. She added that the Memorandum of Understanding with Camden & Islington NHSFT was extremely helpful, and communication between the two organisations had greatly improved since working together on joint investigations.

8.3 **The Board reviewed the SI report and noted the steps being taken to ensure the Trust worked with Camden & Islington NHSFT on the shared production of serious incident investigations; to improve the process for managing trauma patients; and, to investigate and learn from a never event.**

9. Q4 Quality & Patient Safety report

9.1 Julie Andrews introduced the quality and patient safety report for the fourth quarter of 2018/19. She informed the Board that the Standard Hospital Mortality Index (SHMI) showed an upward trend but remained below the national average. She also reported that there was much better coding in place and organisations whose coding improved in quality did tend to see an upwards trend, especially around palliative care deaths. In addition, Julie Andrews provided assurance that the Trust also focussed on reviewing the deaths of patients which occurred 30 days or less after discharge, to ensure that no potentially avoidable deaths were missed.

9.2 For infection prevention and control, Julie Andrews reported that the Trust was successful in meeting the C. difficile target but had missed the target to have no MRSA cases by one. She advised Board members that the care and treatment of patients with sepsis continued to improve, with all patients deemed at risk receiving antibiotics within the first hour of their attending the Emergency Department. Julie Andrews highlighted that the Medicines Safety Committee met six times per year, and its last meeting focused on palliative care. It was noted that nursing Band 5s and junior doctors were very good at reporting concerns; Julie Andrews commented that a higher number of concerns were expected to be reported by pharmacists. Julie Andrews also drew attention to the fact that there were no deaths from 'flu during the year, although there had been 38 instances of patient transmissions, i.e. patients who had caught 'flu whilst in hospital.

9.3 Stephen Bloomer asked Julie Andrews whether any trends had been identified that would suggest care was less good than it had been or whether there were any other causes for concern. Julie Andrews confirmed she was satisfied that there was no cause for concern, and indeed, the potentially avoidable mortality rate had reduced. Siobhan Harrington thanked Julie Andrews for having a good process in place.

9.4 Steve Hitchins informed Board members that, on 1 May, a Grand Round on treating homeless patients would be held at the Whittington Education Centre. Attendees would include colleagues from University College London Hospitals NHSFT and people involved in helping to deliver the NHS Long Term Plan. He commented that the Trust did have a number of patients who became homeless while an inpatient.

9.5 **The Board reviewed and took assurance from outcomes contained in the Q4 quality and patient safety report.**

10. Safeguarding children declaration

10.1 Michelle Johnson informed the Board that this declaration was an annual statutory requirement. The report summarised the Trust's compliance with its statutory safeguarding duties. The Trust was a member of the children's safeguarding boards in both Islington and Haringey and was fully compliant with all section 11 audits. From 1 April, the two separate internal safeguarding committees for children and adults respectively would be abolished and be replaced by a new, joint safeguarding committee, which was particularly important as moving from the children's to the adult service could result in a gap in service for some vulnerable people.

10.2 The Board:

i. received and understood the Trust's responsibility for safeguarding children;

ii. was assured that the Trust continued to follow statutory requirements (Children's Act 2004, Local Safeguarding Children Boards procedures and Pan London Safeguarding Children Procedures) to protect children at risk of abuse and neglect; and

iii. approved the annual statement of assurance.

11. Performance dashboard

11.1 Carol Gillen clarified that:

- the new performance report would come to the Board's May meeting
- the ECIST team was now focussing on the ambulatory care unit
- the Trust was fully compliant with all cancer targets in March
- an improvement programme for theatre utilisation was being implemented and trajectories were being set; Nick Harper, Clinical Director for the Surgery & Cancer ICSU would be the clinical lead for this work
- Good progress had been made within district nursing and generally on community outcomes, particularly the excellent achievements in Haringey by the new birth visiting team

11.3 Carol Gillen also reported that the Workforce Assurance Committee had met earlier that day, and had discussed the need for the Trust Management Group to consider the options for action to improve compliance with staff appraisal and annual statutory and mandatory training requirements, including agreeing revised performance trajectories. In answer to a question from Steve Hitchins about whether appraisals were linked to the Trust's corporate objectives, Norma French provided assurance to the Board that they were and that the new template was being linked to the new obectives. Carol Gillen provided assurance to Steve Hitchins that teams had access to a comprehensive range of performance data for their area through ClickView which was scrutinised as part of the quarterly performance review meetings or ICSUs and corporate areas.

11.4 **Board members reviewed the performance dashboard report and took assurance that remedial actions were in place for any indicators off target. The Board also noted the new 2019/20 performance report would be discussed at its May meeting.**

12. Financial report

12.1 Stephen Bloomer apologised for the late circulation of the report. He informed the Board that the Trust had delivered its 2018/19 control total as Agenda for Change pay award funding had been excluded from the final calculations. This meant that the Trust had qualified for additional provider sustainability funding (PSF) of £6.2m, and thereby was reporting an adjusted surplus of £28.2m including £27.6m of PSF income.

12.2 Stephen Bloomer raised concern about the underlying deficit. He reported the Trust had continued to spend more on pay expenditure than planned and had exceeded its agency expenditure cap. One or two areas remained particularly challenged, and all efforts were being made to help those areas manage within their budgets. He was also pleased to report that the Trust had spent £14.6m of its capital allocation against planned capital expenditure of £14.8m, and paid tribute to colleagues in Estates, Information Technology and Medical Physics for helping to achieve this outcome.

12.3 In terms of next steps, it was important to close the remainder of the escalation beds, and Stephen Bloomer was confident there were robust plans in place to achieve this. An additional area for focus would be to close the gap in cost improvement programme (CIP) plans as well as setting a higher CIP target to allow for any schemes that did not fully proceed. Stephen Bloomer advised Board members that the aim was reduce the underlying deficit by 50% in 2019/20 and by a further 50% in 2020/21.

12.4 Steve Hitchins welcomed the delivery of the 2018/19 capital expenditure plan and asked whether there was any learning from the previous year which might benefits capital plans in 2019/20. In reply, Stephen Bloomer said the need to have additional resource in place for the programme management of estate schemes had been identified. In addition, he reported the Trust would improve how it could bring forward elements of the capital programme, where possible.

12.5 **The Board noted the 2018/19 financial outcome and recognised the need to improve income delivery, to reduce agency staffing expenditure and to improve the delivery of run rate reducing CIP plans.**

13. Quarter 4 Assurance on 7 day services

13.1 Julie Andrews reminded the Board that Trusts providing acute services were required to make a quarterly return on compliance with ten clinical standards. She was pleased to report that the Trust was fully compliant with standards 2, 5, 6 and 8 except for having a full seven day access to echocardiograms. Julie Andrews provided assurance that this impacted on very few patients, and those requiring the service were referred to Bart's Health NHST. Performance against the other standards was carried out through self-assessment, and Julie Andrews reported the Trust was not yet fully compliant with standard 4 (handover of patients) but she was confident that the planned move to electronic handover systems in the next twelve months would remedy this.

13.2 **The Board reviewed the assurance on seven day services for quarter four and welcomed the green-rated compliance with clinical standards 2, 5, 6 and 8.**

14. 2018/19 Corporate objectives – review of quarter 4 delivery

14.1 Jonathan Gardner presented a report on progress against the Trust's corporate objectives for 2018/19 and drew attention to the progress that had been made on integrating care in the localities, and also the ongoing work on quality and safety overseen by the Patient Safety and Quality Committees. Siobhan Harrington advised Board members that reports on the delivery of 2019/20 corporate objectives would include smart metrics and reported that the only objective not achieved in 2018/19 was to meet the agency staffing expenditure £8.8m cap; Norma French had scheduled a further round of meetings with the ICSUs to help progress work in this area.

14.2 **The Trust Board reviewed and welcomed the outcome for the quarter four delivery of the 2018/19 corporate objectives and noted that the only objective not achieved was to meet the agency staffing expenditure cap.**

15. 2019/20 Corporate objectives

15.1 Jonathan Gardner explained that the four draft 2019/20 corporate objectives were drawn from the revised 2019/24 strategy agreed at the March. He would be reporting progress to the Board based on clear indicators, which would be discussed at the June 2019 Board seminar.

15.2 Steve Hitchins stressed that the accompanying indicators should be smart to allow the Board to objectively review the progress achieved. He also suggested a need to have a focus on community and population health. In reply to a question from Anu Singh, Jonathan Gardner confirmed that the corporate objectives would form part of the annual appraisal of all staff and would have an executive lead responsible officer. He also said that the objectives had been informed by the ICSU planning process, and would accordingly be built into the quarterly review process.

15.3 **The Board:**

i. approved, the proposed 2019/20 corporate objectives; and

ii. agreed that there should be there are smart metrics to measure delivery of the 2019/20 strategic objectives, and include a community and population health focus.

16. Board Assurance Framework (BAF)

16.1 Jonathan Gardner informed the Board that there were three distinct elements to the report: first, the last BAF report for the 2018/19 financial year which provided an assessment of the position at the end of March; a new 2019/20 BAF based on strategic objectives agreed for the 2019/24 strategy; and finally, drew attention to the draft risk appetite statement which set out the different type of risks faced and Whittington Health's overall position in relation to them. The statement had been prepared using guidance produced by the Good Governance Institute and looking at other Trust models.

16.2 Siobhan Harrington suggested it would be appropriate to have a fuller discussion of the proposed risk appetite statement at Board seminar. Jonathan Gardner urged Board members to come back to him with any specific comments or queries. Siobhan Harrington and Jonathan Gardner thanked Swarnjit Singh for all the work he had carried out to produce the report.

16.3 In answer to a question about whether the Lower Urinary Tract service (LUTS) needed to remain on the BAF, Jonathan Gardner said that it remained a fragile service and a second consultant had not yet been appointed.

16.4 **The Board:**

i. **reviewed the final, updated BAF for Q4 in 2018/19;**
ii. **reviewed and approved the draft 2019/20 BAF based on the new agreed strategic objectives;**
iii. **agreed the draft risk appetite statement be discussed at the May Board seminar; and**
iv. **agreed that board assurance committees review respective BAF entries as standing items at their meetings.**

17. Corporate risk register (CRR)

17.1 Michelle Johnson reported that the Board was scheduled to review the CRR quarterly, particularly risks rated as 16 or above, with risk entries rated 15 or below being scrutinised by appropriate an committee.

17.2 It was noted that one risk had been closed which related to pressurised gas manifolds used in microbiology. The risk relating to lease issues at Simmons House had been downgraded. There was one new risk, relating to the staffing of the central booking team which Michelle Johnson felt this was likely to reduce fairly quickly as posts were filed.

17.3 **The Board reviewed all CRR risks rated at 16 or higher an agreed that there were adequate mitigating actions and assurance in place for the effective management of these operational risk entries. The Board agreed that none of the operational risks rate at 16 or higher be included on the BAF.**

18. Use of the Trust seal

18.1 Board members reviewed and noted the annual report to the Board on the use of the seal.

19. Any other business

19. Anu Singh delivered a verbal report of the Workforce Assurance Committee meeting which took place that morning. The Committee had discussed the cultural improvement agenda taking place and would map how this related to its work. She highlighted the need for sufficient resources available being made to support this work and wondered whether it might be appropriate to include programme management office arrangements. Anu Singh also reported that the Committee had discussed performance on statutory and

mandatory training and staff appraisal and agreed this be reviewed along with expected trajectories by the Trust Management Group. The updated terms of reference circulated had been discussed and approved. Board members noted the verbal update on the Committee's meeting.

20. Questions from the public

Mr Philip Richards asked the three following questions:

Q: Could printed Board papers please be made available to members of the public wishing to read them beforehand as not all had access to information technology?

A: Siobhan Harrington agreed to this request.

Q: Did the LUTS patient support group take place?

A: Jonathan Gardner confirmed that the March meeting took place and the group was happy with the meeting at which they met the new consultant for the first time and the longer term plan was to have a second consultant in place; a representative from the University College London research team was also present. He reported that a new protocol was to be agreed and progress was positive. It was also noted that the service was to move from Hornsey to the Archway site, thus improving links with the pathology service.

Q: Were any objections raised to the changes to be made to the non-urgent patient transport service?

A: Stephen Bloomer advised that it was not possible to answer this currently due to reasons of commercial confidentiality as a procurement process was in place for a new patient transport service to commence from 1 July. However, this information could be provided once the new contract had been awarded.

Action logs, April 2019 Public Board meeting

Action items carried forward:

Item	Action	Lead	Progress
Matters arising	1. Standardised terms of reference for Board Committees to come to the April Board meeting	Committee Chairs, lead executive directors, Swarnjit Singh	On agenda
	2. Accountability framework and escalation arrangements to be considered at a future Board seminar	Carol Gillen, Jonathan Gardner	A draft accountability framework, including self-assessment has been developed and shared with executives and ICSUs. It is being reviewed prior to being used as part of quarterly performance reviews
Patient story	Share the video with Haringey CCG's Director of Quality	Michelle Johnson	Completed - the film has been shared with the CCG and scheduled for a follow up discussion by the end of May
Chief Executive's report	1. Bring back a report on the role and appointment of the Trust's Wellbeing Guardian to a future Board meeting	Siobhan Harrington	Completed – on agenda for May Board meeting
	2. Attend the opening ceremony for the Trust's new obstetric theatre	All Board members	An opening ceremony date is being confirmed in advance of the theatre coming into use from 17 June

Item	Action	Lead	Progress
Performance scorecard	Review our communication and awareness campaign for pressure ulcer prevention and look at performance by ward and community area	Michelle Johnson	Completed - the amended governance reporting will be discussed and reviewed at the next nursing and midwifery executive committee (June) and next patient safety committee (July)
Quality Committee meeting minutes	Include a Board seminar item on Quality Improvement as soon as possible	Michelle Johnson	Completed - a provisional date of September 2019 is scheduled, following prior consideration by the Quality Committee

Action log for 24 April Public Board meeting

Item	Action	Lead	Progress
Chairman's report	Communicate thanks to all teams and staff for helping deliver the 2018/19 financial outturn	All Directors	Completed
2019/20 Strategic objectives	Ensure there are SMART metrics to measure delivery of the 2019/20 strategic objectives, and that there is a community and population health focus	Directors	The metrics were discussed by the Executive team and will be brought to the June Board
Board Assurance Framework	Hold a discussion at the May Board seminar	Jonathan Gardner	Completed

Meeting title	**Trust Board – public meeting**	**Date: 29 May 2019**
Report title	**Chief Executive's report**	**Agenda Item: 7**
Executive director lead	Siobhan Harrington, Chief Executive	
Report author	Swarnjit Singh, Trust Corporate Secretary	
Executive summary	This report alerts Board members' to recent national and local developments and also highlights and celebrates achievements by the Trust and its staff.	
Purpose:	Review	
Recommendation(s)	Board members are invited to review the report and its content.	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	None	
Appendices	None	

Chief Executive's report
This report provides Board directors with highlights of key developments within the health and social care sector at a national and local level:

1. National news

NHSX

1.1 NHSX[1] is the new NHS organisation for digital, data and technology. Its mission statement is to make sure that both patients and staff have the digital technology they need. From July, NHSX will bring together teams from the Department of Health & Social Care, NHS England and NHS improvement and will mandate the use of internationally recognised technology and data standards across the NHS to ensure that all systems can talk to each other appropriately.

Accountability framework

1.2 On 21 May, the Department of Health & Social Care published their accountability framework with NHS England and NHS Improvement[2] which combines the annual statutory mandate to NHS England with its remit for NHS Improvement, their specific objectives, financial directions and budgets for 2019 to 2020. The accountability framework also takes into account the joint working to lead the NHS in taking forward its Long Term Plan.

Long Term Plan

1.3 The NHS Long Term Plan[3], published in January 2019, included aspirations to boost out-of-hospital care, and breakdown the historic divide between primary and community health services and to create a new NHS offer of support for urgent community response and recovery, backed by additional investment. To help with this direction of travel, Matthew Winn, Chief Executive of Cambridgeshire Community Services NHS Trust, has been appointed on a part time basis for six months, in addition to his Chief Executive role, as the senior responsible officer for the "ageing well" programme element of the Long Term Plan. Martin Vernon, a national clinical director at NHS England, will work with Matthew as clinical director for the programme.

NHS pensions

1.4 From April 2019, employer contributions will rise from the previous level of 14.6% to 20.6%. NHS funding has been allocated for the current financial year to support NHS organisations; however, for contracts funded by public health, this had not yet been confirmed and is being discussed nationally in an attempt to try and reach a resolution. This issue is likely to create a significant cost pressure for such services.

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[1] https://www.nhsx.nhs.uk/

[2] https://www.gov.uk/government/publications/nhs-accountability-framework-2019-to-2020?utm_source=ff1cbc97-4361-4523-90c9-1f1ba5eb2bc7&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate

[3] https://www.longtermplan.nhs.uk/

2. Local news

Quality and safety performance

2.1 In April, overall performance against the 95% four hour standards was 84.6 %, against the trajectory of 90% (NHS Improvement plan). Patient attendance numbers at the Emergency Department totalled 9,079 in April 2019, which equated to a 5% increase in attendances compared with April 2018. There was one 12 hour mental health breach where a patient waited for a mental health bed, out of area in Bristol, and there was no capacity available, despite escalation processes being followed. Challenges in relation to mental health bed capacity were also identified towards the latter part of April as a London wide problem and an audit of the mental health pathway will also take place in May. The Trust was compliant in April in meeting targets for referral to treatment and diagnostics.

2.2 In line with the Trust's Emergency Department improvement plan, the following actions are being taken to help ED performance:

- implementation of the revised front of house model i.e. streaming, redirection, triage & rapid assessment triaging
- reviewing the current structure of clinical decision unit (CDU) and restructuring CDU pathways to include direct access to CDU
- reviewing and implementing internal professional standards in relation to speciality responses
- increasing direct patient pathways to ambulatory emergency care (AEC) to fully optimise AEC capacity
- piloting London Ambulance Service direct access to AEC for appropriate patients

2.3 As part of the Trust's BetterNeverStops campaign, 20-29 May has been declared a "Perfect Week". This will focus on dedicated support from the executive team for consultants and clinical teams to improve patient flow and reduce number of patients in hospital longer than seven days prior to the bank holiday weekend. Actions being taken to help make the week a success include:

- significantly reducing non-essential email traffic for the week
- cancelling all non-essential meetings to release staff to focus on patients
- supporting consultants to cancel non-clinical sessions in favour of direct clinical care for the week
- holding daily walk-around visits to wards and departments by executives and senior consultants
- committing to no diagnostic or therapy delays
- reassigning non-clinical staff to support the wards in resolving problems and bottlenecks to enable clinical staff to focus on direct patient care

2.4 Performance in responding to 80% of complaints within 25 days was 75% and plans are in place to recover and sustain the improvements that had been made over the past year in responding to patient feedback.

2.5 A round of performance reviews with Integrated Clinical Service Units (ICSUs) was completed during April. Two of the five ICSUs are agreeing more targeted support.

Finance

2.6 The Trust is reporting a deficit of £1.5m for the first month of the year (month 1) which is behind plan by £1m and has not assumed any Provider & Sustainability Funding (PSF) relating to its financial performance against control total. Income performance is marginally ahead of plan including high cost drugs over performance and PSF income behind plan. Pay costs were in excess of budget by £0.3m. Bank staffing expenditure in month was £1.8m with agency expenditure £0.9m. Agency staffing costs need to be tightly managed to ensure the Trust remains within the NHS Improvement annual agency ceiling of £8.8m. Non-pay expenditure was £0.7m overspent in month.

Workforce

2.7 Current compliance rates for staff appraisals are 71% and 81% for mandatory training. Staff sickness absence rates were 2.45% against a Trust target of 3.5%. Staff turnover has improved month on month, with current levels at 10.61% against a target of 10%. Work is ongoing with NHSI to improve retention, and results are being seen with the reduction in turnover. The time taken to hire new staff is currently 8.9 weeks against a target of 8 weeks. Responsibility for temporary staffing transferred to Bank Partners on 20 May and service level agreements are in to help reduce agency staffing usage and to increase fill rates for bank staff.

Organisational culture and development

2.8 On 9 May, over 100 Trust staff leaders were fortunate to attend a masterclass delivered by Michael West, Professor of Work and Organisational Psychology at Lancaster University Management School and a King's Fund Senior Fellow. His talk, “Compassionate and inclusive leadership for high quality care”, was thought-provoking, highlighted a range of underpinning evidence-based research and emphasised the need for compassionate leaders to deliver the following to help them deliver compassionate health services:

- Attending: listening with fascination and paying attention to staff
- Understanding: a shared understanding of what staff face
- Empathising: feeling staff distress at a sympathetic level
- Helping: practically helping through intelligent action

2.9 The seminar was followed by a culture fair in which a variety of Trust offerings to support people and enhance our culture were on display. The fair also hosted the last voting for the branding of the culture and leadership collaborative programme (with three other trusts) being run by University College London (UCL) Partners and NHSI, and the winner was “Caring for those who care”.

2.10 The Learning and Development and Recruitment teams have worked with other providers in the NCL sector to improve mandatory training compliance (and portability of staff and training data) through the ‘Streamlining’ project,

which is designed to eliminate wasted time repeating training already undertaken.

NHS North Central London (NCL) medium term financial strategy

2.11 On 3 May, senior NHS leaders from across NCL met to discuss the sector's 2019/20 financial position and highlighted areas where further efficiencies might be identified, as part of a medium term financial strategy. In terms of next steps, Caroline Clarke, Group Chief Executive of the Royal Free Hospital, is the senior responsible officer, leading for a small group which will develop the financial strategy for review and approval in late May.

Barnet, Enfield and Haringey and Camden and Islington NHS Trusts' Strategic Alliance

2.12 Two local providers, Camden and Islington and Barnet, Enfield Haringey NHS Trusts have announced plans to develop a formal strategic alliance with closer collaboration in some areas to significantly improve the care provided across their local population. Both trusts will remain distinct organisations with individual authority and control.

Bishop of London's visit

2.13 On 14 May, Dame Sarah Mullally, former Chief Nursing Officer for England and now The Right Reverend and Right Honourable Bishop of London, came to the Whittington Hospital site. She joined morning prayer in the chapel before meeting staff and patients from the Maternity & Women's health team.

International nurses' day

2.14 Michelle Johnson, Chief Nurse, joined other senior nursing colleagues to go out and about across the trust to thank our nursing and health visiting for all their hard work in celebration of International Nurses Day which was on Sunday, 12 May.

Summary Hospital-level Mortality Indicator (SHMI)

2.15 Figures published by NHS Digital on 17 May showed that Whittington Health was are one of just 16 NHS Trusts whose SHMI (the actual number of deaths following time in hospital compared with the expected number of deaths) were lower than expected. This is excellent news and everyone across the trust (not just those colleagues who work in the hospital) should be proud that these figures are part of evidence that can demonstrate high quality, safe and effective care.

Patient safety

2.16 Whittington Health is one of five trusts awarded over £40,000 of funding by UCL Partners to develop new ways of improving patient safety. UCL Partners set up the new fund to support frontline teams and organisations from across the North Central London region to further develop and spread interventions to help improve patient safety. The Trust will use the funding to introduce a programme to train health care assistants to provide enhanced care ('one-to-one') for vulnerable or critically ill patients in hospital. This project will aim to enhance the experience of care for patients and families as well as to develop the skills and autonomy of staff.

Shortlisting for a national CHKS quality of care award

2.17 The CHKS Top Hospital awards[4] celebrate excellence throughout the UK and are given to acute sector organisations for their achievements in healthcare quality and improvement. Whittington Health is one of five NHS trusts shortlisted for the quality of care award, a national acknowledgement, given for excellence in high quality care to patients, appropriate to their diagnosis. It is based on a number of criteria including the length of time patients stay in hospital, the rate of emergency re-admissions and whether the care pathway proceeded as originally intended. The award is also based on an analysis of outcomes against 14 indicators and the data analysed by CHKS comes from information that is regularly submitted by hospitals to NHS Digital to help track performance.

International clinical trials' day

2.18 On Monday, 20 May, the research team celebrated international clinical trials day. Being innovative is one of our core values and taking part and promoting opportunities for our patients to become involved in clinical trials is central to this.

Dementia action week

2.19 Dementia action week[5] took place from 20-26 May. Despite almost all of us knowing someone affected by dementia, two thirds of people living with dementia, report feeling isolated and lonely. Research shows that many of us are worried about "saying the wrong thing" to people living with dementia. The Alzheimer's society has encouraged people to start a conversation within someone living with dementia they know and have produced a helpful booklet to help people have such conversations with a relative or neighbour who has dementia[6]. At Whittington Health, frontline staff were out on wards and in community teams asking people to make a pledge as to "What they would do differently to help better support those living with dementia whilst at Whittington Health?" and a stall in the atrium helped to raise awareness of social isolation in dementia.

Dying matters week

2.20 The Trust held its first Death Café during Dying Matters week 2019. The Death Café provided an open and relaxed space for conversation about death, dying and grief accompanied by tea and cake. It is confidential, non-judgemental and was facilitated by our Palliative Care team on 16 May.

Future healthcare environment

2.21 The following developments have taken place:

- Engagement and planning work with staff, with all invited to attend one of a series of briefing sessions, to find out about plans and to feedback comments about priorities and principles going forward. A strategic outline case of proposals will be presented at the June 2019 Board meeting

[4] http://www.chks.co.uk/Top-Hospitals-Awards-2019
[5] https://www.alzheimers.org.uk/get-involved/dementia-action-week

[6] https://www.alzheimers.org.uk/sites/default/files/2019-05/DAW2019%20Booklet%20-%20English.pdf

- Work with Camden and Islington NHS Foundation Trust continues in order to provide co-ordinated mental and physical healthcare – a new mental health inpatient unit will start to be built on the Whittington Hospital site next year. To make way for this, work will begin next month to demolish the Waterlow Building to make way for modern, efficient and fit-for-purpose education facilities. The education facilities will open in early 2020
- At the same time, an exciting piece of work has begun to look at how Whittington Health will continue to improve the ways care is delivered in the future and how our buildings can support our staff to provide care to our patients. We are working alongside local boroughs, the Greater London Authority and other partners who will be key in helping us develop our plans
- The Trust will continue to provide care at both Whittington Hospital and from a number of locations in the community we serve but we want to meet the expectations people have to receive healthcare in modern facilities, near their homes and with the opportunity to use technology
- Our Integrated Clinical Service Units have already been feeding into discussions about what this might look like for each area and the project team will keep information on the intranet page updated and visit teams in some of our community locations next week

Haringey and Islington Wellbeing Partnership

2.22 There was a meeting of the Haringey and Islington Wellbeing Partnership this month. It was decided at this meeting that, given the progression of NCL as an integrated care system and the momentum towards borough level partnership boards, that the work of the Wellbeing Partnership needed to evolve into the next stage of the development of Borough Partnerships. The work done by the partnership around frailty, diabetes, integrated care etc. will continue through each Borough Partnership. There is a huge opportunity now to progress some of the locality work at pace in different ways to suit the different populations we serve. Whittington Health and our partners are now setting up separate partnership boards with the providers and commissioners in each borough and we look forward to continuing the collaborative approach to improving the integration of care with our local communities.

Staff excellence awards - Raegelle Sy, Cavell Ward Manager, and Ali Gungor, Housekeeping Team

2.23 This month there are two colleagues who will receive an award for displaying the Trust's excellence value:

2.24 The citation for Raegelle highlighted the fantastic job he is doing on Cavell ward. He stepped up into this post a few months ago at a time when there was a rapid turnover of patients and a high number of complex patients requiring high intensity nursing care – all in addition to the challenges of managing a recently reopened ward. Raegelle has done a remarkable job of picking up all the nuances of geriatric medicine and complex discharge planning. Junior doctors have given regular positive feedback that he has solved issues or diffused stressful situations, while being polite, cheerful and caring. His nomination noted that he works to anticipate problems, that nothing is too much effort and that he is role modelling and leading by example with great effect.

2.25 Ali received three nominations which said that he is so diligent, pleasant and hardworking and that he goes above and beyond what his job entails. They recognised how much pride Ali takes in his work and that he always looks for extra things to do each week. Staff in the Jenner Building commented that he is a lovely person to have around and a very hard worker. He is always friendly with a beaming smile on his face and is always willing to help and take on any requests.

Meeting title	**Trust Board – public meeting**	**Date: 29 May 2019**
Report title	**Trust Wellbeing Guardian**	**Agenda item: 8**
Executive director lead	Norma French, Director of Workforce	
Report author	Norma French, Director of Workforce	
Executive summary	This paper provides: • the Whittington Health Trust Board's response to the NHS Health & Wellbeing Framework, in particular, the appointment of a Wellbeing Guardian for the Trust and sets out specific recommendations for action; and • further assurance of the Board's commitment to enhancing the Trust's cultural agenda and details of the assigned specific responsibilities for Board members.	
Purpose:	Approval	
Recommendation(s)	The Board is asked to approve the recommendations as set out in section 4 of this paper	
Risk Register or Board Assurance Framework	People 1 - Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs (e.g. Nursing, junior doctors, medical posts) People 2 - That the culture of the organisation does not improve, and bullying and harassment continue, such that retention of staff is compromised and staff morale affected and ultimate patient care suffers as a result	
Report history	Trust Management Group, 28 May 2019	
Appendices	None	

NHS Health and Wellbeing Framework – Trust Wellbeing Guardian

1. Background

1.1 The "NHS Health and Wellbeing Framework" was published in 2018 by Health Education England and included recommendations that reference the importance of protecting and supporting the wellbeing of NHS staff and the people learning in NHS settings. Within the Framework each NHS organisation has been asked to establish a Wellbeing Guardian.

2. Health and Wellbeing at Whittington Health

2.1 The Trust has an established Staff Health and Wellbeing (H&WB) Group which oversees the implementation of the Trust's Health and Wellbeing strategy. This Group meets quarterly and is chaired by the Director of Workforce. It has staff representation from different work areas and services from across the Trust. Staff Side and trade union colleagues are also represented. The Group reports to the Workforce Assurance Committee (WAC).

2.2 The Director of Workforce reports staff sickness absence data monthly to the Trust Board and quarterly through the WAC. This data is combined with data on staff engagement and morale, on a regular basis, to allow managers to make the link between staff absence and general wellbeing. The H&WB strategy was approved by the WAC and is reviewed annually by the H&WB Group. The Trust Board continues to advocate that supportive leadership is critical for promoting individual and organisational health, performance and effectiveness and aims to model the culture it wants for the organisation and the way it wants staff and wellbeing to be valued.

3. NHS Health and Wellbeing Framework

3.1 There is clear evidence that Trusts with higher engagement levels have lower levels of sickness absence among staff, and also have lower spend on agency and bank staff. NHS leaders are encouraged to investigate the importance of nurturing positive, trusting cultures within which staff have high levels of wellbeing. There is a correlation between working environments where staff are more supported and wellbeing is good, and high quality patient care. It is essential that all NHS Trusts put staff health and wellbeing at the heart of their work, with a clearly identified board-level champion and senior management support. At Whittington Health, we are driving this agenda through our Culture Programme.

3.2 The Framework requests that there is a named Board member responsible for staff health and wellbeing planning and delivery. It also recommends that Board members actively promote health and wellbeing, and lead by example through visibly participating in interventions, health and wellbeing planning and setting the culture they want to see across the organisation.

4. Recommendations

4.1 It is recommended that:

i. The Trust Health & Wellbeing Group continues to drive implementation of the Trust's Health and Wellbeing strategy and continues to formally report to the Board through the Workforce Assurance Committee;

ii. All Board Directors actively promote health and wellbeing, and lead by example through visibly participating in interventions, health and wellbeing planning and setting the culture they want to see across the organisation;

iii. The Trust Health and Wellbeing Lead is the Director of Workforce, who has operational responsibility for Occupational Health & Wellbeing; and

iv. The named Board member responsible for staff health and wellbeing planning as Wellbeing Guardian is the Chief Executive Officer.

Meeting title	**Trust Board – public meeting**	**Date: 29 May 2019**
Report title	**Quality Assurance report: Care Quality Commission (CQC) compliance update**	**Agenda item: 9**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Patient Experience	
Report author	Kat Nolan-Cullen, Compliance and Quality Improvement Manager	
Executive summary	The Trust Board is presented with an update covering: • compliance with Care Quality Commission inspection recommendations and readiness; • good to Outstanding progress and preparation meetings and activity • the CQC's Mental Health Act (1983) monitoring visit at Simmons House	
Purpose:	Review	
Recommendation(s)	Board members are asked to: i. review the work undertaken to monitor the delivery of actions identified in previous inspections; ii. approve the preparation methodology; and iii. take assurance that there is appropriate attention and preparation ahead of any announced inspection.	
Risk Register or Board Assurance Framework	BAF entry 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.	
Report history	Quality Committee, 8 May 2019	
Appendices	None	

Quality Assurance report: Care Quality Commission (CQC) compliance update

1 Introduction

1.1 We are registered with the CQC without any conditions. The CQC's last targeted inspection of the organisation took place in October 2017 and was published in February 2018. The overall rating for the organisation remains as 'Good'. We are taking steps to prepare for the next targeted inspection which we expect to be undertaken in 2019 to ensure a 'business as usual' approach, and minimise disruption to services.

2 CQC improvement plan 2017/18

2.1 There were 34 recommended improvement actions from the CQC following the last inspection, from which the trust developed 52 specific actions. 45 of the actions have been addressed and seven remain in progress. These are now over their completion date, but are regularly reviewed and updated by the relevant Integrated Clinical Service Units (ICSUs) and are reviewed at the Trust's CQC steering group's meetings. There is a clear plan in place for the completion for each action. It is important to note that the immediate concerns raised by the inspection team have been responded to and addressed within the required timeframe.

2.2 Work is also in progress reviewing the 2016 inspection action plan and CQC reports to ensure that there is sustainability in the recommendations made following the last comprehensive inspection held 8-11 December 2015.

2.3 Nine further actions have been added following the identification of emerging issues from recent quality and estate walkabouts and service peer reviews.

3 Next inspection

3.1 The Trust's new relationship manager met with the Chief Nurse in April 2019 and described a slightly different approach to the CQC inspection process. The Trust can expect an unannounced or announced inspection within the year and it is likely to be a targeted inspection, similar to that of 2017 rather than the full inspection of 2015.

3.2 Prior to any announced inspection the Trust is expected to receive a Provider Information Request (PIR), twelve weeks ahead of inspection period. The Trust has not received any notification as of yet. In addition, notification of the annual announced well-led inspection has not yet been received.

3.3 The well-led and use of resources inspection are usually carried out annually and normally follow shortly after core services inspection. We have not been notified of any forthcoming inspections to date.

4 Improvement work – CQC 'Good to Outstanding' preparation

4.1 The trust wide CQC steering group has been meeting fortnightly with representation from each ICSU, estates, finance, human resources, corporate

and communications teams. From April 2019, the frequency of meetings will reduce from fortnightly to monthly with more time dedicated to supporting peer reviews and evidence gathering.

4.2 All 'core services', as defined by the CQC, have completed or are in the process of undertaking self-assessments of their services. This is led and monitored by the ICSU senior management teams. Action plans are being developed to address areas of concern highlighted in the self-assessments. The self-assessments and supporting action plans will be reviewed at ICSU quality boards and the steering group to help form the well-led evidence base, as well as support ICSUs with preparation.

4.3 Forty completed service self-assessments have been received from the ICSUs so far and there are 93 services still to finalise their self-assessments. The ICSUs have been tasked with ensuring these are completed in a timely manner.

4.4 Communications have launched the '**Better Never Stops Hub**' which has tools, tips, resources and advice available on the intranet to assist services in their journey to outstanding.

4.5 In addition, a communication campaign has begun to distribute messages across the Trust to support staff in improvement work and to provide key information for staff to help prepare for an inspection. This has included themes identified from other trusts which currently hold an outstanding rating. There will also be a focus on driving a culture of ownership, and what 'you' as an individual can do to improve care for the patient rather than 'the trust'.

4.6 Our Quality Assurance service peer reviews entitled '**Next Steps to Outstanding'** continue across the Trust and have increased to two per week. The peer review teams recently included two of our commissioners. Health Watch will also join reviews depending on their availability. Following the inspections, ward managers, matrons and associate directors of Nursing/Midwifery are provided with targeted improvement actions that will help to bring the ward or department up to outstanding when addressed. The trust quality governance team are providing support required in order to overcome barriers the may prevent the action from being completed.

4.7 A project is underway to provide every ward and community site with standardised noticeboards, which comprise clear information and monthly performance run charts for staff and patients on, staffing levels, you said: we did, falls/pressure ulcers (Pus) and infection rates etc.

4.8 Targeted walk rounds with estates and facilities have continued to look at the décor and general upkeep of the Trust remedial or urgent maintenance work. Prioritisation of this work is through agreement with the ICSU and quality governance team on whether the work is overdue maintenance work or specifically considered as CQC improvement work.

4.9 A ‘Dump the Junk’ week was held in March 2019 to clear clinical and office areas in the hospital of unwanted or broken furniture and equipment with a collection rota provided by Estates and Facilities. The week was not as successful as anticipated; however, there is committed support from Estates to continue repeat the event on a regular basis and to establish a similar process in community settings.

4.10 There is a reciprocal agreement with the North Middlesex University Hospital (NMUH) Trust to join mock inspections of each other’s organisation with the NMUH undertaken on the 28 February 2019, it has been agreed to reciprocate at Whittington Health once we have received our PIR.

5 CQC Mental Health Act 1983 monitoring visit at Simmons House

5.1 On the 27 February 2019 the CQC released a report ‘Monitoring the Mental Health Act’ (MHA) at Simmons House. They attended the Child and Adolescent Mental Health Services inpatient unit for an unannounced monitoring visit on the 7 March 2019.

5.2 The focus of the monitoring visit was in relation to compliance with the unit application of the Mental Health Act 1983 and the use of the Code of Practice. Their findings and feedback were provided to the organisation on the 13 March 2019.

5.3 The feedback was very positive. They noted further improvements had been made since they last reviewed the service in November 2017. The inspectors spoke very highly of the staff and patients they observed during their inspection. This was reflected in the CQC report.

5.4 There were only four recommendations made by the CQC inspectors, and no patient specific recommendations.

5.5 The recommendations included:

i. Ensuring that discussions of rights in relation to the MHA are completed and recorded with all detained patients in a timely manner. Ensuring that patients are reminded of their rights from time to time.
ii. Seeking and fully recording the views of patients in relation to their care and treatment.
iii. How the trust will adhere to the Code of Practice by making sure all young people have their capacity or competence to consent to admission and treatment accurately recorded in the notes.
iv. How the trust will adhere to the Code of Practice by ensuring that the treating clinician fully records any record of discussion or capacity assessment relating to the completion of a T2 certificate.

5.6 The Provider Action Statement was completed and submitted ahead of the CQC deadline. The majority of the actions have already been completed and there are realistic deadlines for the remaining. This will be monitored by the Children and Young People’s ICSU with support from the Quality Governance Team.

6 Other Assurance/External Peer Reviews

6.1 Islington Joint Area Targeted Inspection (JTAI) - Safeguarding school-aged children (focus on sexual abuse in the family home) conducted in November 2018. The formal response to this inspection was released on 29 January 2019 by the lead inspectors Ofsted.

6.2 The CYP ICSU is contributing to the delivery of a robust multiagency action plan to respond to the small number of health service related recommendations (will be monitored by ICSU and by the Local Safeguarding Board). Notably around the consistency of staff competence to identify risk around child sexual abuse in the family home. Improvements to interagency working around when to escalate concerns and staff to be confident to challenge other agencies when views differ. The final area was around ensuring that written information received from other agencies is uploaded onto Whittington Health RiO and Medway electronic patient record as appropriate.

6.3 An assurance peer review visit of the children and young people haemoglobinopathies service is due to be undertaken in June 2019.

7 Recommendations

7.1 Board members are asked to

i. review the work undertaken to monitor areas of actions identified in previous inspections;
ii. approve the preparation methodology; and
iii. take assurance that there is appropriate attention and preparation ahead of any announced inspection.

Meeting title	**Trust Board – public meeting**	**Date: 29 May 2019**
Report title	**Serious Incidents update – April 2019**	**Agenda item: 10**
Executive director lead	Julie Andrews, Acting Medical Director	
Report author	Jayne Osborne, Quality Assurance Officer and Serious Incident (SI) Co-ordinator	
Executive summary	This report provides an overview of serious incidents (SI) submitted externally via the Strategic Executive Information System (StEIS) during April 2019. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.	
Purpose:	Review	
Recommendation(s)	The Board is asked to recognise and discuss the assurances contained within this report demonstrating that the serious incident process is managed effectively, and that lessons learnt as a result of serious incident investigations are shared widely. The Board is invited to focus discussion on steps being taken to: • work within the Healthcare Safety Investigation Branch (HSIB) framework for relevant maternity incidents investigated by HSIB under the Each Baby Counts programme • investigate and learn from an information governance breach with implications for safeguarding • investigate and learn from a Never Event	
Risk Register or 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.	
Report history	Report presented at each public Board meeting	
Appendices	None	

Serious Incidents: April 2019 report

1. Introduction

1.1 This report provides an overview of serious incidents submitted externally via Strategic Executive Information System (StEIS) during April 2019. 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

2.1 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 Quality Governance 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 four serious incidents during April 2019, which is two less than were reported the same time last year.

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

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

The Healthcare Safety Investigation Branch (HSIB)

3.4 From 1 April 2018, HSIB became responsible for all patient safety investigations of maternity incidents occurring in the NHS that meet the criteria for the Each Baby Counts programme. HSIB conducts independent investigations of patient safety concerns in NHS-funded care across England and are funded by the Department of Health & Social Care and hosted by NHS Improvement. They operate independently and are also independent from regulatory bodies such as the Care Quality Commission (CQC).

3.5 The purpose of the programme is to achieve rapid learning and improvement in maternity services, and to identify common themes that offer opportunity for system-wide change. For these specific incidents the HSIB investigation replaces the trust local investigation, however, the trust remains responsible for Duty of Candour and for referring the incident to HSIB.

3.6 HSIB reports are provided directly to the families involved in these incidents and to the trust. The trust is responsible for taking forward all safety recommendations which are made as a result of these investigations.

3.7 The Trust currently has two investigations being undertaken by HSIB (references 30069 & 3556 in table below.

3.8 The table below details the Serious Incidents currently under investigation.

Category	Month declared	Summary
Unexpected admission to NICU Ref:30069	Dec 18	Baby born in poor condition at 38 weeks and two days gestation and required resuscitation and ventilation. The baby was transferred to the tertiary neonatal unit for total body cooling (HSIB Investigation).
Intrauterine Death Ref: 3556	Feb 19	A pregnant woman reporting reduced fetal movements attended the Maternity Assessment Unit (MAU). Following review no fetal heart rate could be located and fetal demise (intrauterine death) was confirmed on ultrasound scan (HSIB Investigation).
Maternal Death Ref: 5255	Mar 19	An 18 week pregnant woman brought in to Emergency Department (ED) via blue light ambulance in cardio-respiratory arrest having suffered a major haemorrhage; resuscitation attempts were unsuccessful and the woman died.
Pressure Ulcer Ref: 8029	April 19	A community patient developed two grade 3 pressure ulcers which became infected resulting in patient having to be admitted to hospital for further treatment.
Assault on staff Ref:8646	April 19	A mental health patient became agitated and tense and proceeded to randomly attack staff in the ED department.
Ref:9259	April 19	A patient who had recurrent breast cancer after two breast conserving surgery and radiotherapy treatments, required further surgical intervention (mastectomy). An agreed different procedure was carried out resulting in the patient having to return for a third surgical operation.
Pressure Ulcer Ref:9470	April 19	A community patient developed multiple pressure ulcers and sepsis resulting in patient having to be admitted to hospital.

3.9 The table below details serious incidents by category reported to the NELCSU between April 2018 and March 2019:

SI 2018-19 Category	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total
Apparent/actual/suspected self-inflicted harm	0	0	0	0	0	0	0	1	0	0	0	0	1
Confidential information leak/information	0	0	0	0	0	0	0	0	0	0	0	0	0
Diagnostic Incident including delay	2	0	1	0	0	0	0	0	0	1	0	0	4
Disruptive/ aggressive/ violent behaviour	0	2	0	1	1	1	2	0	0	0	0	0	7
Environment Incident meeting SI criteria	0	0	1	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	0
HCAI/Infection control incident meeting SI	0	0	0	0	0	0	0	0	0	0	0	0	0
Maternity/Obstetric incident mother and baby	0	0	0	0	0	0	0	0	0	0	0	0	0
Maternity/Obstetric incident mother only	2	2	0	0	0	1	0	1	1	0	1	0	8
Medical equipment/devices/ disposables	0	0	0	0	0	0	0	0	0	0	0	0	0
Medication Incident	0	0	0	0	0	0	0	0	0	0	0	0	0
Nasogastric tube	0	0	1	0	0	0	0	0	0	0	0	0	1
Pressure ulcer meeting SI criteria	0	0	0	0	0	0	0	0	0	0	0	0	0
Slip/Trips/Falls	0	0	0	0	0	0	0	0	0	0	0	1	1
Sub Optimal Care	1	0	0	0	0	0	0	1	0	0	0	0	2
Surgical/invasive procedure incident meeting	1	0	0	0	0	0	0	0	0	0	0	0	1
Treatment Delay	0	1	0	0	0	0	0	0	1	0	0	0	2
Unexpected death	0	2	0	0	0	0	0	0	0	0	0	0	2
Retained foreign object	0	1	0	0	0	0	0	1	0	0	0	0	2
HCAI\Infection Control Incident	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**6**	**8**	**3**	1	**1**	**2**	**2**	**4**	**2**	**1**	**1**	**1**	**32**

3.10 The table below details serious incidents by category reported to the NELCSU between April 2016 and April 2019:

SI 2019-20 Category	2016/17 Total	2017/18 Total	2018/19 Total		Apr 19	Total 19/20 ytd
Safeguarding	5	1	1		0	0
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	0	0		0	0
Confidential information leak/information governance breach	6	3	4		0	0
Diagnostic Incident including delay	8	7	7		1	1
Disruptive/ aggressive/ violent behaviour	0	1	1		1	1
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	0	3	0		0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7	2	8		0	0
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	1		0	0
Nasogastric tube	1	0	0		0	0
Pressure ulcer meeting SI criteria	0	0	1		2	2
Slip/Trips/Falls	7	6	2		0	0
Sub Optimal Care	4	2	1		0	0
Surgical/invasive procedure incident meeting SI criteria	0	0	2		0	0

Treatment Delay	3	4	2		0	0
Unexpected death	10	4	2		0	0
Retained foreign object	1	1	0		0	0
HCAI\Infection Control Incident	0	1	0		0	0
Total	**58**	**38**	**32**		**4**	**4**

4. Submission of Serious Incident reports

4.1 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.

4.2 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.

4.3 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.

4.4 The Trust has executed its duties under the Duty of Candour for the investigations completed and submitted in April 2019.

4.5 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, 'message of the week' in Maternity and EIM, and '10@10' in the 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.

5. The Trust submitted two reports to NELCSU during April 2019

5.1 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.

Summary	Actions taken as result of lessons learnt include;
Ref: 29134	**The administration of an inter-scalene nerve block on the wrong side – Never Event** • To ensure all staff aware of the wrong sided block, the 'Stop Before You Block Process' is being embedded into clinical practice. Labels are being used to enable staff to document the performance of the 'Stop Before You Block' and an audit of this process is being undertaken to ensure compliance • A meeting was held with theatre staff (Anesthetists, Anesthetic nurses and ODP's to discuss this incident and the lessons learned.

Summary	Actions taken as result of lessons learnt include;
	• Several reminders have been sent to all Anesthetists, Anesthetic Nurses and ODP's reiterating the use of 'Stop Before You Block'. • The wrong-sided block is to be one of the items on the 'Big 4', a weekly message containing the 4 most important things that colleagues need to know about within the theatre complex.
Ref.2062	**Information Governance Breach** Confidential patient information was changed on the Trust electronic system and the patient's contact number given to an estranged family member although a safeguarding alert was present. • Additional local training sessions have been arranged for the Access Centre staff focussing on Alerts and information Governance. • A written call script has been produced for all the access centre staff which includes security questions and escalation when fail to answer. • A local escalation plan has been developed regarding persistent callers and shared with all the Access staff to inform staff how and when to escalate. • The learning from this incident will be shared across the trust via trust wide communication to ensure all staff are aware of the processes and procedures to follow when experiencing persistent requests/callers. • As a result of this incident and feedback from staff it has been identified that the format of the mandatory training workbook does not relate specifically to the work within the Access department as such the IG department have developed an annual IG bespoke training to give staff the chance to talk about specific issues relevant to local practice and activity.

6. Shared learning

6.1 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; for example, learning from a community SI where a patient experienced burns following the use of an emollient cream and an information governance serious incident.

6.2 Themes from serious incidents are captured in quarterly aggregated learning reports along with an annual review, outlining areas of good practice and areas for improvement and trust wide learning. Safety and Quality Board Reports 2018/19

have focussed on the progress the trust has made against its Quality Account Priorities for 2018/19, of which one of the three priority areas is patient safety.

6.3 We are continuing to review and improve how we share our learning from all incidents, near misses and SIs to ensure we mitigate against future risks and fully embed actions and learning.

Meeting title	**Trust Board – public meeting**	**Date: 29 May 2019**
Report title	**2018/19 Quality Account**	**Agenda item: 11**
Executive director lead	Michelle Johnson, Chief Nurse and Director of Patient Experience	
Report author	Kat Nolan-Cullen, Compliance and Quality Improvement Manager	

Executive summary	**Background**
	NHS Providers are required to publish a Quality Account annually which must meet the requirements set annually by NHS Improvement by containing:
	• A statement of quality from the Chief Executive *(final version is agreed once approval from Committee)*
	• Statements of assurance from the Board around:
	  ○ Patient experience
	  ○ Clinical effectiveness
	  ○ Patient safety
	• Statements from external bodies
	• Priorities for improvement
	
	Board members are presented with the 2018/19 Quality Account for Whittington Health. It contains progress against the quality priorities set for 2017/2018 and includes the priorities set for the coming financial year.
	
	Patients and their families want to know they are receiving the very best quality of care from Whittington Health. The Quality Account helps providers to improve public accountability for the quality of care they provide.
	
	NHS Improvement asked providers to take heed of two additional considerations for quality accounts this year: first, providers of acute services are asked to include a statement regarding progress in implementing the priority clinical standards for seven day hospital services; and secondly, to include details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment.
	
	The following pieces of data and information are still required in relation to final quarter data and will be included in the final published version:	

	• Quarter four – Commissioning for Quality and Innovation (CQUIN) information, learning from deaths • KPMG audit data – Venous thromboembolism (VTE) assessment and Clostridium difficile healthcare-acquired infection • Statements from CCG and Health Watch • Final signatures
Purpose:	Approval
Recommendation(s)	The Board is asked to: i. review and approve the 2018/19 Quality Account for submission to NHS Improvement by the 28 June 2019; and ii. agree delegated authority for the Chief Executive, Chairman and Chief Nurse to agree the final version for submission and inclusion on the Trust's webpages.
Risk Register or Board Assurance Framework	Aligns with BAF Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.
Report history	2019/20 Quality priorities were agreed by the Trust Management Group on 23 April 2019 and the draft 2018/19 quality account was reviewed by the Quality Committee on 8 May 2019 and was also presented to the Audit and Risk Committee on 16 May 2019.
Appendices	Appendix one – 2018/19 Quality Account

Appendix one

Quality Account 2018/19

Contents

Part 1: Statement on Quality from the Chief Executive

Welcome to the 2018/19 Quality Account for Whittington Health NHS Trust. Here, we outline how we performed on quality last year and set out our priorities for 2019/20. All of our priorities are produced in consultation with clinical staff, managers, patients and external stakeholders and I would like to thank them for taking the time to contribute to this process.

I am pleased to report that we successfully met 25 out of the 30 priorities we set ourselves for 2018/19. Particular highlights include improvements in District Nursing continuity of care, no avoidable grade 4 pressure ulcers in the hospital and more people with learning disabilities being involved in trust activities. We also increased the number of patients recruited to research studies, contributing to future clinical improvements, and significantly improved the response rate for the Friends and Family Test in podiatry, maternity and outpatients, helping us to learn more about the care and treatment we provide and where it can be improved.

We set ourselves stretching targets last year, so there were areas where more progress was needed and these will continue to be priorities for this year. These include reducing the number of outpatient clinic cancellations, seeing more patients with an autism spectrum condition or learning disability who come to our Emergency Department within 2 hours and completing more medicine safety reviews for grade 3 Acute Kidney Injury patients within 24 hours.

Other highlights of the year include

- The 2018 CQC Maternity Survey showed that 100% of women said they were treated with respect and dignity, 98% had confidence and trust in staff, and 96% felt involved enough in decisions about their care
- Our Improving Access to Psychological Therapies (IAPT) service in Haringey received Centre of Excellence status for Employment Support – the first and only IAPT service in the country to receive this
- We implemented the updated National Early Warning Score 2 (NEWS2) system
- CareFlow Vitals, a new system for electronically recording patient observations, was rolled out across our hospital wards
- Colette Datt, a Nurse Consultant in Children and Young People's services, took home the Nurse Leader of the Year Award at the 2018 Nursing Times Awards
- Our haematology team were 'Highly Commended' for their work to prevent patients from developing dangerous blood clots at the Anticoagulation Achievement Awards
- We had the third highest uptake of the flu vaccine by our staff across London at 83.4%
- More staff than ever before took part in the annual staff survey – 48% nearly 2,000 members of staff

- We led the way in educating people in and celebrating the services we have to support older people and provide the right care and treatment at an event for staff at Whittington Health as well as other local NHS, public and voluntary sector organisations involved in caring for older people

These are all the more impressive when we consider that they were achieved against a backdrop of increased demand in our services. We saw 108,640 people – a 6.7% rise compared to the previous year – attending to our Emergency Department (ED) throughout 2018/19. However, we provided many of these individuals with same-day care or treatment, meaning that the proportion of people who needed to be admitted to a hospital bed from our ED is actually coming down. These improvements, despite rising demand, are a testament to the hard work of our staff.

I am proud to say that the number of clinical audits we participated in went up last year. These audits, whether mandatory or not, are not only vital in helping us to continually improve the care and treatment that we offer, but also contribute to findings across the NHS to identify success or areas for action or further investigation. We took part in a total of 88 national clinical audits, national confidential enquiries and non-mandatory national audits in 2018/19.

Our 28 priorities for the coming year have been developed to reflect the needs of our patients and local community and will contribute to Whittington Health leading the way in the provision of excellent integrated community and hospital services. As part of this process, we have considered previous successes and challenges, looked at our new Strategy for 2019-2024 and engaged with staff, patients and stakeholders. 20 of them are new – 8 have been retained from last year because we believe that there is more to do or they are of particularly high importance. These form the basis of our focus on quality this year and will help us to achieve our ambition to become one of the leading NHS health care trusts. I look forward to reporting on our achievements and setting out how we will go even further to improve quality next year.

I confirm that this Quality Account will be discussed at the Trust Board, and I declare that to the best of my knowledge the information contained in this Quality Account is accurate.

tbc

Siobhan Harrington, Chief Executive

Part 2: Priorities for Improvement and Statements of Assurance from the Board

As an integrated care organisation (ICO) with community and hospital services across Islington, Haringey and further, Whittington Health is in a unique position to deliver the strategic objectives of the North Central London (NCL) emerging and integrated care system that is, working in an integrated and collaborative way to provide high quality health and social care for our local population.

Our Trust's vision, embedded within our clinical strategy and quality account, is to 'help local people live longer, healthier lives'. A key strategic goal is to deliver the right care, at the right time, and at the right place for our patients. This is underpinned by the six strategic objectives for 2018-19 which are:

1. **Secure the best possible health and wellbeing for all our community**
2. **Integrate and coordinate care in person-centred teams**
3. **Deliver consistent, high quality, safe services**
4. **Support our patients and users in being active partners in their care**
5. **Be recognised as a leader in the fields of medical and multi-professional education, and population based clinical research**
6. **Innovate and continuously improve the quality of our services to deliver the best outcomes for our local population.**

The Trust strategic objectives have been revised for 2019-20 and the priorities for the next year have been aligned with the new four shared objectives:-

- **Deliver outstanding, safe and compassionate care in partnerships with patients.**
- **Empower support and develop engaged staff.**
- **Integrate care with partners and promote health and well-being.**
- **Transform and develop financially sustainable innovative services.**

Priorities for improvement 2019/20

This section of the Quality Account is forward looking and details the quality priorities that the Trust has agreed for 2019/20. The rationale for including these priorities is based on factors such as data from the previous year, clinical or public request, and an ambition to be a leading Health Care Trust.

Our quality priorities for 2019/20 are aligned to the Trust's commitment to helping local people live longer, healthier lives. A number of areas chosen as quality

improvement priorities last year have been retained for the forthcoming year for one of three reasons:

- the 2018/19 targets were not met,
- we have made significant improvements in certain areas and wish to continue this progress,
- we consider certain areas as highly important to the trust.

We have also introduced new priorities that we believe are important to our patients and the community that we serve.

Our consultation process

Our quality priorities have been developed following consultation with staff and stakeholders and are based on both national and local priority areas.

We have utilised a range of data and information, such as learning from serious incidents, reviews of mortality and harm, complaints, claims, clinical audits, patient and staff experience surveys, and best practice guidance from sources such as the National Institute for Health and Care Excellence (NICE) and national audit data, to help establish what our 2019/20 priorities should be.

As part of our consultation process, external stakeholders, patients, and staff have been invited to share their views on our proposed quality priorities. A meeting was held with Health Watch Islington and Haringey in February 2019 to review and hear feedback to consider the priorities for our local population.

Further to this, each priority has been refined and agreed by clinicians and managers who will have direct ownership and approved at the relevant Trust committees. The quality account, including the 2019/20 priorities, have been shared with our commissioners and external auditors, whose comments can be seen within the appendices.

Priority 1: Improving Patient Experience

Our Patient Experience Quality Priorities for 2019/20 are below. Progress against these priorities is monitored at the patient experience committee and escalated to the quality committee as necessary. Performance information will be provided for key performance reports, integrated CSU dashboard reports and deep dives.

Domain	Rationale	Actions
Communication (Trust wide)	Improve the quality of information available to patients and families - This has been highlighted by Health Watch and is a top theme and area	1. We will continue with our trust wide review of patient information quality and availability and aim to improve information in accessible formats. 167 leaflets were reviewed and updated in 2018/19
		2. Explore better use of media and photo based patient information

Domain	Rationale	Actions
	of learning from PALS/complaints.	3. Review signage at the Trust site to ensure that the information provided in letters for appointments matches with the signage directing patients to appointments. (This is in response to concerns raised in the Health Watch 'Enter and View visit' report for imaging, fracture and antenatal clinics)
		4. Review noticeboards in 75% of Trust and community settings. Aim to standardise information available to patients and staff, to improve and build on the 'You said, We did' programme work started in 2018/19.
Patient Satisfaction (Hospital only)	Increase Patient Friends and Family Test (FFT) response in the Emergency Department	1. Increase the FFT completion rate to 15% -Overall completion rate for ED remains low at 13% for 18/19
		2. Increase the FFT rate of patients recommending treatment in ED to 86% (National average) - Overall recommend rate for 18/19 was 82%
Patient Feedback (Trust wide)	Develop a central catalogue of patient stories and empower staff and families to assist with the process	1. Increase the number of patient stories presented at Trust board, sub board committees and Integrated clinical service units (ICSU) boards to 24 in 2019/2020
		2. Have 10 patients physically attend to present their patient story in 2019/2020.
Volunteering (Community)	Expand the volunteering team to assist with community services to support patients at home.	1. Aim is to approve the volunteer strategy and develop specialised volunteer roles. Introduce 5 cohorts of volunteers supporting patients alongside Trust staff at community sites and in patient homes. Ensuring volunteers receive the same level of training as lone workers and safeguards are in place as lone workers.

Priority 2: Improving Patient Safety

Our Patient Safety Quality Priorities for 2019/20 are below. Progress against these priorities is monitored at the patient safety committee and escalated to the quality committee as required.

Domain	Rationale	Actions
Falls (Hospital)	National and local priority, learning from serious	1. We will increase compliance with our STOPfalls bundle to 85% on our adult inpatient wards

Domain	Rationale	Actions
	incidents, building on improvement work in 2018/19. Further work planned for 2019 to increase compliance. Falls CQUIN for the Trust in 2019/2020	2. Reduce the number of falls per 1000 bed days to 2.5 (18-19 total was 2.8)
		3. Reduce the number of falls resulting in severe harm or death by 25% compared to 2018/2019
Patient Safety Incidents (Trust wide)	Recent NRLS report has shown the Trust data quality and number of patient safety incidents reported could be improved.	1. Increase the number of 'Near miss/ good catch' patient safety incidents reported on Datix for 2019/2020 compared to 2018/2019
		2. Increase the overall number of incidents reported by 5% compared to 2018/19 (2018/19 total reported incidents 6754)
Acute Kidney Injury (Hospital)	National and local priority, target not achieved in 2018/19, ongoing priority for the trust	1. We will increase our medicine safety reviews for grade 3 AKI patients within 24 hours from 53% to 75% by March 2020
Pressure Ulcers (Trust wide)	National and local priority, learning from incidents and complaints, target not achieved in 2018/19, trust KPI	1. We will reduce the number of avoidable grade 4 pressure ulcers by 10% in Trust and community areas
		2. We will reduce the number of avoidable grade 3 pressure ulcers by 10% in Trust and community areas
		3. Improve the governance and oversight arrangements for investigating pressure ulcers to ensure appropriate investigation takes place in a timely manner.
Care of Older People (Trust wide)	Care of patients with dementia highlighted by Health Watch as a priority area, national audit data, national campaign, learning from incidents	1. We will promote John's campaign – '*for the right to stay with people with dementia'* – whilst patients with dementia our in our care
		2. All patients have a Rockwood Frailty Score and Comprehensive Geriatric Assessments completed on admission. We have a clearly defined Frailty Pathway and MDT approach in place.
		3. GPs are using EFI (Electronic Frailty Index) with EMIS; some of the Community Teams are using Rockwood Clinical Frailty Scale or Prisma 7.
Learning Disabilities and / or Autism	Improving experiences and increasing staff awareness of	1. Within our emergency department we will see 75% of patients with an autism spectrum condition or a learning disability in under two hours

Domain	Rationale	Actions
(Trust wide)	patients with LD and autism a priority for the trust and highlighted by Health Watch	2. Develop mandatory LD and Autism awareness training for all staff
		3. Develop a suite of learning resources to support staff, patients and families with LD and Autism
Mental Health (Hospital)	Experience of people with mental health in ED highlighted as an area for improvement by CQC at our 2015 inspection	1. Reduce the number of ED patients with mental health needs waiting over 24 hours for a mental health bed.

Priority 3: Improving Clinical Effectiveness

Our Efficiency, Research and Education Quality Priorities for 2019/20 are below. Progress against the patient flow action is monitored through ICSU performance and trust performance reports, clinical research and education are monitored by their respective committees reporting to Quality Committee, Workforce Assurance Committee and Trust Management Group.

Priority	Rationale	Actions
Development and Training roles within clinical workforce (Trust wide)	The Nursing Associate role is a new support role that sits alongside existing healthcare support workers and fully qualified registered nurses to deliver hands on care for patients.	1. Ensure an adequate number of vacant positions available for nurse associate graduates
	Clinical Workforce development and training is paramount to the Trust. A highly skilled and trained workforce provides better quality care	2. We will strengthen our work on development and leadership and in particular the development of our BAME staff through mentoring programmes.
Clinical Research (Trust wide)	Clinical research is how we develop new treatments and knowledge for better health and care,	1. Maintain the number of specialties participating in research.
		2. Develop a greater paediatric research portfolio.

Priority	Rationale	Actions
	building the evidence for new approaches that are safe and effective.	
Multi-Disciplinary Research (Trust wide)	Clinical research is how we develop new treatments and knowledge for better health and care, building the evidence for new approaches that are safe and effective.	1. Raise the profile of research with clinical teams so that it can become embedded in patient care.
Reducing 28 Day readmissions (Hospital)	28 day readmissions are an issue for the Trust. We want to ensure our patients are appropriately treated prior to discharge and the relevant safety netting procedures are in place to reduce 28 day re admissions to hospital	1. Increase utilisation of 'Hospital at home' service and 'Virtual Ward' to aid in expediting safe discharges but also in reducing the numbers of patients requiring potential readmission within 28 days of discharge. 28 day re admission rates to be monitored.
		2. Improve the quality and timeliness of discharge summaries being sent to GP's and primary care.
Staff wellbeing and engagement (Trust wide)	The most recent national staff survey results indicate that Bullying and harassment is still a cause for concern to the Trust. We aim to hold more inclusion and wellbeing events for staff to ensure a happy, motivated, effective workforce.	1. Improve culture at work for staff by ensuring there are bimonthly engagement / social events.
		2. Ensuring leaders and senior managers adopt a more robust and purposeful leadership style to support colleagues and tackle issues in timely and well-ordered fashion. Create a culture of openness where people feel comfortable raising concerns - Raise trust awareness about the role of "The Freedom to Speak Up Guardian". Ensure we act and deliver care meeting our Trust Core Values.
Integrated Multiprofessional Education (Trust wide)	Education and training of staff to create a workforce that is dedicated, motivated and trained to the highest standards to provide excellent quality medical care	1. Develop new innovative placements for our Medical, AHP, Nursing and Midwifery students, focusing on driving the quality of the experience for both the student and the practice area. Increase placements by 5%
		2. Developing individualised learning experiences for our undergraduate workforce. Success to be measured using Student survey / feedback

Priority	Rationale	Actions
	for all patients.	3. Increase the delivery of MDT training for post registration placements by 10%
		4. Develop and implement a 'Learning from excellence' tool to enable staff to receive positive feedback to colleagues in relation to excellence at work.
Learning from National Audits and Compliance with NICE guidance (Trust wide)	To ensure that we provide adequate assurance on learning from National Audits and the implementation of the NICE Guidance and standards	1. Review of the governance and reporting framework from teams to quality committee

Statements of Assurance from the Board

The Trust provides statements of assurance to the Trust Board in relation to:

- Modern slavery
- Safeguarding children and young people
- Mixed gender hospital accommodation

Modern Slavery Act

It is our aim to provide care and services that are appropriate and sensitive to all. We always ensure that our services promote equality of opportunity, equality of access, and are non-discriminatory. We are proud of our place in the local community and are keen to embrace the many cultures and traditions that make it so diverse. The diversity of this community is reflected in the ethnic and cultural mix of our staff. By mirroring the diversity that surrounds us, our staff are better placed to understand and provide for the cultural and spiritual needs of patients. In accordance with the Modern Slavery Act 2015, the Trust has made a statement on its website regarding the steps taken to ensure that slavery and human trafficking are not taking place in any part of its own business or any of its supply chains.

Safeguarding Children and Young People

Whittington Health NHS Trust (WH) is committed to achieving and maintaining compliance with national safeguarding children standards and guidance to ensure that children and young people are cared for in a safe, secure and caring environment. The WH Safeguarding Children team works closely with the Safeguarding Adults lead to ensure a 'joined up' approach exists to safeguard the entire population the Trust serves. This includes fully embedding strategies linked to

protection from domestic abuse, child sexual exploitation and adhering to the PREVENT strategy in protecting vulnerable groups from radicalisation.

Safeguarding and promoting the welfare of children is of paramount importance to the organisation. The welfare of children is embedded across every part of the Trust and in every aspect of our work. The Trust has clear controls and arrangements in place through regular audit, review and quality improvement led by skilled and competent named professionals, supported and challenged by the Trust Board and Clinical Commissioning Groups.

Whittington Health is an active member of three local Local Safeguarding Children Boards in Haringey, Hackney and Islington. Local Safeguarding Board Section 11 audits into safeguarding compliance across the Trust are completed, as required.

Mixed Gender Hospital Accommodation

To ensure that we met national reporting requirements in relation to mixed sex/gender accommodation, we revised our reporting of mixed gender accommodation breaches in the hospital for patients who were well enough to step down care from intensive care. This meant that we experienced incidents of mixed gender accommodation for a short number of hours for some patients. The initial reporting was significant with the first few months of 2018/19 reporting between 5-7 breaches each month. This reduced over quarter two and three then as winter progressed there were a small number of accommodation breaches. This was due to bed capacity issues within the Trust where there was no medical bed available; however, privacy and dignity were maintained at all times and patients were informed and comfortable.

Sub Contracted Services

Whittington Health provided 150 different types of health service lines (61 acute and 89 community services) in 2018/19. Of these services the following were subcontracted:

Organisation details	Service details
Barts Health NHS trust	Service and development support for immunology/allergy
Camden and Islington NHS foundation trust	Mental health services, ILAT , mental health lounge contract and psychological service
UCLH foundation trust	South Hub TB resources
UCLH foundation trust	ENT services

The Royal Free London NHS foundation trust	Provision of PET/CT Scans
The Royal Free London NHS foundation trust	Ophthalmology services
Middlesex University	Provision of Moving and Handling Training Sessions
GP subcontractors – Medical practices Morris House Somerset Gardens Tynemouth road	Primary care anticoagulation service for Haringey CCG
Whittington Pharmacy CIC	Provision of pharmacy services
WISH Health Ltd A network of 8 local practices – four in north Islington and four in west Haringey	Primary care services to the urgent care centre at the Whittington hospital

The Trust has reviewed all data available to them on the quality of care in these relevant health services through the quarterly performance review of the ICSU and contract management processes.

The income generated by the relevant health services reviewed in 2018-19 represents 100% of the total income generated from the provision of relevant health services that Whittington Health provides.

Participation in Clinical Audits 2018-2019

During **2018/19**, **62** national clinical audits including **7** national confidential enquiries covered relevant health services that Whittington Health provides.

During that period, Whittington Health participated in **100% of** relevant national clinical audits and **100%** of national confidential enquiries.

The national clinical audits and national confidential enquiries that Whittington Health was eligible to participate in, and participated in, during 2018/19 are listed below. This includes the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title of audit	Management body	Participated in 2018/19	If completed, number of records submitted (as total or % if requirement set)
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	✓	11 cases

Case Mix Programme (CMP) - Intensive Care Audit	Intensive Care National Audit & Research Centre	✓	625 cases
Elective Surgery (National PROMs Programme)	NHS Digital	✓	185 cases
Falls and Fragility Fractures Audit programme (FFFAP) – Inpatient Falls	Royal College of Physicians of London	✓	Organisational Questionnaire submitted. Data collection commenced Jan 2019 – 1 case
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Royal College of Physicians of London	✓	116 cases
Inflammatory Bowel Disease (IBD) programme / IBD Registry	IBD Registry Limited	✓	109 cases
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol's Norah Fry Centre for Disability Studies	✓	7 cases
Major Trauma Audit	Trauma Audit & Research Network	✓	128 cases 68% case ascertainment
Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research	✓	92 cases
National Audit of Breast Cancer in Older People	Royal College of Surgeons	✓	68 cases
National Audit of Intermediate Care	NHS Benchmarking Network	✓	185 cases
National Bariatric Surgery Registry	British Obesity and Metabolic Surgery Society	✓	130 cases
Bowel Cancer (NBOCAP)	NHS Digital	✓	64 cases
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre	✓	41 cases
National Diabetes Audit - Adults - National Diabetes Foot Care Audit	NHS Digital	✓	44 cases
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDIA)	NHS Digital	✓	Submitted Organisational questionnaire as required
National Diabetes Audit - Adults - National Diabetes Harms Audit (NaDIA)	NHS Digital	✓	2 cases

National Diabetes Audit - Adults - National Core Diabetes Audit	NHS Digital	✓	2130 cases
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	NHS Digital	✓	36 cases 86% case ascertainment rate as 5 patients moved out of area
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	✓	103 cases
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	✓	126 cases
National Joint Registry (NJR) - Knee and Hip replacements.	Healthcare Quality Improvement Partnership	✓	Ongoing
National Lung Cancer Audit (NLCA)	Royal College of Physicians	✓	104 cases
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	✓	3485 cases
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	✓	456 cases
National Oesophago-gastric Cancer (NAOGC)	NHS Digital	✓	21 cases
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	✓	Ongoing 2018/19 data to be submitted by 31 May 2019. 111 cases recorded locally as at March 2019
National Prostate Cancer Audit	Royal College of Surgeons	✓	92 cases
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	✓	137 cases 88% case ascertainment rate as 17 cases not included
Feverish Children (care in Emergency Departments)	Royal College of Emergency Medicine	✓	132 cases
Vital Signs in Adults (care in emergency departments)	Royal College of Emergency Medicine	✓	126 cases
VTE risk in lower limb immobilisation (care in emergency departments)	Royal College of Emergency Medicine	✓	131 cases
National Adult Community Acquired Pneumonia Audit	British Thoracic Society	✓	Ongoing Project: 1.12.18 - 31.5.19
Non-Invasive Ventilation	British Thoracic Society	✓	Ongoing Project: 1.2.19 – 30.6.19

Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Public Health England	✓	35 cases
National Audit of Dementia - care in general hospitals	Royal College of Psychiatrists	✓	50 cases
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Royal College of Paediatrics & Child Health	✓	43 cases
National Comparative Audit of Blood Transfusion programme: Management of Massive Haemorrhage	NHS Blood and Transplant	✓	5 cases
National Early Inflammatory Arthritis Audit	British Society for Rheumatology	✓	309 cases
National Cardiac Rehabilitation Audit	University of York	✓	419 cases
Reducing the impact of Serious infections (antimicrobial resistance and sepsis) - antibiotic consumption	Public Health England	✓	On going reviews the number of antibiotics dispensed per 1,000 admissions. Data submitted quarterly to PHE
Reducing the impact of Serious infections (antimicrobial resistance and sepsis) - antimicrobial stewardship	Public Health England	✓	On going 30 patients diagnosed with sepsis randomly selected each quarter
Surgical Site Infection Surveillance Service	Public Health England	✓	On going no infections occurred
Seven Day Services Self-Assessment Survey	NHS England	✓	138 cases
National Audit of Care at the End of Life	NHS Benchmarking Network	✓	27 cases

Maternal, Newborn and Infant Clinical Outcome Review Programme data on 21 cases were submitted to MBRRACE-UK who allocate to the appropriate work stream			
Perinatal Mortality Surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Perinatal morbidity and mortality confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Maternal Mortality surveillance and mortality confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Maternal confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing

Medical, Surgical and Child Health Clinical Outcome Review Programme			
Young People's Mental Health	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3 cases

Long-term Ventilation in children, young people and young adults	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	On going
Acute Heart Failure	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3 cases
Cancer in Children, Teens and Young Adults	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	No applicable cases. Organisational questionnaire submitted
Perioperative Diabetes	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	4 cases
Pulmonary Embolism	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3 cases
Acute Bowel Obstruction	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	On going 1 case submitted

Mental Health Clinical Outcome Review Programme			
Suicide, Homicide & Sudden Unexplained Death	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	If cases identified to WH then participate - none to date
The Assessment of Risk and Safety in Mental Health Services	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	

National Asthma and Chronic Obstructive Pulmonary Disease Audit programme			
Asthma Paediatric in Secondary Care	Royal College of Physicians	✓	Commences June 2019
Pulmonary rehabilitation	Royal College of Physicians	✓	Commenced March 2019
COPD in Secondary Care	Royal College of Physicians	✓	108 cases
Adult Asthma in Secondary Care	Royal College of Physicians	✓	24 cases

Additional (non-mandatory) National Audits undertaken during 2018/19

Title of audit	Management Body	Participated in 2018/19	Status
National study of HIV in Pregnancy and Childhood	NSHPC	✓	On going
BLISS Family Friendly audit	BLISS Charter	✓	completed
IMAGINE: Ileus MAnaGement INtErnational An international, observational study of postoperative ileus and provision of management after colorectal surgery	EuroSurg Collaborative	✓	completed
National clinical audit on the management of bullous pemphigoid	British Association of Dermatologists	✓	completed
PELOTS Paediatric Evaluation of the London Major Trauma System	London Major Trauma System	✓	completed
The Ricochet Study	British Society for Gastroenterology, Birmingham Clinical Trials Unit, Pancreatic Cancer UK, WM Research Collaborative	✓	completed
RCR national audit of radiology involvement in cancer multidisciplinary team meetings	Royal College of Radiology	✓	completed
United Kingdom Obstetric Surveillance System – national audits of rare conditions of pregnancy	UKOSS National Perinatal Epidemiology Unit	✓	On going
Each Baby Counts & NHS Resolution	Royal College of Obstetricians and Gynaecologists	✓	On going
Community Services Benchmarking Project 2018	NHS Benchmarking Network	✓	Completed
Compliance with the BSH guidance for the management of acute chest syndrome in sickle cell disease	NHS England, CQUIN	✓	completed
National Lung Cancer Audit (NLCA) Spotlight Audit	Royal College of Physicians	✓	completed
Acute management of ankle fractures (AUGMENT)	British Orthopaedic Foot & Ankle Society	✓	completed
NAMM - National audit of meningitis management	Royal Liverpool University based on UK Joint Specialist Society Guidelines	✓	completed
Fever in returning Traveller	Collaborative audit of North London Hospitals	✓	On going
Antimicrobial prophylaxis for surgical patients national audit	Collaborative audit with Barts Health NHS Trust	✓	Completed

NCL improving access to Diabetes Inpatient Specialist Nursing	NHS England Diabetes Transformation Fund Project	✓	On going
Respiratory Complications after Abdominal Surgery (RECON)	STARSurg Collaborative	✓	Completed
National Mortality Case Record Review Programme	Royal College of Physicians	✓	On going

Whittington Health intends to continue to improve the processes for monitoring the recommendations of National Audits and Confidential Enquires in **2019/20** by ensuring:

- National audit and national confidential enquiries will remain the key component of our Integrated Clinical Service Unit (ICSU) Clinical Audit and Effectiveness programmes;
- Performance outcomes will be discussed appropriately, with multidisciplinary focus where possible and cascaded to all staff grades;
- Collaborative clinical and managerial leadership will remain optimal in order to ensure national project completion and reflection;
- There will be continued emphasis upon learning from excellence;
- A clinical audit patient ambassador role is to be considered and patient/carer representation in national clinical audit is to be prioritised;
- Multidisciplinary quality governance sessions will continue to include reflective learning on national clinical audit findings;
- In-house clinical audit workshops will continue to provide practical support to staff.
- Consideration will be given to the introduction of a National Clinical Audit Working Group, with a primary aim to oversee national audit projects and action plans. This forum would run in addition to the existing reporting structure and would include representation from the area of clinical risk and legal services.

The reports of **18** national clinical audits/ national confidential enquiries were reviewed by the provider in 2018/19 and Whittington Health intends to take the following actions to improve the quality of healthcare provided:

Fractured Neck of Femur - Care in the Emergency Department

The Royal College of Emergency Medicine

The Fractured Neck of Femur Audit is overseen by the Royal College of Emergency Medicine (RCEM). Across the country 65,000 patients a year suffer a fractured neck of femur, the majority presenting via the Emergency Department (ED). The focus in ED should be on pain relief including nerve blocks and making the correct diagnosis through the use of MRI and CT scans, where necessary. The purpose of the audit is to identify current performance in EDs against Royal College of Emergency Medicine clinical standards.
Of the nine standards audited, Whittington Hospital did not achieve any of the standards set by RCEM.

Actions taken following the audit:

1. An Emergency Department consultant has assented to the role as the fracture neck of femur lead to ensure that local trust guidelines are being followed;
2. The ED fracture neck of femur pathway has been updated to reflect the RCEM guidance and ED are utilising the trust guidelines with slight alterations in that most of the fascia iliac blocks are performed by appropriately by trained ED consultants and registrars. These are usually performed using ultrasound guidance for those who have been appropriately trained to do so.
   The fracture neck of femur lead is also meeting with a multidisciplinary team including representation from geriatrics and the musculoskeletal advanced recovery team in order to facilitate further development of the pathway.
3. Our local clinical management guideline has been updated to reflect NICE guidance. Updated content was reviewed and ratified at the Trust Clinical Guidelines Committee in 2018

National Emergency Laparotomy Audit

NELA
National Emergency Laparotomy Audit

This audit is overseen by the Royal College of Anaesthetists and the Royal College of Surgeons, reviewing the care of patients who undergo emergency bowel surgery via laparotomy.

In the past year, and the fifth consecutive year of data entry, a total of 103 cases were submitted to the national database by Whittington Health.

Data collection is now prospective rather than retrospective. This means that the surgeons and anaesthetists will enter data to the national database at the time of

surgery.

This has resulted in the Trust consistently being shown as 'green' with ≥ 85% of caseload entered on the NELA progress list.

In April 2019, the national audit is launching a best practice tariff which relates to increased revenue for a Trust performing emergency laparotomies. The criteria for meeting the tariff are as below:

- All appropriate cases to be entered on to the national database.
- 80% of patients need to receive consultant delivered care AND be admitted to critical care.
- A pathway of care on how these patients are managed is to be created and agreed.

Whittington Health has introduced a proactive, multidisciplinary, multi-grade NELA working group to oversee all aspects of the study. This has included significant preparatory work in advance of the Best Practice Tariff launch.

What actions have we taken to improve upon last year's performance?

In last year's quality account it was highlighted that there was a gap in the care for our elderly patients who undergo this type of surgery.

In the intervening period, the NELA audit has been instrumental in securing a geriatric liaison consultant. This will allow specific and appropriate management for this cohort of patient, whilst enabling compliance with the requirement of a surgical liaison geriatrician assessment.

Following the publication of the Year 4 report for 2016/17 data, we noted that the standard on CT scan performed and reported by a consultant radiologist before surgery was 55%. This appeared significantly lower than the national mean of 73%.

Following discussion with the Radiology department, a prospective, in-house review of our year 5 data was therefore undertaken and this demonstrated that 88% of scans were reported by a consultant, with the remaining 12%, reported by a registrar.

Radiology consultant membership of the NELA working group is now in place, to ensure all future data compliance for this standard is robust and appropriately validated.

Neonatal Intensive and Special Care (NNAP)

NNAP monitors aspects of the care that has been provided to babies on neonatal units in England, Scotland and Wales.

In one year, approximately 95,000 of all babies born will be admitted to a neonatal unit which specialises in looking after babies who are born too early, with a low birth weight or who have a medical condition requiring specialist treatment.

At Whittington Hospital, 5/8 standards audited achieved above the national average,

with two standards achieving 100% as below:

Poster 1

National Neonatal Audit Programme

RCPCH Audits

Your baby's care

Measuring standards and improving neonatal care

WHITTINGTON HOSPITAL takes part in the **National Neonatal Audit Programme (NNAP)** which monitors aspects of the care that has been provided to babies on neonatal units in England, Scotland and Wales. This poster shows how the 2017 results for WHITTINGTON HOSPITAL compare with national rates, as indicated in the NNAP 2018 Annual Report on 2017 data.

Antenatal steroids

Mothers who delivered babies between 24 and 34 weeks gestation who were given antenatal steroids. This is recommended to help prevent breathing problems in baby.

Our unit 93% | National rate 89%

Antenatal magnesium sulphate

Mothers who delivered babies below 30 weeks gestation who were given magnesium sulphate in the 24 hours before delivery. This is recommended to help prevent cerebral palsy in baby.

Our unit 57% | National rate 64%

Temperature on admission

Babies born at less than 32 weeks gestation who had an appropriate temperature (between 36.5°C and 37.5°C) on admission to the neonatal unit.

Our unit 62% | National rate 64%

Consultation with parents

Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of a baby's admission.

Our unit 100% | National rate 95%

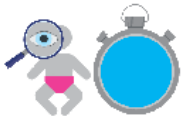
Parents on ward rounds

The proportion of admissions where parents were present on at least one consultant ward round during a baby's stay.

Our unit 82% | National rate 74%

Screening for retinopathy of prematurity

Babies who are born weighing less than 1501g, or are born at less than 32 weeks gestation who receive on-time screening for retinopathy of prematurity



Our unit 100% | National rate 94%

Mother's milk at time of discharge

Babies born at less than 33 weeks who were receiving some of their mother's milk, either exclusively or with another form of feeding, when they were discharged from neonatal care.

Our unit 81% | National rate 60%

Follow-up at two years of age

Babies born at less than 30 weeks who had received documented medical follow-up at two years of age.

Our unit 60% | National rate 63%

Please see **Poster 2** for this unit's response to the results.
To find out more about how we use your baby's information, please visit:
www.rcpch.ac.uk/nnap

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

Actions taken:

The following actions are being taken to address the lower performing areas:

- To support and improve awareness of giving antenatal magnesium sulphate to mothers of 30 weeks gestation, the Neonatal and Maternity Unit are participating in the PreCePT (Prevention in Cerebral Palsy in Pre-term labour) study.

- The standard of temperature on admission is 2% below national average but above average for NE and Central London. However, there is ongoing awareness for all staff.

- Ongoing appointments and improved administration has helped to increase the number of neurodevelopmental follow up appointments at 2 years. It is estimated that this has now increased from 60% at the time of the audit to 70% of children receiving an appointment.

The reports of **69** local clinical audits were reviewed by the provider in **2018/19** and Whittington Health intends to take the following 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 **2019/20** by ensuring:

- Reactive local audits, vital to patient safety, will remain the key component of the Integrated Clinical Service Unit (ICSU), Clinical Audit and Effectiveness programmes;
- Project proposals will continue to be subject to a centralised quality review in order to prevent duplication and to ensure alignment to speciality priorities;
- Demonstrable improvements to patient care and service provision will be identified on a rolling basis to support organisational 'learning from excellence' initiatives;
- 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;
- In-house clinical audit workshops will continue to provide practical support to all staff grades;
- Correct, legible and appropriate clinical documentation remains an intrinsic area of medico legal practice. A new clinical documentation audit will be relaunched to work on a rolling basis throughout the year, reflecting the standards that are a requirement of our Records Management Policy.

Anaphylaxis NICE Guidelines: Are we following the guidelines or is there is still a need to improve adherence?

RCPCH
Royal College of
Paediatrics and Child Health
Leading the way in Children's Health

Accepted as an abstract by the Royal College of Paediatrics and Child Health

In the UK the incidence of anaphylaxis is increasing and it is estimated that 220,000 people up to age of 44 years have a nut-induced anaphylactic reaction with a risk of recurrence. It is also estimated that 1/1,333 of England's population has experienced anaphylaxis at some point in their lives and there are approximately 20 deaths per year.

The audit was to ascertain if the Paediatric Department at Whittington Hospital are following the NICE Guidance -published December 2011 - on *Anaphylaxis: assessment and referral after emergency treatment* with regard to the assessment and referral process of children being treated for anaphylaxis.

Aim:

Our team investigated whether the paediatric staff in the Emergency Department, have been following the NICE guidelines in regard to the assessment, management and referral process of children treated for anaphylaxis.

Method:

A total of 23 children up to the age of 16 years were included in this project and followed retrospectively over a 12 month period. Their clinical notes were reviewed to assess the presence of the key criteria points of the guideline. The Anaphylaxis NICE data collection tool was utilised.

Data was then analysed and compared, to assess our level of compliance.

Results:

Good compliance (>95%) was demonstrated in the following areas:

- documentation of acute symptoms;
- admitting patients for observation;
- referring patients to an allergy service;
- offering appropriate adrenaline auto injector to take home.

Acceptable compliance (75% - 94%) noted in;

- documenting the circumstances prior to the onset of symptoms.

There was notable poor compliance (<74%) with the following:

- recording the time of onset of anaphylactic reaction;
- information provision to patients and parents on anaphylaxis follow-up and self-management.

Conclusion:

In general, there is good adherence to the anaphylaxis NICE guideline. However, there are some areas for improvement. It was observed that in cases where an anaphylaxis discharge checklist document was used, the department was more compliant with the guidelines. Improving department education and providing a checklist to be completed with every adrenaline auto injector being prescribed may improve guideline adherence.

Actions:

- The discharge checklist was updated to support information required;
- Further education of staff was undertaken both at the induction of new staff members and in departmental teaching sessions;
- Re-audit has been scheduled take place within 12 months.

Management of Fragility Fractures in Orthopaedic Outpatient Clinic

Fragilit fractures are fractures that result from mechanical forces that would not ordinarily result in fracture, known as low-level or 'low energy' trauma. The World Health Organization has quantified this as forces equivalent to a fall from a standing height or less.

Reduced bone density is a major risk factor for fragility fracture. Other factors that may affect the risk of fragility fracture include the use of oral or systemic glucocorticoids, age, gender, previous fractures and a family history of osteoporosis.

Aim:

This re-audit was undertaken in order to identify the number of patients presenting with a fragility fracture, who were suitably assessed for future risk of fracture.

The NICE guidance on *Osteoporosis: assessing the risk of fragility fracture*, published in August 2012 and updated in February 2017, states that risk of future fractures should be assessed and managed appropriately in specific populations of patients presenting with fragility fractures to fracture clinic.

The British Orthopaedic Association Guidelines further state that all patients presenting with a fragility fracture must be provided with written information giving advice on the nature of fragility fractures, bone health, lifestyle, nutrition and bone protection treatment.

Our audit results showed a higher number of patients being identified as having a fragility fracture in comparison to the previous audit, but poor compliance with early identification and/or appropriate risk assessment.

Action taken:

- Education of fracture clinic healthcare providers, emphasising the importance of considering fragility fracture risk. This was achieved through audit presentation and the creation of posters to be displayed in fracture clinic;
- The assessment of fragility fracture risk is now undertaken in fracture clinic using Q-fracture score. The Q-fracture score estimates an individual's ten year risk of developing both hip and major osteoporotic fractures, including hip, spine and wrist. The score is then discussed and agreed by the orthopaedic team;
- A GP standard letter is now to be given to the patient during clinic, stating that the patient has a fragility fracture and needs further assessment and appropriate management of future risk.

Have all new referrals for atrial fibrillation been seen within one week of being referred?

Atrial fibrillation (AF) is the most common sustained cardiac rhythm disorder. It is a significant risk factor for stroke, as people with AF have a five-fold increased risk when compared to people with a normal heart rhythm. The major aim of AF treatment is to prevent ischaemic stroke by providing anticoagulation to those at risk.

The aim of this audit was to determine if all new referrals for AF are seen within one week of being referred, in line with the London Clinical Networks 'Excellence in anticoagulant care'.

The audit identified that 37% of our patients were seen within one week of being referred.

Action taken:

- A review is underway to determine if more rooms can be available for patient counselling in order to minimize the waiting time. Whilst outstanding, this issue has been escalated to the Trust's Risk Register.
- Pharmacy staff have been trained to deliver anticoagulation counselling on the wards, thereby reducing the waiting time.
- The direct oral anticoagulants (DOAC) referral form has been simplified and approved at CCG level.
- The counting for the referral now commences on the day that a complete referral is received to ensure that screening delay will not exceed the one week time limit.

Islington Nursing Home Nutrition Screening and Care Planning Audit

The NICE guidance on *Nutrition Support for Adults: oral nutrition support, enteral tube feeding and parenteral nutrition* published in February 2006, outlines the importance of nutritional screening. Screening should be carried out by health care professionals with the appropriate skills and training. The guidance also states that people in care homes should be screened on admission and when there is clinical concern.

A validated screening tool such as the British Association for Parenteral and Enteral Nutrition (UK) (BAPEN) Malnutrition Universal Screening Tool (MUST) is recommended.

The audit reviewed the following criteria, none of which achieved the 100% standard set:

1. Referrals to the dietitians should include a weight, height, BMI and MUST score;
2. The MUST score documented on the referral form is accurate;
3. Patients referred to the dietitian were appropriately identified as having a MUST >2;
4. Patients referred to the dietitian have a food chart in place;
5. Patients referred to the dietitian have a nutrition care plan in place.

Most referrals to the dietitian were appropriate but often the referrals did not contain accurate MUST scores. This could indicate that some patients are being identified as high risk too late. Only some patients had nutrition care plans or a food chart in place before the dietitian review, which can result in further deterioration of nutritional status. Lack of food charts also makes it difficult for the dietitian to complete their nutritional assessment and can result in delayed or insufficient care.

Action taken:

- The audit was discussed with the nursing home managers in order to gain their feedback and for them to identify areas with which they require support;
- Nursing home managers to allocate a nutrition champion. This has now been achieved in most of the homes.
- In November 2018, a nursing home training day was held to show the nursing home staff how to calculate MUST and how and when to refer to a dietitian. Additional guidance was provided on information to be included on the referral form, the importance of care plans and the availability of resources to support this.
  On the day, a care plan was devised, which is to be used in all homes as well as a dietitian screening tool.
- Training will continue via a new style of consultation entitled, 'group consultations'. The first of these has already been held and received positive

feedback from the patients and staff who took part. Group consultations will now be rolled out to other nursing homes.

Seasonal influenza vaccination of inpatients admitted to hospital with acute exacerbations of COPD – a missed opportunity?

Background:

A high number of patients are admitted to Whittington Hospital each year with acute exacerbations of chronic obstructive pulmonary disease (AECOPD). Acute exacerbations are often triggered by respiratory viruses including influenza and are associated with significant morbidity and mortality. Patients with COPD are at a higher risk of death following influenza infection.

NICE guidelines state that all patients with COPD should receive annual seasonal influenza vaccination; however, we have anecdotally noticed inpatients with COPD who have had repeat admissions in the winter flu season with neither prior flu vaccination nor vaccination during admission.

Aim:

- To identify inpatients admitted with COPD who neither had flu vaccine prior to admission nor were offered it on discharge;
- To implement change by adding flu vaccination status to the COPD discharge bundle and encourage pharmacists and junior doctors to identify and offer flu vaccination to inpatients with COPD.

Results:

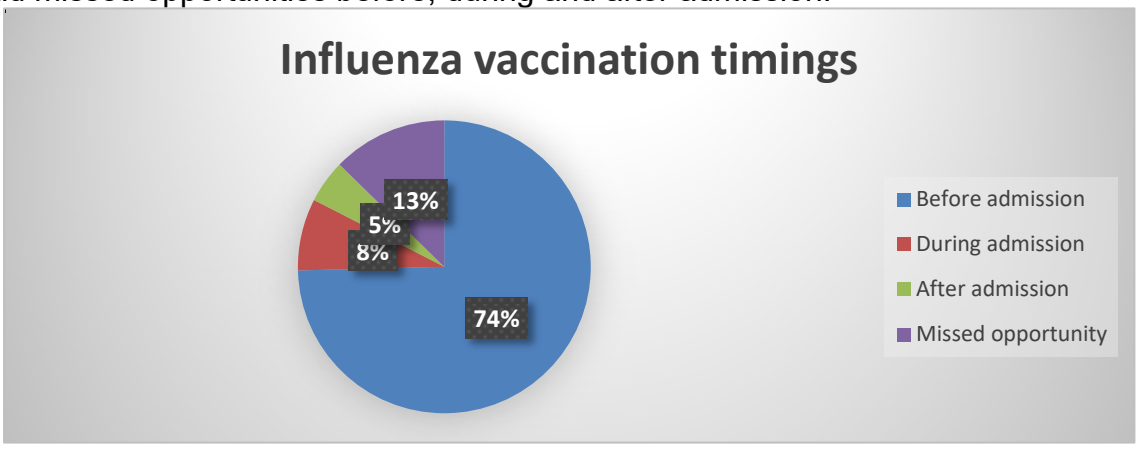
There were 92 admissions to Whittington Hospital between October 2017 and March 2018, with acute exacerbations of chronic obstructive pulmonary disease. Of these admissions, a total of 11 were re-admissions and one was disqualified as an infective exacerbation of bronchiectasis rather than COPD.

Of these patients, a total of 63 had a working Medical Interoperable Gateway. A Medical Interoperable Gateway refers to information that is available from the GP about a patient, for example; medicines prescribed and test results.

We noted:

- Forty seven patients had a flu jab before admission;
- Five patients received a flu jab during admission;
- Three patients had a flu jab after discharge;
- Eight patients had not received a flu jab by the end of March.

Those without flu jabs represent 12.6% of the total patient population. These patients had missed opportunities before, during and after admission.



Recommendations

- To add influenza vaccination to the COPD discharge summary, thus making it a compulsory component of patients with AECOPD being discharged home. If the patient is too unwell at that time, the GP should be prompted in the discharge letter to supply this later;
- To add influenza vaccinations to the medicine reconciliation for pharmacists;
- To ensure adequate supply of vaccinations on the wards;
- To add a “flu jab” box on the ward discharge board;
- To re-audit next flu season (October-March), in order to compare results.

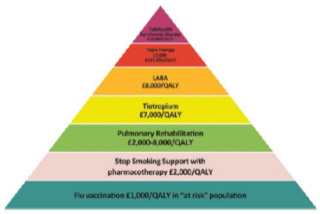
This audit was submitted to and presented at Primary Care Respiratory Society. Abstract below;

Seasonal influenza vaccination of inpatients admitted to hospital with Acute Exacerbations of COPD - a missed opportunity?

Pierre Vila, Kristina Foley, Ameet Vaghela, Louise Restrick
Whittington Health Integrated Respiratory Team - London N19 5NF

Introduction

- Acute exacerbations of COPD (AECOPD) are often triggered by respiratory viruses including influenza and are associated with significant morbidity and mortality[1]
- Around 2% of admissions for acute respiratory illness are explained by influenza and 10% of GP consultations for acute respiratory illness are influenza related[2]
- Annual influenza vaccination is a high value intervention in COPD (Figure 1; COPD Value Pyramid) and is recommended by NICE[3]
- Historically, hospitals do not offer influenza vaccinations to patients admitted with AECOPD during the "flu season"



Thorax 2014;69:973–975

Figure 1: COPD "Value" Pyramid developed by the London Respiratory Network 2011

Aims

1. To quantify the number of inpatients admitted with AECOPD at one London Acute Trust who did not receive their recommended influenza vaccination during a 6 month "flu season"
2. To evaluate the role of offering vaccination during admission to patients admitted with AECOPD
3. To use this data to develop out inpatient team approach to addressing influenza vaccination in a systematic way.

Methods

- Data* was collected retrospectively on patients admitted with AECOPD between October 2017 and March 2018 (representing one "flu season").
- Patients were identified via COPD national audit data, and data collected from GP summary care records, hospital discharge summaries and hospital electronic prescribing records
- Re-admissions and other primary respiratory conditions were excluded

**Data refers to patient details (age, smoking/tobacco dependence (self-reported), MRC breathlessness, spirometry, and admission date); and outcomes (dates of vaccination administration).*

MRC BREATHLESSNESS SCALE

1. I get breathless on strenuous activity.
2. I walk slower than people my age on the level because of breathlessness.
3. I get short of breath when hurrying on the level or on a slight hill.
4. I have to stop for breath after walking 100 metres or after a few minutes on the level.

5a. I am too breathless to leave the house but independent in washing and/or dressing.

5b. I am too breathless to leave the house and dependent in washing and dressing.

Results & Case for change

- 63 patients were admitted between October 2017 and March 2018 with AECOPD

Age	
Mean (range)	48 (39-94) years
Smoking /tobacco dependence (self-reported)	
Current smoker	29/63 (46%)
Ex-smoker	34/63 (54%)
FEV1	
Mean (SD)	0.91 (0.39) litres
FVC	
Mean (SD)	1.91 (0.70) litres
MRC breathlessness score	
Median (range)	4 (2-5)

Table 1: Patient demographics

- 16/63 patients (25%) were not vaccinated pre-admission
- Of these 5/16 (31%) were vaccinated during admission
- Only 3/11 (27%) discharged without influenza vaccination were subsequently vaccinated

Timing of influenza vaccination relative to inpatient admission

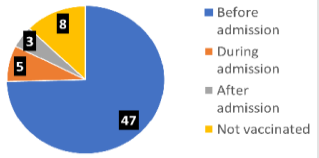


Figure 2: Timing of influenza vaccination relative to inpatient admission

Discussion

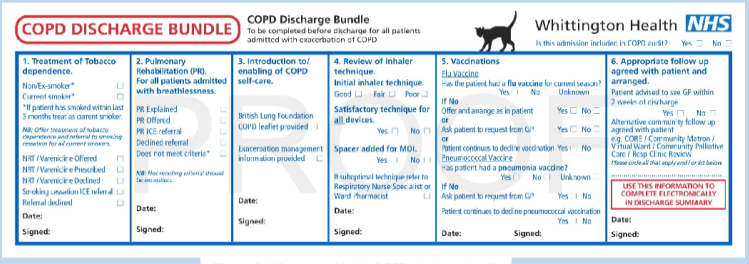
- Patients admitted to hospital with AECOPD are recognised to be one of the patient groups at highest risk of harm from influenza, and therefore at the greatest need of influenza vaccination
- Whilst 75% of patients had received vaccination pre-admission, 13% of this vulnerable group had still not been vaccinated by "flu-season" end.
- This data suggests that hospital admission should be used as an opportunity to offer influenza vaccination to patients admitted with AECOPD who have missed out on vaccination prior to admission.
- This approach has also been recommended in the new NICE guidance 'Flu vaccination: increasing uptake' published in August 2018. This guidance recommends that patients in eligible groups should be offered flu vaccination "at every opportunity", including outpatient clinics and hospital admissions[4].
- We believe that offering influenza vaccination to inpatients with COPD, who are no longer unwell from infection, in the 24-48 hours prior to discharge, is a safe and high value intervention for this patient group, particularly when comparing the relative costs of vaccination versus readmission secondary to influenza[4].
- We believe there is a strong case for systematically including the offer of influenza vaccinations to inpatients admitted with AECOPD.

Next steps & recommendations

- We recommend that hospital trusts explore the value of providing influenza vaccination to inpatients with COPD who have not already received theirs in the "influenza season" in a trust-wide systematic way.
- At our trust we have added influenza vaccination as a component of our COPD discharge bundle (figure 3), and will evaluate the impact in the the coming "flu season" (2018/19)

References

1. Miles, G. Influenza vaccination: helping respiratory consultations. Primary Care Respiratory Update. 2018; 5 (2):23-26
2. Cromer D, van Hoek AJ, Jit M, Edmunds WJ, Fleming D, Miller E. The burden of influenza in England by age and clinical risk group: a statistical analysis to inform vaccine policy. J Infect. 2014;68(4):363-71
3. Chronic obstructive pulmonary disease in over 16s: diagnosis and management. Clinical guideline [CG101]. NICE. June 2010
4. Flu vaccination: increasing uptake. Clinical guideline [NG 103]. NICE. August 2018


COPD DISCHARGE BUNDLE

COPD Discharge Bundle
To be completed before discharge for all patients admitted with exacerbation of COPD

Whittington Health NHS

Is this admission included in COPD audit? Yes ☐ No ☐

1. Treatment of Tobacco dependence.	2. Pulmonary Rehabilitation (PR). For all patients admitted with breathlessness.	3. Introduction to/ enabling of COPD self-care.	4. Review of inhaler technique.	5. Vaccinations	6. Appropriate follow up agreed with patient and arranged.
Non/Ex-smoker* ☐ Current smoker* ☐ *If patient has smoked within last 3 months treat as current smoker. NB: Offer treatment of tobacco dependence and referral to smoking cessation for all current smokers. NRT / Varenicline Offered ☐ NRT / Varenicline Prescribed ☐ NRT / Varenicline Declined ☐ Smoking cessation ICE referral ☐ Referral declined ☐ Date: Signed:	PR Explained ☐ PR Offered ☐ PR ICE referral ☐ Declines referral ☐ Does not meet criteria* ☐ NB: Not meeting criteria should be uncommon. Date: Signed:	British Lung Foundation COPD leaflet provided ☐ Exacerbation management information provided ☐ Date: Signed:	Initial inhaler technique. Good ☐ Fair ☐ Poor ☐ Satisfactory technique for all devices. Yes ☐ No ☐ Spacer added for MDI. Yes ☐ No ☐ If suboptimal technique refer to Respiratory Nurse Specialist or Ward Pharmacist ☐ Date: Signed:	Flu Vaccine Has the patient had a flu vaccine for current season? Yes ☐ No ☐ Unknown ☐ If No Offer and arrange as in patient or Ask patient to request from GP Yes ☐ No ☐ or Patient continues to decline vaccination Yes ☐ No ☐ Pneumococcal Vaccine Has patient had a pneumonia vaccine? Yes ☐ No ☐ Unknown ☐ If No Ask patient to request from GP Yes ☐ No ☐ Patient continues to decline pneumococcal vaccination Yes ☐ No ☐ Date: Signed:	Patient advised to see GP within 2 weeks of discharge Yes ☐ No ☐ Alternative community follow up agreed with patient e.g. CORE / Community Matron / Virtual Ward / Community Palliative Care / Resp Clinic Review Please circle all that apply and tick if not below USE THIS INFORMATION TO COMPLETE ELECTRONICALLY IN DISCHARGE SUMMARY Date: Signed:

Figure 3: Whittington Health COPD discharge bundle

Participating in Clinical Research

Involvement in clinical research demonstrates the trust's commitment to improving the quality of care we offer to the local community as well as contributing to the evidence base of healthcare both nationally and internationally.

Our participation in research helps to ensure that our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to better patient outcomes.

We are four years on from the ratification of the Whittington Health Research strategy that underpins the clinical strategy and reflects the aim of enabling local people to 'live longer healthier
lives'. A key strategic goal is to become a leader of medical, multi-professional education and population based research.

Participation in clinical research demonstrates Whittington Health's commitment to improving the quality of care that is delivered to our patients and also to making a contribution to global health improvement. We are committed to increasing the quality of studies in which patients can participate (not simply the number), and the range of specialties that are research active, as we recognise that research active hospitals deliver high quality care.

The trust's research portfolio continues to evolve to reflect the ambitions of our integrated care organisation and also reflects the health issues of our local population. The research portfolio includes:

Anesthesia	Bariatrics
CAMHS	Dermatology
Diabetes and endocrine	Emergency medicine (and ICU)
Haemoglobinopathies	Gastroenterology
Health visiting	Hepatology
Infectious diseases (TB)	IAPT
MSK	Microbiology
Orthopaedics	Oncology
Speech and language therapy	Paediatrics

Urology	Surgery
	Women's health

In 2018/19, 1,074 patients who received their care through Whittington Health were recruited into studies classified by the National Institute of Health Research (NIHR) as part of the NIHR research portfolio. This is the highest annual number recruited at Whittington Health and represents an increase of 323 patients compared to last year and 532 on the previous year.

There were 50 NIHR portfolio studies in progress and recruiting at Whittington Health last financial year compared to 39, 48 and 41 studies in 2017/18, 2016/17 and 2015/16 respectively. Having seen a reduction in the number of studies but improved our recruitment to time and target (RTT) metrics in line with the NIHR High Level Objectives last year we have been able to maintain better RTT metrics and increase study numbers this year ensuring improved quality and quantity in the delivery of studies.

Portfolio adopted studies are mainly, but not solely, consultant led and are supported by the trust's growing research delivery team to facilitate patient recruitment. In addition to the NIHR portfolio studies, an additional 10 non-portfolio studies commenced in 2018/19, unfortunately a reduction of 50% on the previous year. Increasing locally lead and locally focused research is a vital aspect of delivering the research strategy. Most non-portfolio research studies are undertaken by nurses, allied health professionals, and trainee doctors and the impact of these studies are frequently published in peer reviewed publications, at conference presentations, and are valuable in their ability to innovate within the trust. In addition, small locally funded studies can provide the evidence needed to secure grant funding for larger scale projects and their potential to build capacity and capability to undertake larger research studies should not be underestimated.

Development of nursing and multidisciplinary research is evolving with the successful award to a nurse consultant from the national Institute for Health research (NIHR) to build research and evidence based capacity across the clinical workforce. This work will start in 2019.

CQUIN Payment Framework

A proportion of Whittington Health's income is conditional on achieving quality improvement and innovation goals between Whittington Health and our local CCGs through the Commissioning for Quality and Innovation payment framework.

Our CQUINs for 2017-19 are:
• Improvement of Staff Health and Wellbeing

- Reducing the impact of Serious Infections (AMR and Sepsis)
- Improving services for people with mental health needs who present to ED
- Transitions our of Children and Young People's mental health services
- Offering advice and guidance
- NHS e-Referrals
- Supporting proactive and Safe Discharge
- Improving the assessments of wounds
- Personalised care and support planning

Our CQUINs for 2019-2020 are:

- Antimicrobial Resistance
- Staff Flu Vaccinations
- Alcohol and Tobacco (screening for use)
- Three High Impact Actions to prevent hospital falls
- Same Day Emergency Care

Further details of the agreed goals for 2017-19 are available electronically at:

https://www.england.nhs.uk/wp-content/uploads/2018/04/cquin-guidance-2018-19.pdf

In 2018/19, 2.5 percent of our income was conditional on achieving quality improvement and innovation goals agreed between Whittington Health and our local commissioners through the CQUIN payment framework. These goals were agreed because they all represent areas where improvements result in significant benefits to patient safety and experience. Both Whittington Health and our commissioners believed they were important areas for improvement.

There is a CQUIN Project Manager who leads the CQUIN projects and is responsible for the achievement of CQUINs. There is also a clinical lead and operational lead for each individual CQUIN.

Achieved
Not achieved
No requirement
Awaiting confirmation

CQUIN Scheme	Rationale/Objectives	Compliance			
Improvement of Staff Health and Wellbeing	To improve the support available for NHS staff to help promote their health and wellbeing in order for them to remain healthy and well.	Q1	Q2	Q3	Q4
Reducing the Impact of Serious	To make sure that the appropriate patients who attend the trust in an	Q1	Q2	Q3	Q4

Infections (AMR and Sepsis)	emergency are screened for sepsis, and receive the necessary antibiotics To reduce antibiotic consumption, encourage focus on antimicrobial stewardship and ensure antibiotic usage is reviewed within 72 hrs of prescribing.				
Improving Services for People with Mental Health who present to ED		Q1	Q2	Q3	Q4
Transitions out of Children and Young Peoples Mental Health Services	To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services.	Q1	Q2	Q3	Q4
Offering Advice and Guidance	Improve GP to access consultant advice prior to referring patients in to secondary care.	Q1	Q2	Q3	Q4
NHS e-Referrals	All providers publish all of their services and make all first outpatient appointment slots available on e-referral service by 31 March 2018.	Q1	Q2	Q3	Q4
Supporting Proactive and Safe Discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.	Q1	Q2	Q3	Q4
Improving the Assessments of Wounds	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks	Q1	Q2	Q3	Q4
Personalised Care and Support Planning	To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.	Q1	Q2	Q3	Q4
Improving Haemoglobinopathy Pathways through ODN Networks	To improve appropriate and cost-effective access to appropriate treatment for haemoglobinopathy patients by developing ODNs and ensuring compliance with ODN guidance through MDT review of individual patients' notes.	Q1	Q2	Q3	Q4
Nationally Standardised Dose Banding for Adult Intravenous Anticancer Therapy (SACT)	To ensure that we minimise the amount of Oral Chemotherapy that is prescribed, yet not taken by patients - by reviewing length of prescription courses	Q1	Q2	Q3	Q4

Registration with the Care Quality Commission (CQC)

We are registered with the CQC without any conditions. During 2018/19, we participated in the following external quality assurance reviews

In November 2017 a Joint Targeted Area Inspection focusing on Neglect occurred across Haringey Local Safeguarding Children's Board (LSCB). The formal response to this inspection was provided in February 2018, and an extensive action plan with 132 actions has been produced through the LSCB partnership, which has been being implemented throughout 2018. All Whittington Health actions in the LSCB action plan have been completed, with no red actions remaining. Whittington Health undertook a Section 11 LSCB audit in February 2019 which provided evidence of the sustainability of the actions undertaken.

A Joint Targeted Area Inspection focusing on Sexual Abuse in the Family Home occurred across Islington LSCB area in November 2018. The formal response to this inspection was released on 29th January 2019 by the lead inspectors Ofsted. Whittington Health Services were inspected by a CQC team as part of this process. Services specifically reviewed included Children's Emergency Department, Community Child and Adolescent Mental Health Services (CAMHS), and School Nursing and Maternity, as well as a range of other agency and multi-agency services. A multi-disciplinary action plan is being developed to address the areas for improvement noted in the report.

On 27th February 2019 the CQC visited the Child and Adolescent Mental Health Inpatient unit - Simmons House- for an unannounced monitoring visit of the Mental Health Act' (MHA). Their particular focus was in relation to compliance with MHA paperwork. Their findings and feedback were provided to the organisation on the 13th March 2019. The feedback was very positive. They noted further improvements had been made since they last inspected the service in November 2017. The inspectors spoke very highly of the staff and patients they observed during their inspection. This was reflected in the CQC report. There were 4 recommendations made by the CQC inspectors with no patient specific recommendations. A supporting action plan detailing the trusts response and supporting actions addressing the CQC recommendations was submitted to the CQC on 2nd April 2019.

The CQC's last targeted inspection of the organisation took place in October 2017 and was published in February 2018. It's overall rating remains as 'Good' with the hospital moving from Requires Improvement to Good.

Using the CQC inspection methodology, which indicates that all services rated as good will be re-inspected within 3.5 years, we would expect our next inspection to be conducted around summer 2019. The new methodology also includes Well Led and the Use of Resources which will be undertaken by NHS Improvement alongside CQC.

Overall rating for this trust	**Good**	
Are services safe?	**Requiresimprovement**	

Are services effective?	**Good**	
Are services caring?	**Outstanding**	
Are services responsive?	**Good**	
Are services well-led?	**Good**	

Secondary Uses Service

Whittington Health submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and which included the patient's valid General Medical Practice Code were as follows:

	Percentage of records which included the patient's valid NHS number (%)	Percentage of records which included the patient's valid General Medical Practice Code (%)
Inpatient care	97.80%	99.90%
Outpatient care	98.30%	100%
Emergency care	92.60%	99.90%

Information Governance (IG) Assessment Report

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 over the last 5 years have made significant improvements in many areas of information governance, including data quality, subject access requests, freedom of information and records management.

The Data Security and Protection (DSP) Toolkit is a policy delivery vehicle produced by the Department of Health; hosted and maintained by NHS Digital. It combines the legal framework including the EU General Data Protection Regulations 2016 and the Data Protection Act 2018, 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 DSP Toolkit compliance and to improve compliance against other standards. As a result, the Trust met the majority of the mandatory assertions and declared 100% compliance for 2018/19 against the mandatory assertions with an improvement plan in place for IG training which was declared at 76% against a target of 95%. The Trust's DSP Toolkit submission and former IG Toolkit submissions can be viewed online at

www.dsptoolkit.nhs.uk and www.igt.hscic.gov.uk.

All staff are required to undertake IG training. In 2018/19, the Trust reached an annual peak of 81% 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 2018/19 were as follows:

Date of incident	Nature of Incident	ICO Outcome
May 2018	Theft of a backpack of a containing health visitor sheet and diary.	No further action
June 2018	Inappropriate access to staff member's medical record another staff member.	Update from ICO not available
Jan 2019	Staff member inappropriately disclosed the phone number of safeguarding patient's foster carer to the patient's husband, the subject of safeguarding issues.	Update from ICO not available

Data Quality

The trust monitors the quality of data through the use of quarterly benchmarking reports.

In order to improve data quality in 2019-20 the trust will be continuing to embed the actions identified from 2018/19:

- Introduction of data quality dashboards for services to individually monitor their own data quality as required.
- Strengthening the trust Data Quality Group and ensuring representation from each of the seven Integrated Clinical Service Units (ICSUs). This group is responsible for implementing the annual data improvement and assurance

plan and measures the trust's performance against a number of internal and external data sources.

- Taking measures to improve the coding of activity
- Systematic benchmarking of data
- Running a programme of audits and actions plans

Whittington Health has been supplying demographic and risk factor information consistently since the service commenced in October 2015.

Clinical Coding Audit

Whittington Health was subject to the Payment by Results clinical coding audit during the 2018/19 reporting period. Trusts are required to meet 95% accuracy for primary procedure and diagnostic codes, and 90% accuracy for secondary codes.

The error rates reported in the latest (November) published audit for diagnosis coding and clinical treatment coding are:

Area Audited	% Diagnoses coded correctly		% Procedures coded correctly	
	Primary	Secondary	Primary	Secondary
General Surgery	89.19	77.91	96.87	95.65
Trauma & Orthopaedics	95.00	85.9	86.49	84.31
General Medicine	95.00	91.35	100	96.55
Paediatrics	90.91	96.15	88.89	33.33
Gynaecology	87.18	58.49	89.19	78.43
Overall	**91.50**	**84.91**	**91.73**	**87.31**

The trust is taking a number of actions in 2019-20 to improve our clinical coding performance including:

- Acting on feedback from the national audit and coding some care as 'palliative' where this was previously not included
- Having access to more information from clinicians through more detailed recording, death certificates and access to new information (via ICE).
- The coding team have established working relationships and lines of communication with many of the clinical teams which allow them to raise queries and clarify clinical details in a timely way.
- The team had a number of experienced staff leave the Trust in 2018. Posts have been recruited to and bank staff are supporting where possible to ensure the department can improve on the coding performance for last year.

Learning from Deaths

During the period 1 April 2018 to 31 March 2019, 433 Whittington Health patients died in our inpatients or in our emergency department. The following number of deaths occurred in each quarter of 2018/19:

- 109 in the first quarter (April-June 2018)
- 84 in the second quarter (July-Sept 2018)
- 117 in the third quarter (October-Dec 2018)
- 123 in the fourth quarter (Jan – March 2019)

By 31 March 2019 the number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 69/109 deaths in the first quarter
- 50/84 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 mortality reviews includes:

- Ensuring there are more robust mechanisms in place to ensure that our clinically deteriorating patients are referred to our critical care outreach teams in a timely and appropriate way.
- Ensuring we embed learning from end of life care discussions.
- Ensuring all investigations on patients (imaging, pathology) are reviewed and acted upon in a timely and appropriate way.

Actions taken in response to the findings include:

- Presentation of patient cases to a wide audience
- Developing and embedding NEWS2 national early warning scores 2 and escalation protocols in response to introduction of electronic observation systems across the organisation.
- Improved processes of maximising learning from all deaths
- Extending the learning from deaths process to investigate and learn from deaths in patients up to 30 days post discharge.
- 19/20 work commencing around introduction of Medical Examiner.

Patient Reported Outcome Measures (PROMs)

Whittington Health participated in the PROMs project during 2017/18, although at the time of review, there were not sufficient numbers of responses to produce any statistically significant results (a minimum of 30 post-operative results for a given procedure are required). In 2016/17 there were also insufficient response numbers at

the time of reporting, however subsequent publications eventually showed 226 responses from 572 eligible hospital procedures which demonstrated post-operative health gains in line with national averages.

Groin Hernias and Varicose Vein Procedures (note that the most recent finalised data is for the period Apr17-Sep17)

Table 1: Pre-operative participation and linkage

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate	Linkage rate (16/17)	National Linkage Rate
All Procedures (Apr17-Sep17)	161	41	25.5%	21	1.2%	2.7%	1.9%
Groin Hernia (Apr17-Sep17)	152	41	27.0%	21	1.2%	1.8%	8.9%
Varicose Vein (Apr17-Sep17)	*	*	*	*		3.3%	2.3%

Table 2: Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate	Response rate (16/17)	National Response Rate
All Procedures (Apr17-Sep17)	41	31	75.6%	15	8.4%	3.9%	0.9%
Groin Hernia (Apr17-Sep17)	41	31	75.6%	15	8.4%	4.3%	3.1%
Varicose Vein (Apr17-Sep17)	*	*	*	0		3.3%	3.2%

Hip replacements and Knee replacements (note that the most recent finalised data is for the period Apr17-Mar18)

Table 1: Pre-operative participation and linkage

	Eligible hospital procedures	Pre-operative questionnaires	Participation Rate	Pre-operative questionnaires	Linkage Rate	Linkage rate (16/17)	National Linkage Rate

		completed		linked			
All Procedures (Apr17-Mar18)	3 03	1 40	4 6.2%	1 11	7 9.3%	3.6%	5.4%
Hip Replacement (Apr17-Mar18)	1 55	5 1	3 2.9%	4 5	8 8.2%	1.4%	6.8%
Knee Replacement (Apr17-Mar18)	1 48	8 9	6 0.1%	6 6	7 4.2%	5.9%	4.3%

Table 2: Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate	Response rate (16/17)	National Response Rate
All Procedures (Apr17-Mar18)	1 40	1 16	8 2.9%	8 0	6 9.0%	7.9%	0.1%
Hip Replacement (Apr17-Mar18)	5 1	4 9	9 6.1%	3 3	6 7.3%	3.0%	0.9%
Knee Replacement (Apr17-Mar18)	8 9	6 7	7 5.3%	4 7	7 0.1%	2.8%	9.5%

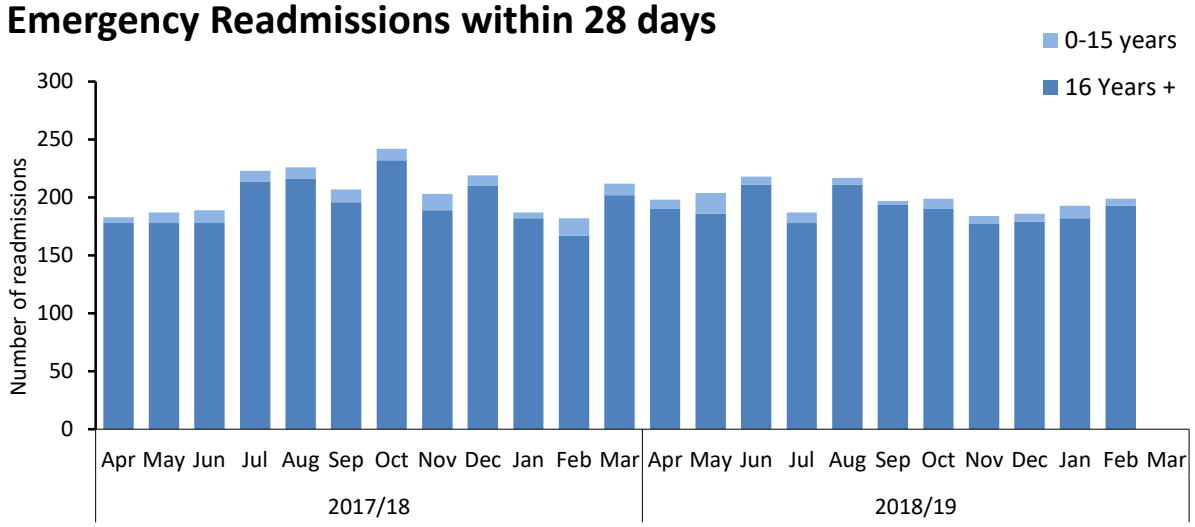
Table 3: Oxford hip/knee score (i.e.: Post-operative health gain)

Oxford hip/knee score	Whittington Health	National avg health gain	National lowest health gain	National highest health gain	Whittington Health 16/17
Hip Replacement (Apr17-Mar18)	21.326	22.21	16.6452	28.4643	19.292
Knee Replacement (Apr17-Mar18)	12.5091	17.102	10.7986	21.7681	12.826

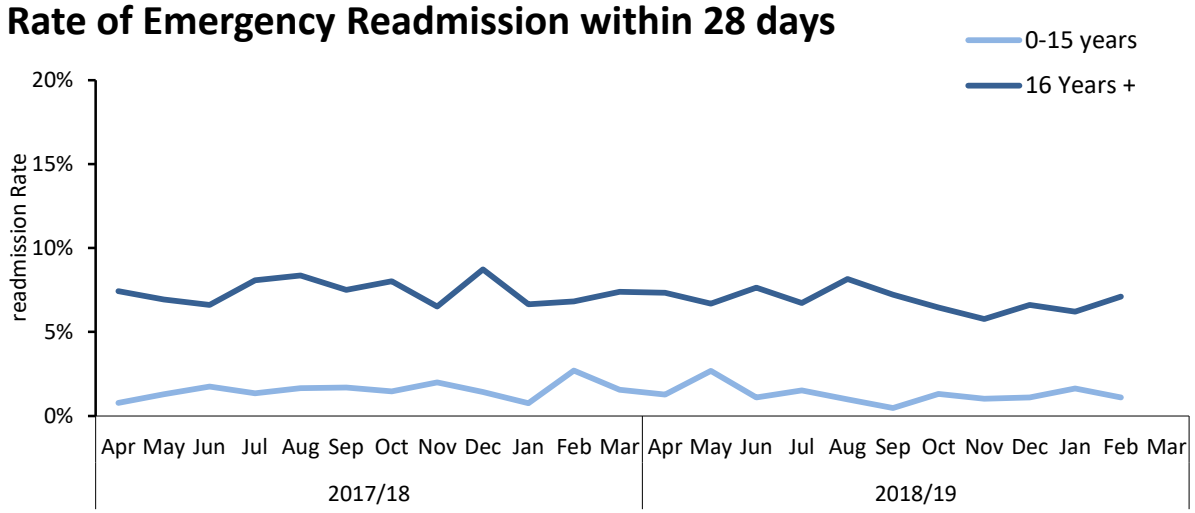
* trusts with <30 responses excluded from highest/lowest

Percentage of patients 0-15 and 16+ readmitted within 28 days of discharge

Emergency Readmissions within 28 days



Rate of Emergency Readmission within 28 days



*Data excludes patients between 0 and 4 years at time of admission

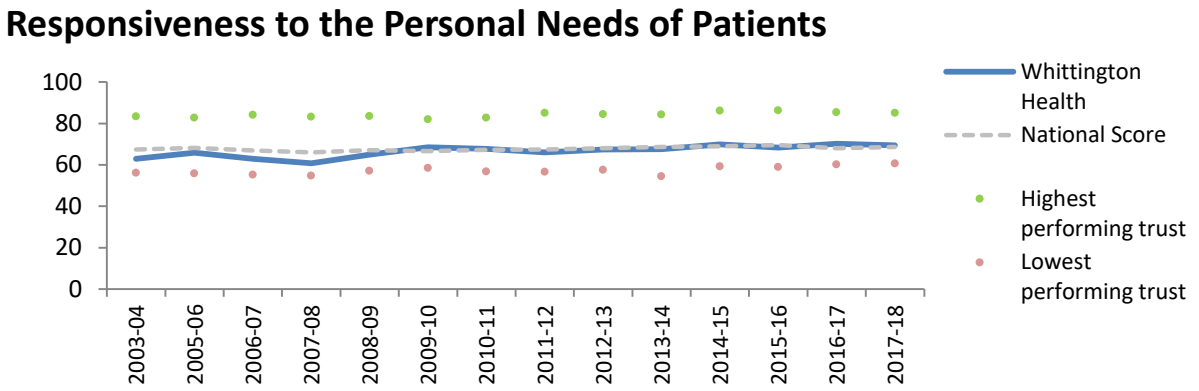
The trust's Responsiveness to the Personal Needs of its Patients

Whittington Health's responsiveness to the personal needs of its inpatients, based on the national inpatient survey, are displayed below. A trust's responsiveness is the weighted average score from five questions (score out of 100) and a higher score is indicative of better performance.

Year	Whittington Health	National Score	Highest performing trust	Lowest performing trust
2003-04	63	67	83	56
2005-06	66	68	83	56
2006-07	63	67	84	55
2007-08	61	66	83	55
2008-09	65	67	83	57

2009-10	69	67	82	58
2010-11	68	67	83	57
2011-12	66	67	85	57
2012-13	67	68	84	57
2013-14	68	69	84	54
2014-15	70	69	86	59
2015-16	68	70	86	59
2016-17	70	68	85	60
2017-18	70	69	85	61

In order to improve our responsiveness to the personal needs of our patients in 2019-20 we are:



The Whittington Health performance score was two percent higher than the national average in 2017/18 this has been maintained since 2016/17. This is indicative of a trust that listens to its patients and responds to their needs.

Staff Friends and Family Tests

Listening to Our Staff

Whittington Health conducted its eighth national staff survey as an integrated care organisation (ICO). The survey was distributed to all staff, rather than a sample, and achieved a response rate of 48% which is the highest response the Trust has received to date and an increase of 6% from last year's 42% response rate. The survey asks members of staff a number of questions on their jobs, managers, health and wellbeing, development, the organisation, and background information for equality monitoring purposes. The purpose is to give staff a voice and provide managers with an insight into morale, culture and perception of service delivery. The trust is very positive about the increase in the response rate and has worked hard to develop a listening culture.

Staff Engagement Indicator

The Care Quality Commission (CQC) report provides an overall indicator of staff engagement for Whittington Health, calculated from nine of the questions. The scoring range has changed this year from 1-5 to a 0-10 point scale (with 0 being poor and 10 being high engagement). Whittington Health staff engagement score in 2018 is 7, which is the national average as well as the average for Combined Acute & Community Trusts. Whilst the nine questions for providing an overall engagement indicator are the same, the previous '32 key findings' in which different questions sat, have now been replaced by ten themes, and all nine questions now make up the 'Staff Engagement' theme

Staff Engagement	Whittington Health Scores	National Scores: Average Combined Acute & Community
I would recommend WH as a great place to work	59.2%	61.1%
I am happy with the standard of care provided	69%	69.9%
Care of patients is a top priority for Whittington Health	78.1%	76.5%
I am able to make suggestions to improve the work of my team / department	73.3%	75.2%
There are frequent opportunities for me to show initiative in my role	74.3%	73.4%
I am able to make improvements happen in my area	58.3%	56.5%
I look forward to going to work	58%	59.3%
I am enthusiastic about my job	71.2%	74.8%
Time passes quickly when I am working	75.7%	77.6%
Overall Engagement Score	**7**	**7**

Top Ranking Scores

Last year the 43 combined acute and community trusts in England were placed in order from 1 to 43 against the 32 'key findings'. In 2018, the same trusts are ranked against the ten themes under 'best', 'worst' and 'average'. This year Whittington Health was not placed in the 'best' ranking for any of the 10 themes and reported at the 'worst' for four of the themes, as detailed below:

Theme	Whittington Health – overall trend
Equality, Diversity & Inclusion	Ranked with '**worst** trusts'. Decline from last year
Health & Wellbeing	Ranked with '**worst** trusts'. Decline from last year
Immediate Managers	Ranked as '**below average**'. Decline from last year
Morale	Ranked with '**worst** trusts'. *No ranking from previous years*

Quality of Appraisals	Ranked as '**above average**'. Decline from last year
Quality of Care	Ranked as '**above average**'. Decline from last year
Safe Environment – Bullying & Harassment	Ranked with '**worst** trusts'. Decline from last year
Safe Environment - Violence	Ranked as **'below average**' Decline from last year
Safety Culture	Ranked as '**below average**'. Same as last year
Staff engagement	Ranked as '**average**'. Same as last year

This is possibly the result of the increased attention and focus on culture throughout the organisation, and the invitation to staff to discuss and share experiences so that they can be improved. We were advised at the outset when commissioning external research into our culture that this may be the initial outcome before things improve.
The table below present the results of significance-testing conducted on this year's theme scores, and those from last year, detailing Whittington Health theme scores for both years and the number of responses on which they are based.

Whittington Health – local changes

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.6**	1613	**8.3**	1861	↓
Health & wellbeing	**5.6**	1652	**5.5**	1894	Not significant
Immediate managers	**6.7**	1621	**6.6**	1896	Not significant
Morale		0	**5.7**	1846	N/A
Quality of appraisals	**5.6**	1337	**5.5**	1576	Not significant
Quality of care	**7.6**	1529	**7.5**	1766	Not significant
Safe environment - Bullying & harassment	**7.7**	1589	**7.4**	1852	↓
Safe environment - Violence	**9.5**	1586	**9.4**	1851	↓
Safety culture	**6.6**	1631	**6.6**	1873	Not significant
Staff engagement	**7.0**	1679	**7.0**	1935	Not significant

Percentage of Staff Experiencing Harassment, Bullying or Abuse from Staff in the Last 12 Months

In 2017, the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months, was one of the Trust's bottom ranking scores, at 22.5% and in 2018 it has gone up to 25.8% which is ranked in the category of 'worst' for national similar trusts. After the 2017 survey, the trust sponsored a piece of independent research led by Professor Duncan Lewis on the level of bullying and harassment

within the trust and the workplace culture. The organisation was informed after the 2017 research survey was conducted, that the results may worsen as staff felt encouraged to speak up.

Key findings from the survey include:

- While 25% reported bullying/harassment, 72% did not.
- 35% of respondents reported observing bullying and harassment.
- Respondents reporting most bullying and harassment emanating from managers and colleagues
- Evidence of inappropriate manager behaviours and a perceived unwillingness by the Trust to do anything when issues were raised.
- Excessive work demands, poor clarity around role and staff fit to strategic goals and objectives, poor change management processes/engagement with change.
- Bullying and Harassment directly impacting upon communications and willingness to speak up which has implications for the effectiveness of the Freedom to Speak Up Guardian role.
- Bullying and Harassment negatively impacting organisational citizenship behaviours but not adversely affecting collegiate citizenship.
- Bullying and harassment directly negatively affecting line manager relationships and a perceived lack of senior manager commitment to safe psychological working which ultimately impacts on organisational effectiveness as well as job satisfaction

C.550 members of staff contributed to the subsequent listening events offering their thoughts on what actions to take in light of the findings.

To continue to engage staff a new PulsePoint survey has been introduced, undertaking a quarterly 'pulse check' of staff satisfaction asking a different question each quarter on a topic that matters to staff. The results from the first PulsePoint that asked how satisfied staff were with the trust's response to bullying and harassment is being fed back to the Board at the end of April 2019.

Percentage of Staff Believing the Trust Provides Equal Opportunities for Career Progression/Promotion

The percentage of staff believing that the organisation provides equal opportunities for career progression or promotion is also one of our five bottom ranking scores, at 73% in comparison to the national average of similar trusts at 85%. The Trust has joined the NHS Improvement 'Inclusion Labs' project to help improve our inclusion performance and has increased the Inclusion Team to support this work.

Progress on the 2017 Staff Action Plan

The focus in 2017 was by aggregating the results in four ways:

1) 2016 focus areas where there has been no significant improvement

2) where there has been deterioration in local performance
3) where the Trust compares less favourably with other combined acute and community trusts
4) additional themes picked up from analysis of staff free text

These themes were shared with the ICSUs and Directorates so they could focus on the areas most relevant to them, working from the top and cascading downwards, using the '***We Said We Did'*** templates to capture improvement work at team level

To support managers and ensure staff were included in the process a number of workshops and support was offered by HR and Organisational Development to 'hot spot' teams. This included attending senior team Away Days, helping managers facilitate workshops to share the data and identify improvement areas, team development workshops, coaching and in some areas mediation.

Below are the comparisons of 2017 and 2018 key findings in relation to 2017 focus areas

2017 Focus Areas	Key Finding	2017	2018	Significant change (as reported by NHS Co-ordination Centre)
Equality & Diversity	KF 20. Percentage of staff experiencing discrimination at work in the last 12 months	19%	22%	Significant increase
	KF 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion Q14 Organisation acts fairly	73%	70%%	Not significant
Errors & Incidents	KF 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	87%	89%	Not significant
Health and Wellbeing	KF 17. Percentage of staff feeling unwell due to work related stress in the last 12 months	45%	44%	Not significant
	KF18. Percentage of staff attending work in the last 3 months despite feeling unwell	56%	55%	Not significant

	because they felt pressure from their manager, colleagues or themselves			
	KF16. Percentage of staff working extra hours	75%	75%	No change
	KF 19. Organisation and management interest in and action on health and wellbeing	3.53	3.46	Significant decrease
Job Satisfaction	KF 8. Staff satisfaction with level of responsibility and involvement	3.87	3.86	Not significant
	KF 14. Staff satisfaction with resourcing and support	3.21	3.22	Not significant
Violence, Harassment and Bullying	KF 23. Percentage of staff experiencing physical violence from staff in last 12 months	3%	3%	No change
	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	29%	32%	Not significant
	KF. 26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	31%	34%	Not significant

Whilst each ICSU/Directorate has identified their own areas of focus across the 2018 ten themes, the whole trust has a commitment to:

a) creating a culture that is equal and welcomes diversity, as well as;
b) ensuring staff health and wellbeing is supported.

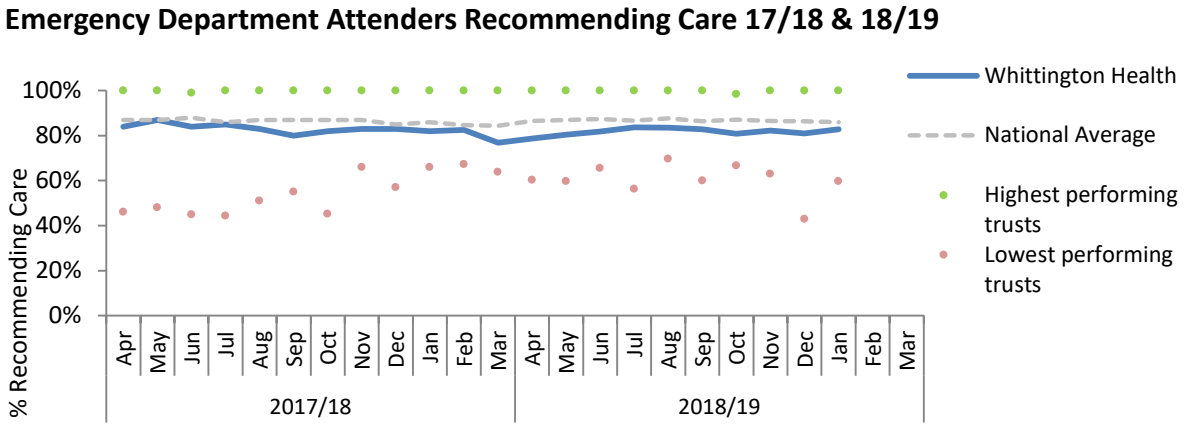
The Trust successfully bid to be one of four London Trusts to join the new NHSI/UCLP Culture and Leadership Collaboration that commenced in January 2019 and runs until 2020.
The Collaborative offers direct teaching, action learning, expert and experienced speakers as well as coaching to support the development of an internal change team (and wider reference group of 100-150 staff) who will help deliver a 2-3 year programme of social movement, helping to develop a culture of compassion and inclusion

The change team and wider reference group will be multidisciplinary and representative of the diverse workforce it serves with sponsorship and support from the Board.

Patient Friends and Family Tests

Whittington Health NHS Trust is dedicated to providing patients with the best possible experience whilst accessing our services. We understand that in order to improve patient experience and quality of care, we need to ensure that our services are listening and responding to patient feedback. We know that improving patient experience and treating our patients with dignity, compassion and respect has a positive effect on recovery and clinical outcomes. One of the primary models we employ trust wide to collect patient feedback is the Friends and Family Test (FFT). The FFT asks patients whether they would recommend Whittington Health NHS Trust to their friends and family if they needed similar treatment.

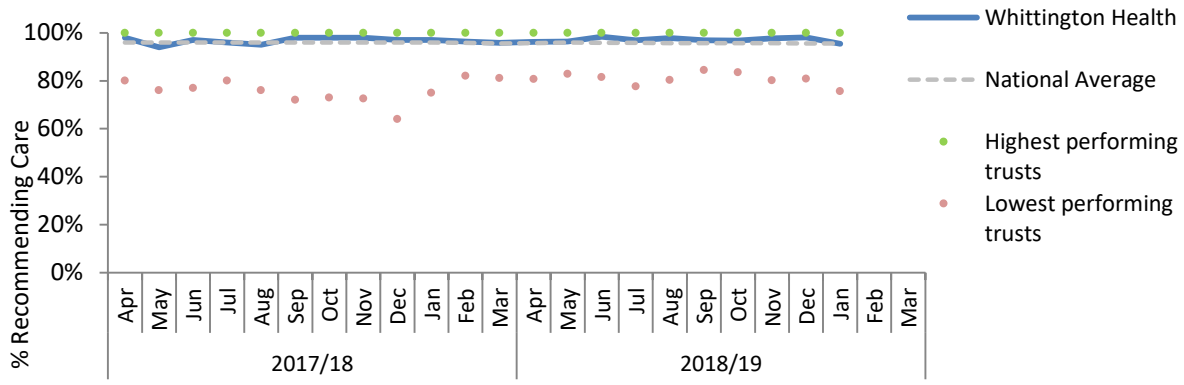
Across 2017/18 the Trust collected 42,080 FFT. For 2018/19, the total amount of FFT collected increased to 44,061. In 2018/19 the average recommend rate across services was 91.76%, this is an increase from 2017/18's average recommend rate of 91.65%.



We are ongoing with work to improve our recommending rate within the Emergency department. Actions here include:

- The department has allocated a patient experience lead from the nursing team. The patient experience team meet monthly with the lead to forward actions towards improving patient experience.
- A child friendly FFT survey was designed and implemented for usage in ED paediatrics.
- Enhanced presence of volunteers throughout 2018/19 to support with FFT collection.

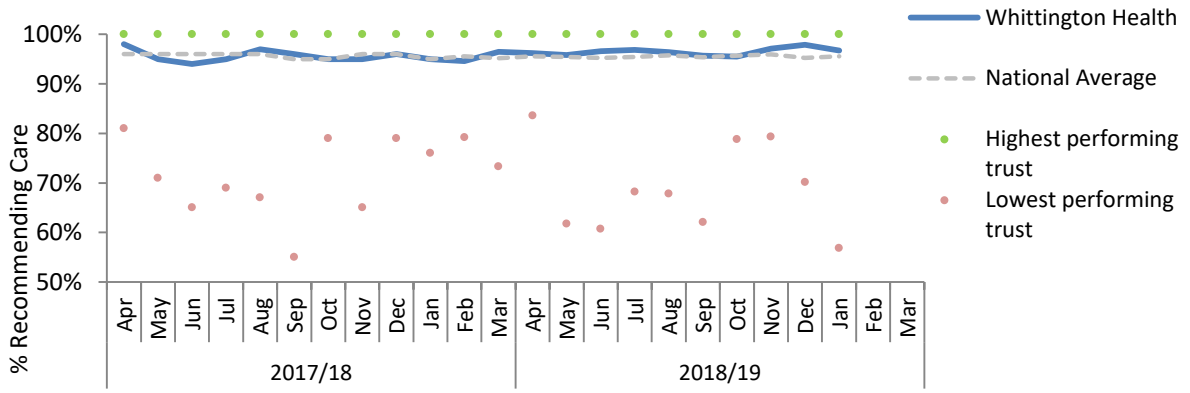
Inpatients Recommending Care 17/18 & 18/19



There has been a consistent improvement among the inpatient recommending rate throughout 2018/19, with the Trust typically performing above the national average. Work ongoing and completed towards improving patient experience and FFT responses has included:

- Introducing RITA (Reminiscence Interactive Therapy and Activities) in response to patient feedback on one of our busier inpatient wards...
- Launching our Sleep Well initiative to improve the night time experience for patients on our adult inpatient wards. This work has been developed in response to patient feedback collected locally through FFT as well as our national surveys.
- An increase in over 30% for the total number of volunteers supporting staff and inpatients on our wards through 2018/19 compared to the previous year.

Community Service Users Recommending Care 17/18 & 18/19



The recommendation rate for FFT collected throughout our community services across 2018/19 has consistently exceeded the national average. In addition to this, the Trust has consistently recorded significantly higher response total than the national average. Only in December 2018 did the Trust's community services record fewer responses than the national average. Actions taken over 2018/19 included:

- One of the patient experience priorities for 2018/19 was to improve the collection of FFT response from podiatry by 50% from the previous year. This was achieved. For 2017/18, podiatry collected 463 FFT; in 2018/19, podiatry collected 1,365 FFT. This sustained improvement has been driven by the SMS FFT alerts introduced in the service.
- Introduction of an iPad stand for the Child Development Centre in St. Ann's. The patient experience team are working with community services and IT to support the allocation of iPads for FFT collection at community sites.

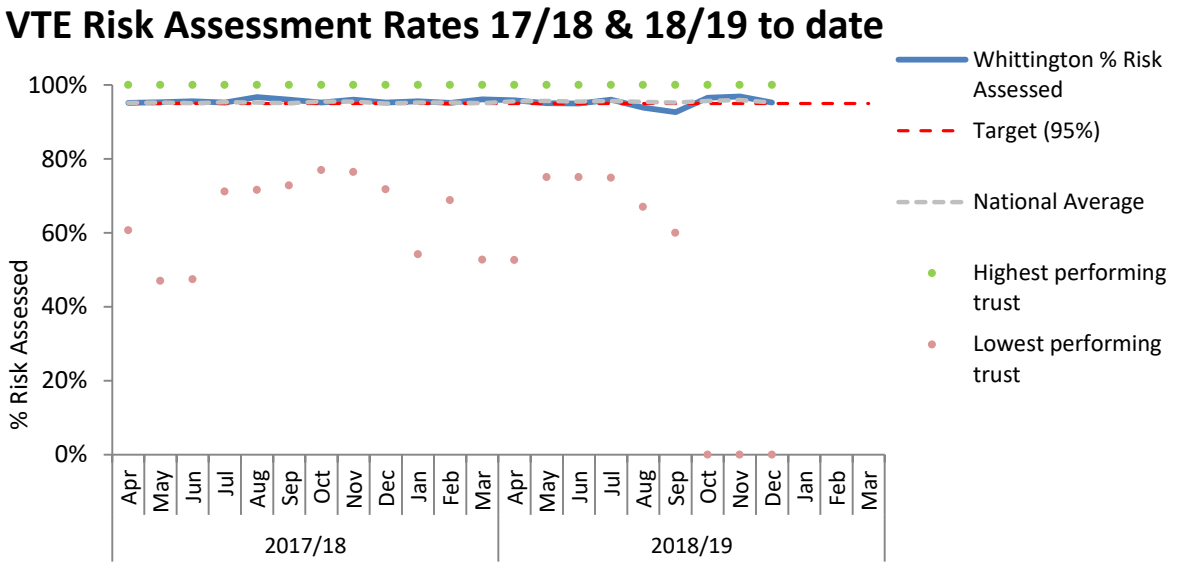
We will be taking the following actions to increase our response rates in 2019/20:

- Enhance the level of volunteer support throughout our community teams in accordance with the voluntary service strategy.
- Expand the distribution of service specific comment trend analyses to ward and service managers to raise awareness around FFT feedback.
- Improve the recommend and response rates in the Emergency Department.

Venous Thromboembolism (VTE)

Every year, thousands of people in the UK develop a blood clot within a vein. This is known as a venous thromboembolism (VTE) and is a serious, potentially fatal, medical condition. At Whittington Health we strive towards ensuring all admitted patients are individually risk assessed and have appropriate thromboprophylaxis prescribed and administered. In 2018/19 we achieved above 95% compliance for VTE risk assessment except for the August and September months. The Trust had just had its new cohort of trainees and the training on VTE assessments was not robust at this time.

In an effort to continuously improve, our medical colleagues undertake regular audits to ensure VTE compliance is robust and aligned with best patient outcomes.



The trust is taking the following actions in 2019-20 to further improve our VTE rates:

- Providing bespoke education on VTE assessments for clinicians
- Ward managers receive a daily email each morning with the patients on their ward who require VTE assessment. This is then picked up with junior doctors
- Matrons carry out regular audits of VTE compliance on their wards

Clostridium Difficile

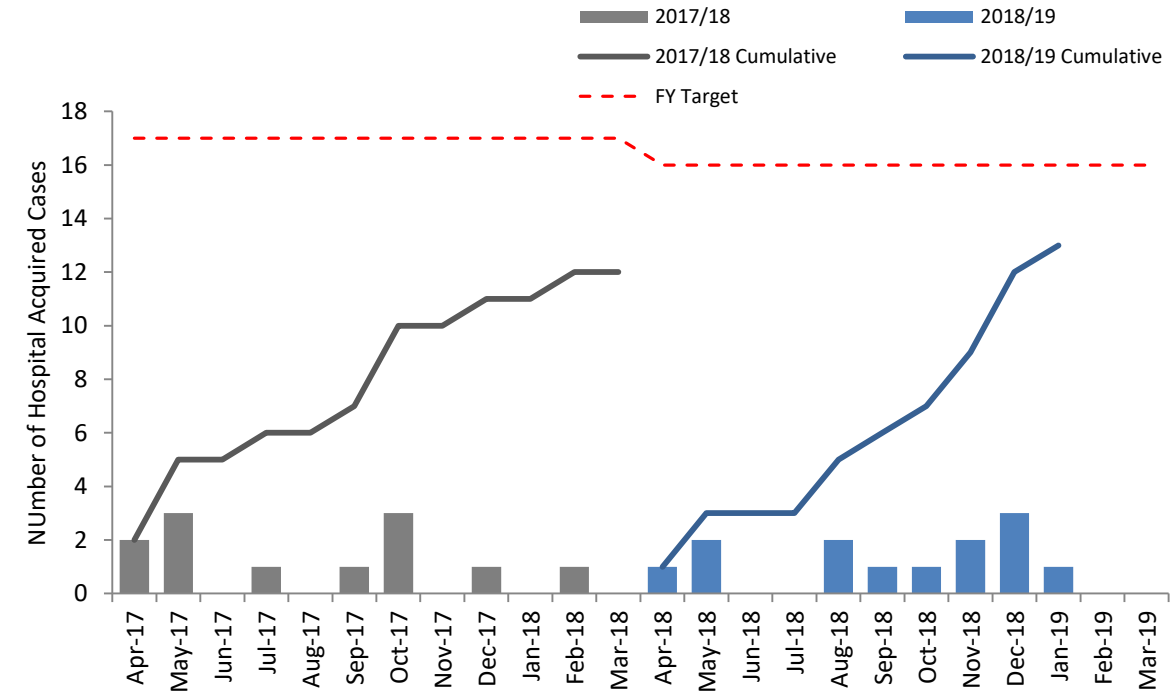
Whittington Health NHS Trust agreed ceiling trajectory for *Clostridium difficile* infections (CDI) in 2018/19 was set at 16 cases. There were 13 CDI's that were Trust attributable. Two of these were identified with no lapse in care whereas 8 notably had lapses of care that may have contributed to infection. Three CDI were deemed with no clear outcomes leading to a change in the process for investigating these infections during Q3. Further actions taken to reduce the number of *Clostridium difficile* cases that are attributable to Whittington Health include:

- Post infection review (PIR) focusing on all aspects of the patient pathway from admission to diagnosis.
- Specimens suspected of cross infection sent to the PHE reference lab for further identification.
- Action plans devised for all CDI's specific to each case, clinical area and speciality.
- Outstanding actions escalated and reviewed at the Infection Prevention and Control Committee (IPCC) meeting.
- Bespoke education sessions on *Clostridium difficile* was carried out in the clinical areas as well during induction and update teaching sessions.
- A multi-disciplinary clinical review of all cases and rapid feedback of lapses in care to prompt ward-level learning has been adopted since November, 2018.

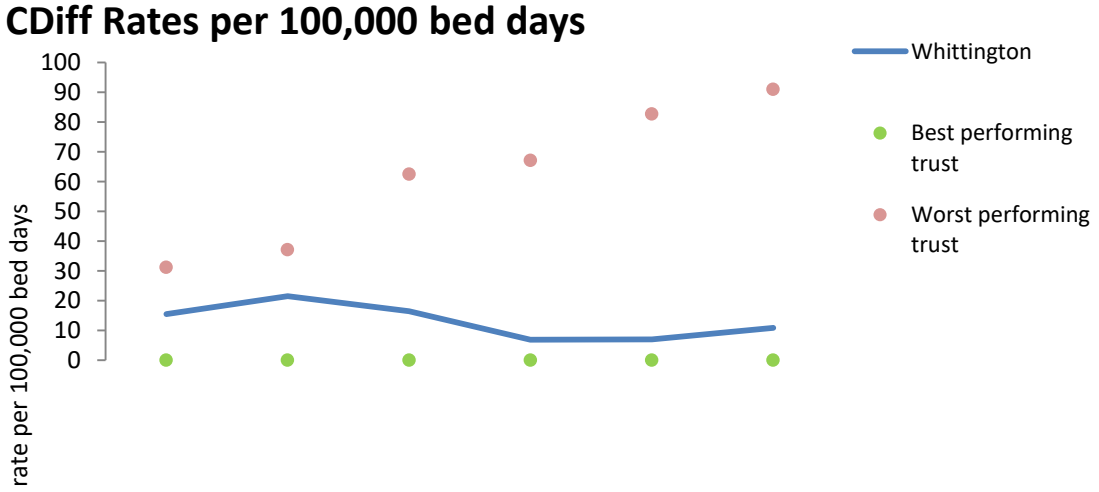
- The robust clinical review process is being supported by the CSU and all outcomes are reported to the CCG.

For 2019/20 our ceiling trajectory has been set at 19. The reason this has been increased, is because, nationally, the time between admission and a specimen being determined as Trust attributable has been decreased by 24 hours. A review of the cases from 2018/19 determined that there would have been no more Trust attributable cases under the revised system.

Clostridium Difficile Rates



CDiff Rates per 100,000 bed days



Trust-attributable Clostridium difficile infection rates at The Whittington Hospital NHS Trust rate as a ‘good news story’. If not comparing to a ‘like for like’ organisation i.e.

size and complexity, Whittington Health demonstrate year on year lower than trajectory for reducing Clostridium difficile infections since 2014.

When benchmarking against England according to fingertips https://fingertips.phe.org.uk/profile/amr-local-indicators/data#page/4/gid/1938133070/pat/158/par/NT_trust/ati/118/are/RKE/iid/91968/age/205/sex/4 we rate over the last four years as best performing.

From 1st April 2019 Trusts/CCG performance will look different in 2019/20 from previous years as PHE have altered the surveillance definitions around C. difficile infection, meaning that more cases will be considered "hospital acquired" going forwards. See the detail below.

Summary of changes to C. difficile surveillance definitions:

- Change to 'Trust case' attribution, from 72 hours post admission to 48 hours. This brings C. difficile in line with blood stream infection reporting and attribution. There will be no change to way we report as a result of this, but a small number of cases that would have been community-attributed will become Trust-attributed.

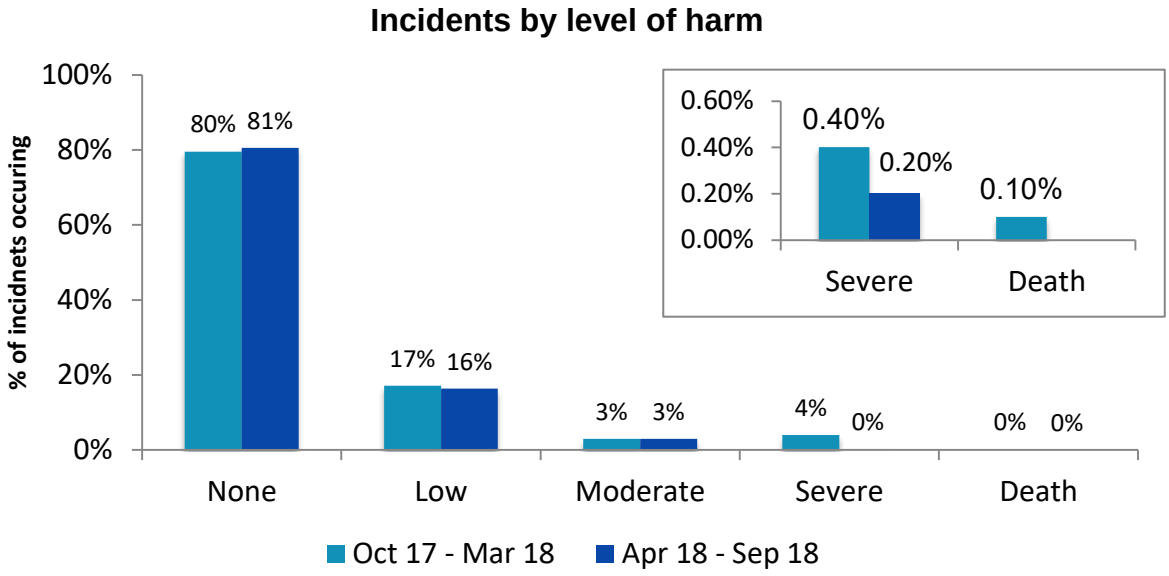
- 'Hospital associated' C. difficile will include two categories of cases:
    - Hospital onset – healthcare associated cases (HO-HA). These are cases where the C. difficile sample is taken 48 hours post admission. This category is synonymous with the Trust-attributable category we have used in prior years
    - Community onset – healthcare associated cases (CO-HA). These are cases where the C. difficile sample is taken pre 48 hours post admission, but where the patient has had an in-patient admission in the 4 weeks prior to the current C. difficile positive result. These cases would previously have been classified as 'non-Trust'

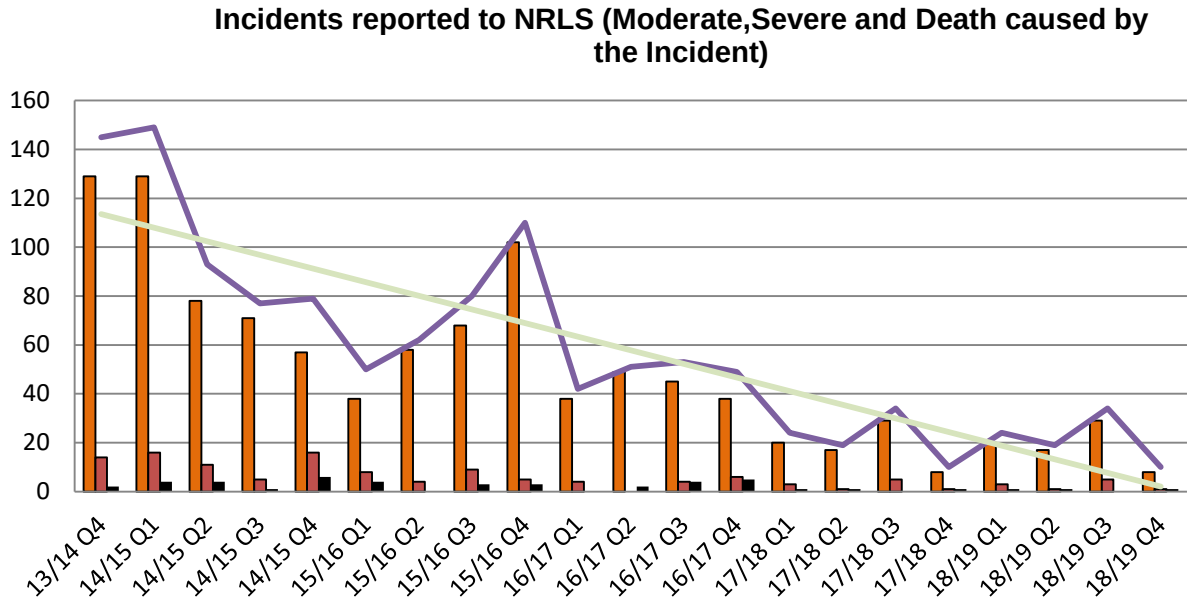
Patient Safety Incidents

Whittington Health NHS Trust actively encourages incident reporting to strengthen a culture of openness and transparency which is closely linked with high quality and safe healthcare. The latest NHS Improvement report shows that we have a very good reporting culture within the organisation, placing us in the top quarter for incident reporting across the country.

Historically, it appeared that the Whittington Health NHS Trust had a higher proportion of incidents causing moderate-severe harm or death compared to the national average for acute non-specialist trusts. However, as the chart below demonstrates, there has been a significant change in the reporting culture in recent years and the classification process for grading the harm of incidents has been aligned with other NHS organisations.

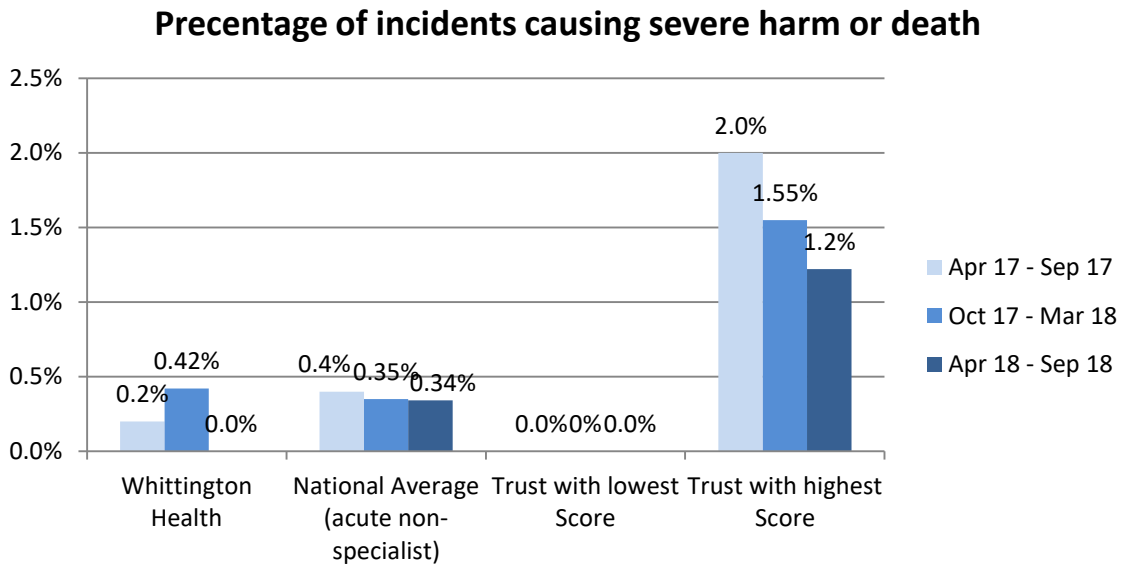
Incident Harm Grading Chart

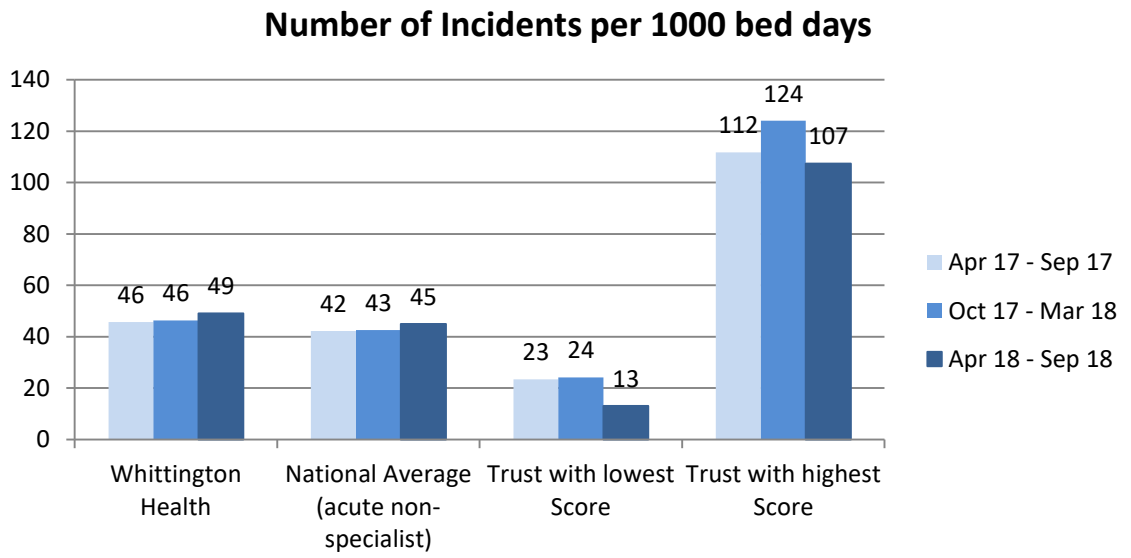




In 2018/19 there were a total of 32 serious incident investigations declared within the trust compared to 38 in 2017/18. During 2017/18 unfortunately the trust recorded one never event, in December 2018, a wrong site surgical procedure. Patient was due for an elective revision of the left shoulder replacement. They received an inter-scalene block awake under ultrasound guidance with peripheral nerve stimulation on the wrong (right) side.This was discovered before any surgery was performed and there was no repeated on-going harm to the patient.

The learning from the incident was disseminated across the organisation and the 'Stop Before you Block Process' was further embedded into clinical practice with audit built into sustainability of practice.





Since 2014 there has been a statutory duty of candour to be open and transparent with patients and families about patient safety incidents which have caused moderate harm or above. The trust complies with its statutory obligations but also strives to apply being open principles for low harm patient safety incidents which do not meet the statutory criteria.

Central Alerting System (CAS) Alerts

Patient safety alerts are issued via the CAS, which is a web-based cascading system for issuing alerts, important public health messages and other safety information and guidance to the NHS and other organisations. The Whittington Health NHS Trust uses a cascade system to ensure that all relevant staff are informed of any alerts that affect their areas. In 2017/18 all CAS alerts were responded to within the predetermined timeframe for the alert and is reported regularly at the trust's Patient Safety Committee.

Freedom to Speak Up

The Trust is committed to encouraging openness and honesty in the workplace, and creating a supportive culture where members of staff feel able to raise concerns without any fear of repercussions. The Trust welcomes genuine concerns and is committed to dealing responsibly, openly and professionally with them.

Staff are encouraged to raise concerns about risk, malpractice or wrongdoing that they think is harmful to the service we deliver. Just a few examples of this might include (but are by no means restricted to):

- unsafe patient care
- unsafe working conditions
- inadequate induction or training for staff
- lack of, or poor, response to a reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter-fraud team)
- bullying and harassment

Healthcare professionals have a professional duty to report a concern.

A whistleblowing policy has been in place at the Trust since 2012. It was reviewed in February 2017 and February 2018 following the launch of the National Guardian Office and, Freedom to Speak up role.

The Trust employed a full time 'Freedom to Speak Up Guardian' in November 2018 to assist staff with raising concerns and to provide confidential advice. Prior to this the role was undertaken by the Associate Director of Nursing for the Children and Young People ICSU.

Seven Day Service Standards

The 7 Day Hospital Services (7DS) Programme supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England.

This work is built on ten clinical standards, four of which were prioritised for delivery to ensure that patients admitted in an emergency receive the same high quality initial consultant review, access to diagnostics and interventions and ongoing consultant-directed review every day of the week.

- Standard 2: Time to initial consultant review
- Standard 5: Access to diagnostics
- Standard 6: Access to consultant led interventions
- Standard 8: Ongoing daily consultant-directed review

We are not fully compliant with our access to 7DS for Echocardiograms and this has been risk assessed, discussed with relevant clinical leads and escalated to the CCG's via Clinical quarterly review group.

A repeat audit looking at compliance with standards 2, 5, 6 and 8 will be carried out by June 2019.

There is a self-assessment for the remaining standards 1, 3, 4, 7, 9 and 10. We are fully compliant with standards 1, 3, 7, 9 and 10. We are partially compliant with standard 4 about handover of patients, our move to electronic systems of patient handover in the next 12 months we allow us to be fully compliant.

Part 3: Review of Quality Performance

This section provides details on how the trust has performed against its 2018/19 quality account priorities. The results presented relate to the period April 2018 to March 2019 or the most recent available period.

Priority not achieved
Priority achieved

Priority 1: Improving Patient Experience

What were our aims for 2018/19?
Development of a Patient Experience Strategy in consultation with patients and families
ACHIEVED The patient experience strategy was developed throughout 2018/19, taking into account the views of patients, Health Watch and our multi-disciplinary teams. The strategy was ratified at Quality Committee in January 2019 and was approved at Trust Board in March 2019. An implementation plan is being developed and the Trust's communications team have created a short animation for patients, the public and staff highlighting the key messages and the ambitions from the strategy. The Strategy will be launched later in 2019.

What were our aims for 2018/19?
We will complete a trust wide review of patient information quality and availability and aim to improve information in accessible formats
PARTIAL ACHIEVED Targeted reviews of particular areas are taking place and information being updated accordingly (current resource only allows a targeted approach). A number of services across the organisation were updated this year. The Trust will build on the excellent work started in 2018/19 for the coming year 2019/20. Further work is taking place updating patient information and leaflets. We will also be reviewing signage and correspondence (Patient letters) to ensure that they contain the right information.

What were our aims for 2018/19?
We will better our 'quality of food' score from the 2017 National inpatient survey, which is based on patient feedback
NOT ACHIEVED however, there will be a significant focus from the nutritional steering group in addressing this which will report to the Patient Experience Committee. Local patient experience feedback throughout 2018/19 has not noted an improvement on patient views around inpatient wards' meals. The 2017 inpatient national patient experience survey presented a marginal improvement on the previous year's feedback around food: 56% of patients reported food was fair or poor in 2017, as compared with 51% in 2016. The Trust has decided not to make this a priority for 2019/20 as there is significant work underway to review patient food which will be reviewed at patient experience committee.

What were our aims for 2018/19?
We will ensure a full range of food choices are available on all hospital wards
NOT ACHIEVED The Trust is currently considering options for the future provision of the service. A key element in all options is to provide ward hostesses to manage the food service on the wards. This will help to address a number of current issues regarding service delivery and quality. Facilities and the nutrition team have been working with Sodexo to introduce a new menu - this should start from then 1st April 2019. A finger food menu was introduced in 2018.

What were our aims for 2018/19?
We will ensure 95% of patients arrive 15 minutes prior to their appointment *We will ensure 95% of patients are picked up within one hour of their appointment ending* *We will complete a survey of patients using hospital transport to establish if providing a 'call ahead' has improved patient experience.*
ACHIEVED Cumulative percentage for December is at 99.48% for Whittington health and 99.42% for Haringey patients arriving 15 mins prior to their appointment. Cumulative percentage for December is at 98.75% for Whittington health and 97.43% for Haringey patients being picked up within one hour of their appointment ending. The Transport service provides a call ahead a few days prior to the patient's appointment. They check the patient transport requirements and ensure the patient is still fit to attend.

	Feedback from patients has been very positive. 89% of patients reported receiving a call prior to the transport arriving. 98% of patients reported that the transport crew introduced themselves and clearly explained what would happen during the journey. 97% of patients reported arriving on time for their journey. 100% of patients reported being treated with dignity and respect.

What were our aims for 2018/19?
We will reduce outpatient clinic cancellations by 3% from our 2017/18 monthly average

	NOT ACHIEVED -Trust cancellation rate for 18/19 12.7% (Monthly average) compared with 11.9% (Monthly average) in 17/18. There has been significant improvement. As the DrDoctor contract has not been renewed the text reminder service for all specialties will move to the Remind+ (Netcall) provider. This will be a phased roll over and will be completed by the end of April (30/04/2019). The Chief Information Officer has developed a task and finish group to manage this change. The transition will mean patients will still receive text messages for their outpatient appointments with specific telephone numbers to call the respective booking teams to manage their appointments leading to an anticipated increase in activity. This is an intermediary solution until the IM&T directorate can procure a viable text message solution that fully integrates with the Trust's PAS system (Medway). There is an increased risk of higher DNA rates as patients are relying on successfully getting through to a member of the administration team to reschedule their appointments as well as added administration pressure of managing the increasing number of phone calls. The DrDoctor platform in which patients have access to for additional information about their appointments will still be live for all patients 6/8 weeks after contract termination. There will be a communication strategy to raise awareness of the changes in process. The classification of cancellations needs to be considered in 2019 as it includes appointment times that change on the same day but are still recorded as cancellations.

What were our aims for 2018/19?
We will improve the continuity of care from district nursing with a particular focus on patients of concern (palliative care patients, those in receipt of continuing healthcare funding, safeguarding concerns and patients with pressure ulcers)

PARTIALLY ACHIEVED
Palliative care patients: We have launched our End of Life toolkit in February 2019. This includes our excellent care in the last days of life booklet which advocates and supports patient choice regarding preferred place of care. We have also identified a link palliative care nurse for each team who will provide most of the care to the palliative care patients to improve continuity.

Continuing healthcare funding: Haringey - We have appointed a named nurse in Haringey responsible for completing assessments across all four district nursing teams. This has reduced the backlog and attendant complaints regarding wait times. Islington CHC patients are now reassessed by the continuing healthcare team. Safeguarding concern: Patients with ongoing safeguarding concerns are logged as such in eCommunity and discussed with the lead DN for the teams on a monthly basis and updates inputted.

Patients with pressure ulcers: streamlined the reporting and management adding regular meetings with TVN, Lead DN, and risk management team to strengthen process and learning. An updated dashboard in Datix management has been created to increase focus and transparency.

What were our aims for 2018/19?

In podiatry we will achieve a 50% increase in Friends and Family Test response rates, whilst maintaining the trust 90% recommendation rate for the service

ACHIEVED The Friends and Family test results for Podiatry have shown an increase of approximately 150% from the most recent round of response rates. This increase has been achieved due to the utilisation of SMS Friends and Family links sent to patients alongside radar reporting, and also due to an enhanced focus on collecting feedback among the local teams.

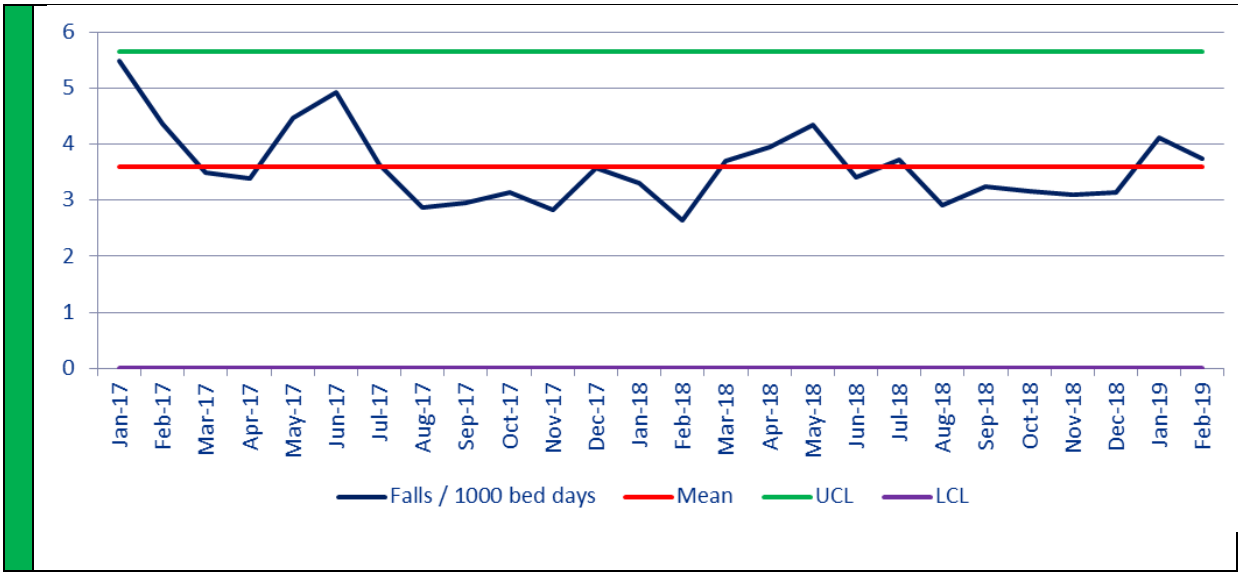
Priority 2: Improving Patient Safety

What were our aims for 2018/19?

We will equal or reduce the number of avoidable falls in the hospital resulting in serious harm to patients compared to 2017/18

ACHIEVED There was reduction in falls with harm as seen in the graph below, between November 17 and August 2018 on Inpatient Wards with the STOPfalls Project.

We have had 3 severe harm incidents and 3 moderate harm incidents (moderate harm incidents peaked in Q3, with 5 reported). This is suddenly increase in severe harm incidents, with none reported in the financial year prior to quarter 4



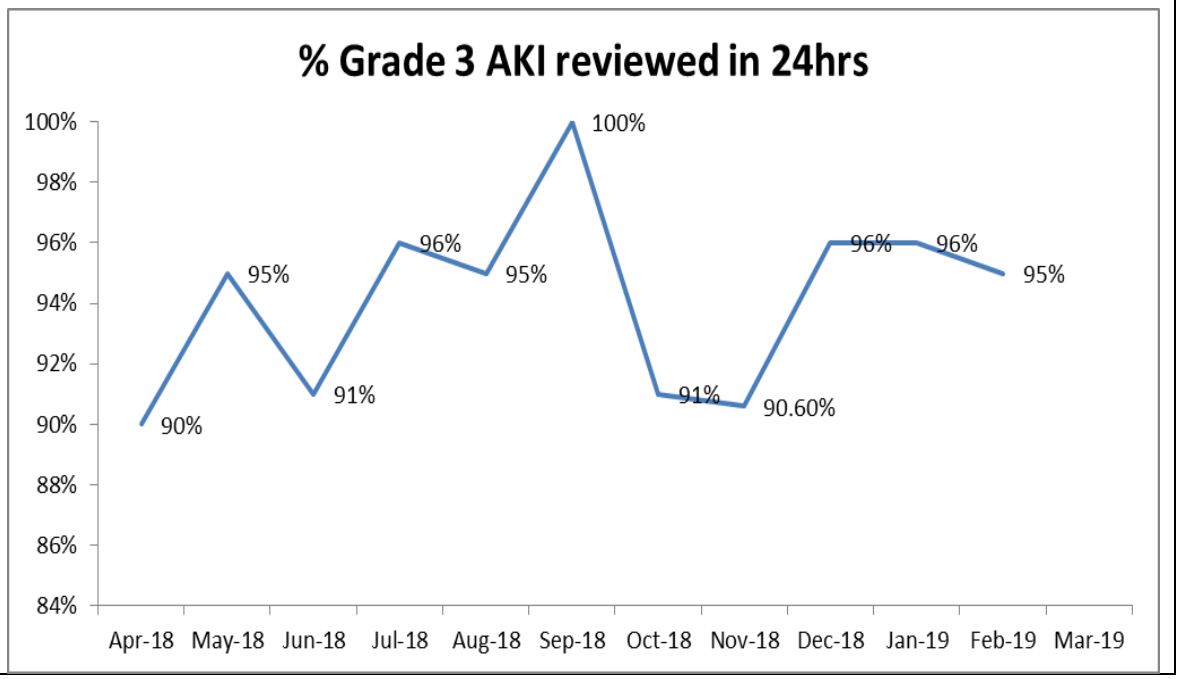
What were our aims for 2018/19?
We will increase compliance with our STOPfalls bundle to 85% in our acute assessment unit (AAU) and care of older people wards

PARTAILY ACHIEVED with increased compliance with our STOPfalls bundle to 85% in our care of older people wards but more improvement needed in AAU.

- To continue to reduce harm caused by falls within the hospital and aim for 100% compliance with the STOPfalls bundle, to work on embedding Johns campaign in practice
- To continue to monitor falls throughout the organisation and target areas using QI methodology that require improvement.
- In Sept 2018 we held an Older Peoples Celebration Day with the following work streams of Frailty, Falls, Dementia, Delirium and Parkinson's disease as a showcase of all work that supports older people across the ICO, this was so well received and reviewed that we hope to make it an annual event.
- A CPEN learning event was held in Jan 2019 this was a great success, so much so we have been asked to provide another day in April, all WH staff are invited to attend
- We have submitted an application for UCLP QI funding regarding a project around Enhanced Care, falls awareness and prevention would be a part of the training package for this project
- Falls training will be included in corporate induction and mandatory training refresher courses as from May 2019.
- Prior to this we are planning to relaunch STOPfalls at the end of April, in a week of Falls awareness across the acute trust in response to the spike in falls that has been experienced recently.
- Baywatch will be the main focus of this awareness raising, as following its initial success following launch in 2017 our recent audits have highlighted poor understanding as to how Baywatch is intended to be implemented.

What were our aims for 2018/19?
We will develop a mandatory training package for falls prevention
ACHIEVED Falls lead attended Mandatory Training working group – 'foot in the door'. Mandatory training package for falls has been developed. Falls mandatory training will start in May 2019.

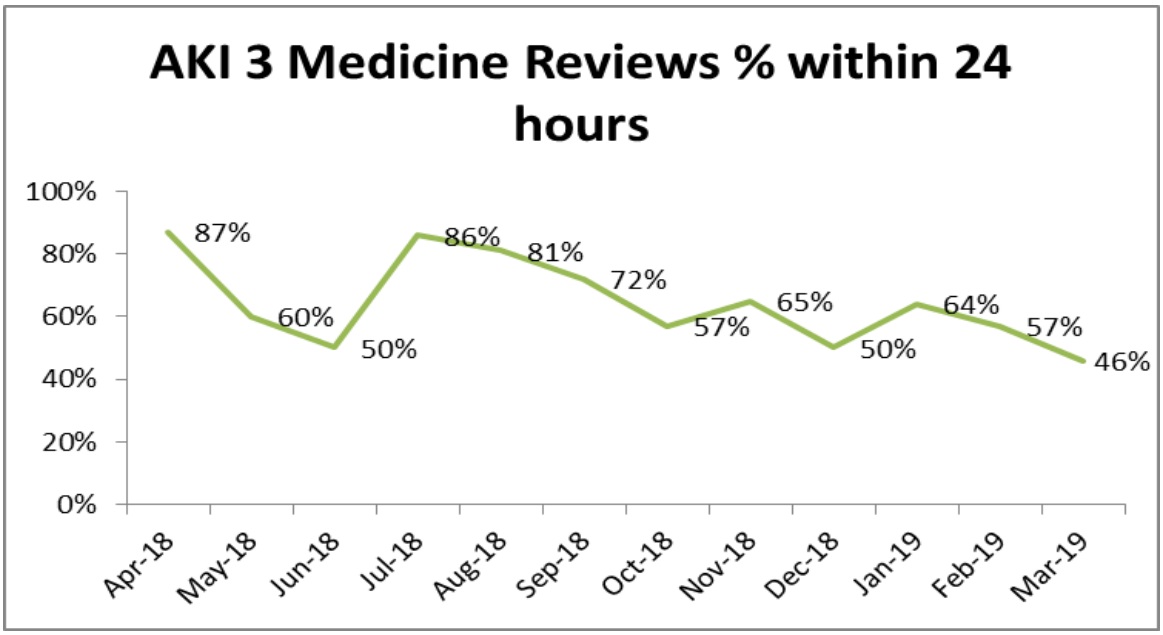
What were our aims for 2018/19?
The Critical Care Outreach Team (CCOT) will review 90% of patients with a grade 3 AKI within 24 hours of detection
ACHIEVED The CCOT team have achieved the 90% and above consistently from Apr 18 - Feb 19.



What were our aims for 2018/19?
We will increase our medicine safety reviews for grade 3 AKI patients within 24 hours from 53% to 75% by March 2019
NOT ACHIEVED Target has been achieved for Q2 2018/19; however, not consistently being met.

Month	No of AKI 3's	No of reviews within 24 hours	% within 24 hours
Apr-18	15	13	87%

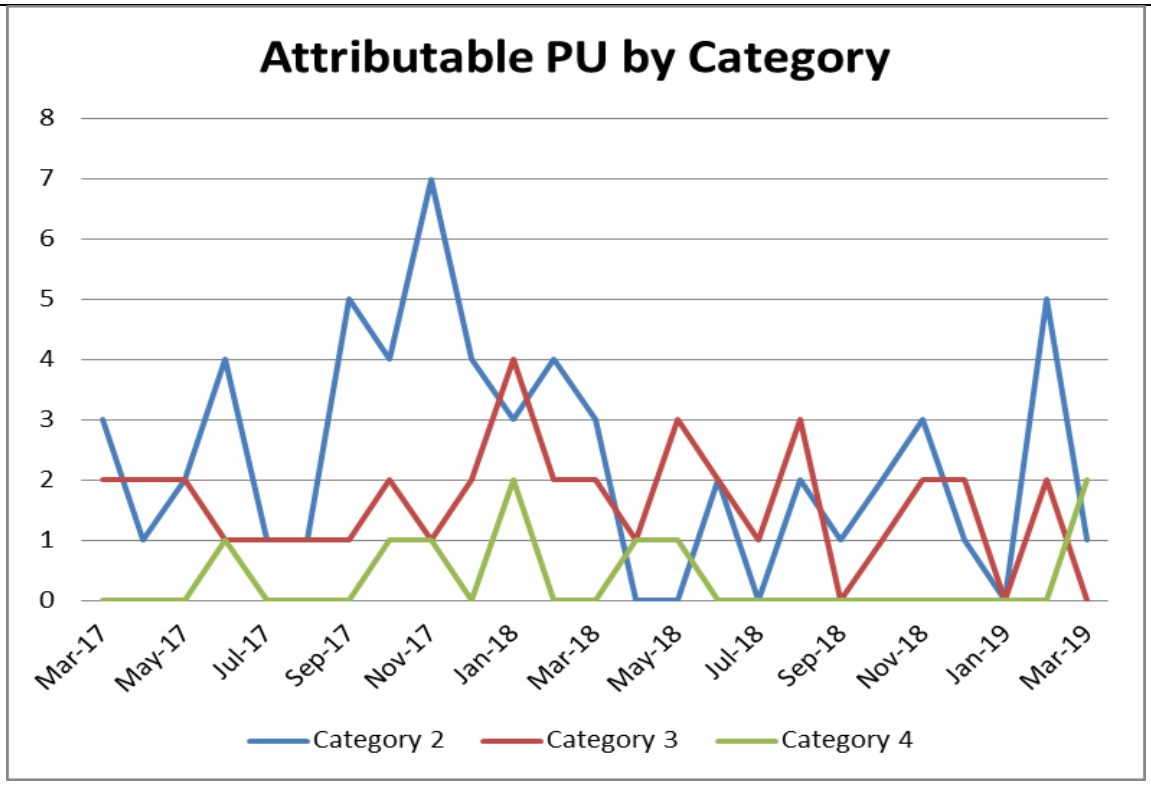
May-18	10	6	60%
Jun-18	10	5	50%
Jul-18	14	12	86%
Aug-18	16	13	81%
Sep-18	18	13	72%
Oct-18	23	13	57%
Nov-18	20	13	65%
Dec-18	24	12	50%
Jan-19	25	16	64%
Feb-19	21	12	57%
Mar-19	26	12	46%



What were our aims for 2018/19?

We will reduce the number of avoidable grade 4 pressure ulcers from 5 in the community and continue to maintain 0 within the hospital

ACHIEVED Two attributable Grade 4 pressure ulcers have been declared in 2018 -19 in the community. No category 4 pressure Ulcers for 8 months up to April 19. Datix dashboard developed



What were our aims for 2018/19?
We will promote John's campaign – 'for the right to stay with people with dementia' – whilst patients with dementia our in our care
PARTIALLY ACHIEVED Dementia Study Day relaunched in March 2019 with the aim to run these quarterly. There is a dementia task group reviewing training and management of dementia pathway. The trust are due to go out to advert for a Dementia CNS who will lead on the implementation of the John's Campaign. Planned visit to Homerton Hospital to see John's Campaign in practice

What were our aims for 2018/19?
We will develop a frailty pathway that will prioritise the care of patients over 75 who have been diagnosed with frailty
ACHIEVED Frailty pathway was relaunched on 23rd April 2018. Patients 75 and above are screened in ED rapid assessment and triage (RAT) using the Rockwood Frailty score. Patients who score 5 and above and have the possibility of being discharged that day are referred to the 'Ambulatory Frailty Pathway' for a comprehensive geriatric assessment and supported discharge.

Frailty Group meets weekly to review project/PDSA progress.

Outcomes from 2018 / 19
3658 Rockwood Frailty Scores recorded in the first year of implementing our Frailty Pathway

Within our first year our ambulance arrivals, 75 and over, given a frailty score: 44%

Electronic Comprehensive Geriatric Assessments completed: 118

375 patients seen under the medical frailty stream

What were our aims for 2018/19?
Within our emergency department we will see 75% of patients with an autism spectrum condition or a learning disability in under two hours
PARTIALLY ACHIEVED: ED achieving an average 73.5% patients seen within 2 hours (range 63% - 89% Apr-Sept 2018)

What were our aims for 2018/19?
We will increase the number of people with learning disabilities involved in trust activities e.g. volunteering, hospital guides
ACHIEVED • Work undertaken with trust Learning disabilities (LD)lead to provide LD people with taster volunteering sessions • LD stall in atrium advertising for volunteers • Volunteers with LD to support and recruit new volunteers during LD week • Met with LD lead to discuss further actions for recruitment into volunteering roles • Volunteer team has formed a link with Samuel Rhodes school (special needs school for children aged 5-19 in Islington) and three volunteers from the school are ongoing in their application • Volunteer team will be involved in the autism project (TAP), in offering three 10 week voluntary administrative placements to autistic service users.

Priority 3: Improving Clinical Effectiveness (Research & Education)

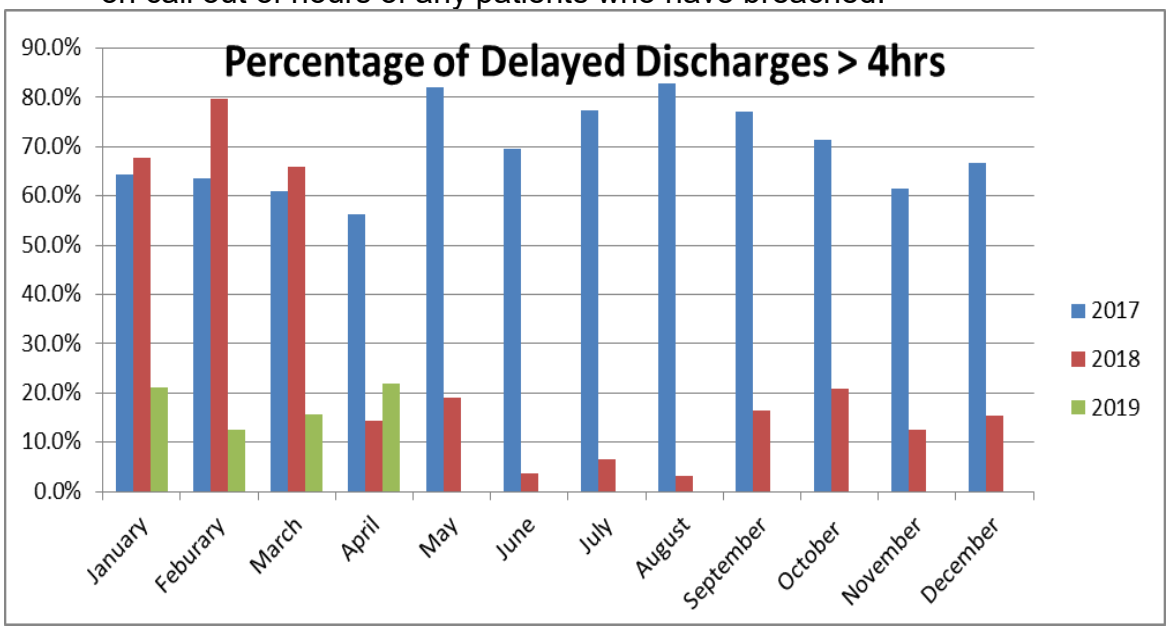
What were our aims for 2018/19?
We will achieve the national target of 95% of critical care unit ward-able patients being stepped down within 4 hours
PARTIALLY ACHIEVED This table shows the percentage of patients who require step down bed following admission to the critical care unit from 2017 to date in 2019

There has been significant progress as seen for 2019 data below. Actions taken include:

- The Unit Matron or Nurse-in-charge attends the 08:30 bed meeting and highlights any patients who are ready for discharge or potentially ready after consultant review.

- There has been a full revision of the bed management policy with particular emphasis on CCU and the need for timely discharges.

- If at 4 hours following decision to transfer, an appropriate clinical bed has not been identified, the CCU Nurse in Charge will escalate to bronze team. If transfer has not taken place at 3 hours following decision to transfer, the CCU Nurse in Charge will escalate to the Associate Director of Nursing for that ISCU. In the event of a plan not in place at 4 hours, the situation will be reported as an incident. The Site Management Team will inform Silver on call out of hours of any patients who have breached.



What were our aims for 2018/19?

We will develop a criteria-led discharge process at point of triage within the emergency department

ACHIEVED We have developed a robust criteria led discharge system which involves trained triage nurses discharging certain presenting complaints from triage, this enables a reduction in waiting times for adults and paediatrics patients who do not require an assessment from a Clinician, thus reducing the number of patients within the department contributing to our Key performance indicators.

We are in the process of developing a streaming model into the Whittington Emergency department. This will include all patients being streamed by an experienced nurses either to an alternative health service or into a queuing system, either avoiding triage altogether or placing them into a queue for triage

for a detailed assessment.

The Rapid assessment area is staffed by a see and treat ENP and Rapid assessment Clinician who will 'pull' patients from the queue and initiate all treatments and investigations which reduces the time to wait for treatment before being seen by a clinician. The ENP sees and treats the minor injuries that require little intervention and time which then allows all other clinicians to dedicate their time to those that require it.

What were our aims for 2018/19?

We will establish robust pathways between the Emergency Department and specialist onsite assessment units (GAU, AEC, EPU) and aim to stream 3% of presenting patients

ACHIEVED 3.3% presenting patients streamed to AEC (Average for the year) Pathways have been established between ED and AEC, UCC.

What were our aims for 2018/19?

We will introduce the delirium rapid assessment test - 4AT - and TIME (trigger, investigate, manage, engage) bundle for delirium identification and streaming on the AAU for patients over 65

ACHIEVED Delirium QI project started in July 2018 on AAU. The Delirium Screening Test implemented is the 4AT - this a document used by various settings internationally and it is in our delirium guideline. We created a Delirium Care plan to be started by nurses when the patient has Delirium. We created a Delirium Screening bundle on ICE.

The delirium care plan and 4AT are currently paper forms. Liaising with teams regarding adding 4AT to the medical clerking documentation.

We are using "pink flower" magnets as Delirium identifiers as well as the blue "forget me not" magnets for Dementia - this is used on patient boards, helpful during board rounds.

What were our aims for 2018/19?

We will increase the number of haematology patients involved in clinical research

ACHIEVED We have recruited 41 haematology patients into two research studies since April 2018 and through collaboration with UCLH have referred 5 patients to participate in trials not open at Whittington Health, so far 3 of these patients have been recruited. (In 2017/18 we did not recruit any haematology patients however we did have patients in follow up stages of trials).

What were our aims for 2017/18?

We will increase the number of clinical specialities and the number of nurses, midwives and AHPs undertaking research in 2018/19 compared to the previous year.
ACHIEVED Additional specialties taking part in research include bariatrics and community SLTs as well as expansion of the portfolio in recently engaged specialities such as anaesthetics and orthopaedics. There has been an increase in the number of nurses, midwives and AHPs taking on the role of PI or supporting studies in other ways - midwifery, in particular the community teams have seen the biggest increase with midwives delivering a novel intervention in the REACH trial.

What were our aims for 2017/18?
We will exceed the 724 patients recruited into research trials during 2017/18
ACHIEVED During 2018/19, 1,023 patients who received their care through Whittington Health were recruited into studies classified by the National Institute of Health Research (NIHR) as part of the NIHR research portfolio, once expected uploads are completed this is predicted to reach 1,050. This compares to 284 patients in 2013/14, 701 in 2014/15 and 720 in 2015/16, 515 in 2016/17 and 751 in 2017/18

What were our aims for 2017/18?
We will increase the number of 'Learning Together' interprofessional workshops from 7 in 2017/18 to 10 in 2018/19
ACHIEVED 11 'Learning together' interprofessional workshops were undertaken in 2018/19.

What were our aims for 2017/18?
Increase teaching satisfaction from 60% to 75% for all medical student placements and increase overall satisfaction for nursing and midwifery courses.
ACHIEVED Teaching satisfaction for Nursing placements for 2018/19 was 94%. Medical Student feedback was also very positive 90% of undergraduate medical students rated their Whittington Health placement as very good or excellent.

What were our aims for 2017/18?
We will increase the content available on the Whittington Moodle (electronic platform for education) and aim to develop a minimum of 5 new educational modules.
ACHIEVED 41 courses currently available on Whittington Moodle @ 31/03/2019 compared with 18 for 2017/18.

Part 4: Other Information

Local Performance Indicators

Goal	*Standard/benchmark*	*Whittington performance*	
		18/19	*17/18*
ED 4 hour waits	*95% to be seen in 4 hours*	***88.03%***	*89.4%*
RTT 18 Week Waits: Incomplete Pathways	*92% of patients to be waiting within 18 weeks*	***92.2%***	*92.2%*
RTT patients waiting 52 weeks	*No patients to wait more than 52 weeks for treatment*	***2***	*5*
Waits for diagnostic tests	*99% waiting less than 6 weeks*	***98.9%***	*99.1%*
Cancer: Urgent referral to first visit	*93% seen within 14 days*	**94.2%**	94.7%
Cancer: Diagnosis to first treatment	*96% treated within 31 days*	**100.0%**	100.0%
Cancer: Urgent referral to first treatment	*85% treated within 62 days*	**86.0%**	88.1%
Improved Access to Psychological Therapies (IAPT)	*75% of referrals treated within 6 weeks*	**94.9%**	95.8%

The Whittington Health NHS Trust considers that this data is as described because it is collected, downloaded and processed in a robust manner, and checked and signed off routinely.

In 2018/19 the trust has performed well compared to benchmarking for local performance indicators and has exceeded standards for Cancer, IAPT and RTT 18 week waits. However, there are two areas where the trust has not met these standards and is taking the following actions to achieve the 'ED 4 hour wait' ,'RTT patients waiting 52 weeks' and 'Waits for diagnostic test' goals.

Examples of actions include:

- We implemented the updated National Early Warning Score 2 (NEWS2) system
- Continue with the excellent work started in 18/19 implementing robust streaming pathways between emergency department triage service and specialist inpatient assessment units, aim to stream 5% of patients for 2019/2020 to these pathways.
- Revision and recruitment of the emergency department workforce in order to facilitate rapid assessment treatment (RAT) criteria led discharges
- Developing enhanced roles for nurses and health care assistants within the emergency department.

- Build on the Frailty work that was started in 2017/18 – Aim to further increase awareness of the 'Ambulatory Frailty Pathway' and increase the number of patients arriving via ambulance being given a frailty score to 50% (44% achieved in 18/19)
- Continue training and promotion of a pre-11 a.m. discharge culture
- System wide improvement: working with Haringey and Islington and the wider Sustainability and Transformation Programmes to improve the performance of ED.

Summary Hospital-Level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following admission to hospital and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI score represents a comparison against a standardised National Average. The 'national average' therefore is a standardised 100 and values significantly below 100 indicate a lower than expected number of mortalities (and vice versa for values significantly above).

Patients who are coded as receiving palliative care are included in the calculation of the SHMI. The SHMI does not make any adjustment for patients who are coded as receiving palliative care. This is because there is considerable variation between trusts in the coding of palliative care.

Using the most recent data published in February 2019 which covers the period from October 2017 to September 2018, the SHMI score for the Whittington is 0.770

Lowest National Score: 0.6917 (Homerton University Hospital NHS Foundation Trust)
Highest National Score: 1.2681 (South Tyneside NHS Foundation Trust)

The Whittington Health NHS Trust considers that this data is as described as it is produced
by a recognised national agency and adheres to a documented and consistent methodology.

Whittington Health is taking the following actions to further improve this score and the quality of its services, by:

- Providing regular learning events and resources for all staff to facilitate learning from incidents and findings from unexpected deaths;
- Ensuring that all inpatient deaths are systematically reviewed, and that any failings in care that suggest a death may have been avoidable are identified, systematically shared, learned from, and addressed

Annex 1: Statements from external stakeholders

Statements from Commissioners and local Health Watch organisations

Health Watch Islington feedback

Health Watch Islington to provide

Health Watch Haringey feedback

Health Watch Haringey to provide

Commissioner feedback

To be provided by Islington CCG

How to provide feedback

If you would like to comment on our Quality Account or have suggestions for future content,
please contact us either:

By writing to:
The Communications Department,
Whittington Health,
Magdala Avenue,
London. N19 5NF

By telephone:
020 7288 5983

By email:
communications.whitthealth@nhs.net

Publication:

The Whittington Health NHS Trust 2019-20 Quality Account will be published on the NHS Choices website on the 29th June 2019.

https://www.nhs.uk/pages/home.aspx

Accessible in other formats:

This document can be made available in other languages or formats, such as Braille or Large Print.

Please call **020 7288 3131** to request a copy.

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance in the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amended Regulations 2011.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

The Quality Account presents a balanced picture of the Trust's performance over the period covered, in particular, the assurance relating to consistency of the Quality Report with internal and external sources of information including:

- Board minutes;
- Papers relating to the Quality Account reported to the Board;
- Feedback from Health Watch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- the latest national patient survey;
- the latest national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment;
- feedback from Commissioners;
- the annual governance statement; and
- CQC Intelligent Monitoring reports.

The performance information reported in the Quality Account is reliable and accurate. There are proper internal controls over the collection and reporting of the measures of performance reported in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and The Quality Account has been prepared in accordance with the Department of Health guidance.

The directors confirm that to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

To be signed by CEO and chairman

Annex 3: Independent Auditors' Limited Assurance Report to the Directors of the Whittington Health NHS Trust on the Annual Quality Account

Being provided by KPMG

Meeting title	**Trust Board – public meeting**	**Date: 29 May 2019**
Report title	Quarterly "Learning from Deaths" Report Quarter 2, 2018/19 (1 July to 30 September 2018)	**Agenda item: 12**
Executive director lead	Dr Julie Andrews, Acting Medical Director	
Report author	Dr Julie Andrews, Acting Medical Director	
Executive summary	This "learning from deaths" report reflects the second quarter of 2018 (July to September). The report describes: a) How we are performing against our local targets, and national expectations, in reviewing the care of patients who have died whilst in this hospital (inpatient and ED deaths); b) What learning we are taking from the themes that emerge from these reviews; and c) What actions we are taking both to improve our care of patients, and to improve the learning from deaths process. In Quarter 2 of 2018/19, 1 July to 30 September 2018, there were **84** inpatient deaths. This includes all inpatient deaths, deaths in the emergency department and neonatal and intra-uterine deaths over 24 weeks gestation. In Q2, **62%** of all inpatient deaths were reviewed using a structured mortality review and then a second review in departmental mortality review meeting, as compared with 63.1% in Quarter 1 2018/19. Each review has a final review by the Medical Director before it is electronically stored to ensure all learning has been shared across departments. In Q2 of 2018/19: • 27 out of 29 (93.1%) of all category A deaths were reviewed (desired performance 90%) • 25 out of 55 (45.5%) of all category B deaths were reviewed (desired performance 25%) There is no benchmarking of data with other trusts, as trusts are encouraged to track their own performance as it changes over time rather than comparing their performance to that of other trusts. We introduced an overarching mortality review group in April 2019	

	which runs concurrently alongside the End of Life Care Group. This will review overarching themes of learning, review 3-4 specific mortality reviews and consider the mortality process as a whole with a view to continuous improvement. This paper gives assurance that this important new process to strengthen governance, learning and transparency around inpatient death is now well-developed and relatively robustly embedded, and that progress continues to be made in developing ways to disseminate the learning and continue to improve the quality of our care. There are some ongoing project manager gaps that need resolving so there is room for improvement in compliance figures and the sharing of learning and extend the learning from deaths process to be able to systemically review deaths in patients post discharge (up to 30 days post discharge). The medical examiner process will become statutory by 1 April 2020. Medical examiners will act independently from the trust to ensure that all deaths not referred to the coroners service have as accurate death certificate as possible and that the family/carers are kept fully informed of the processes around the death of their loved ones. We are in discussions with our local clinical commissioning groups and neighbouring trusts to consider how we contribute to this service as it will require a 7/7 service to be developed. It has been confirmed that medical examiners cannot also hold the learning from death lead role for the trust.
Purpose:	Review - the Board may wish to consider focussing its discussion on: • ways in which the project management part of the learning from death process could be further supported; and • the implications of the introduction of the medical examiner system as a statutory role by 1 April 2020.
Recommendation(s)	Board members are invited to: i. recognise the assurances highlighted for the robust process implemented to strengthen governance and improved care around inpatient deaths and performance in reviewing inpatient deaths which make a significant positive contribution to patient safety culture at the Trust. ii. be aware of the areas where remedial action is being taken to improve compliance data, the sharing of learning and systematically reviewing the deaths of patients who die up to 30 days post discharge; and iii. discuss potential opportunities for further improvement.
Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register
Report history	This quarter's report not previously presented. Previous quarters from April 2017 presented to Trust Board
Appendices	Appendix 1: NHS England Trust mortality dashboard

Quarterly "Learning from deaths" report Quarter 2 2018/19 (covering 1 July to 30 September 2018)

1. Introduction

This report reflects quarter 2 of 2018/19 to Trust Board on learning from deaths. These reports describe:

a) performance against local targets and national expectations in reviewing the care of patients who have died whilst in this hospital (inpatient deaths),
b) the learning taken from the themes that emerge from these reviews,
c) actions being taken to both to improve our care of patients and to improve the learning from deaths process.

There has been an informal system of departmental mortality review processes at Whittington Health, in line with domain 2 of General Medical Council *Good Medical Practice*, for many years. Following the launch of the NHS Quality Board "*National guidance on learning from deaths*[1]" (March 2017) we introduced a systematised approach to reviewing the care of patients who have died in hospital (individual review using a structured mortality review form then a departmental agreement in a mortality meeting). This process formally commenced on 1 April 2017, when Dr Julie Andrews, Acting Medical Director was appointed as Trust Mortality Lead. An overarching mortality review group will commence in April 2019 to ensure that learning across the trust is maximised and the process reviewed quarterly.

The aims of this process are to:

- Engage with patients' families and carers and recognise their insights as a source of learning, improve their opportunities for raising concerns;
- Embed a culture of learning from mortality reviews in the Trust;
- Identify, and learn from, episodes relating to problems in care;
- Identify, and learn from, notable practice;
- Understand and improve the quality of End of Life Care (EoLC), with a particular focus on whether patients' and carer's wishes were identified and met;
- Enable informed and transparent reporting to the Public Trust Board, with a clear methodology;
- Identify potentially avoidable deaths and ensure these are fully investigated through the serious incident (SI) process, and are clearly and transparently recorded and reported.

2. Potential Avoidability of Death – Judgement Scoring System

National guidance on learning from deaths was published in response to a number of high level reviews which concluded that learning from deaths was not being given sufficient priority in some NHS organisations and that this meant that there were missed opportunities to improve NHS

[1] "*National guidance on learning from deaths*" (NHS Quality Board, March 2017) available from https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

services through the review of deaths. A retrospective study across 34 English acute hospital trusts conducted in 2015 estimated that 3% of all deaths in hospital were potentially avoidable[2].

The Avoidability of Death Judgement Scoring System (Table 1) was developed by the Royal College of Physicians (RCP) and it is this scoring system that has been adopted by the Trust to conduct Structured Judgement Mortality Reviews by individuals and then reviewed in departments.

Table 1 – Avoidability of Death Judgement Scoring System

Score	Description
1	Definitely avoidable
2	Strong evidence of avoidability
3	Probably avoidable, more than 50/50
4	Possibly avoidable but not very likely, less than 50/50
5	Slight evidence of avoidability
6	Definitely not avoidable

3. Our performance against our local targets for the proportion of deaths that should be reviewed

The definitions of category A and category B deaths are given below. The Trust has set an internal target that 90% of all category A deaths and 25% of all category B deaths should be reviewed.

The Trust has set an internal target that 90% of all discharge summaries for patients who die in hospital should be completed.

Category A deaths are:

- Deaths where families, carers or staff have raised concerns about the quality of care provision;
- All inpatient deaths of patients with learning disabilities;
- All inpatient deaths of patients with a severe mental illness (SMI) diagnosis;
- All deaths in a service where concerns have been raised either through audit, incident reporting processes or other mortality indicators;
- All deaths in areas where deaths would not be expected, for example deaths during elective surgical procedures;
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had sepsis, diabetic ketoacidosis, or a recent fall;
- All inpatient paediatric, neonatal and maternal deaths;
- Deaths that are referred to HM Coroner's Office.

Category B deaths are:

- All deaths of inpatients that do not meet any of the criteria of Category A deaths.

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1. [2] *HOGAN H, HUTCHINGS, A, BLACK, N ET AL. PREVENTABLE DEATHS DUE TO PROBLEMS IN CARE IN ENGLISH ACUTE HOSPITALS: A RETROSPECTIVE CASE RECORD REVIEW STUDY, BMJ 2015;351:H3239*

4. NHS Mortality Dashboard

The *National Guidance on Learning from Deaths* gives a suggested dashboard which provides a format for data publication by Trusts. Whittington Health has chosen to adopt this dashboard locally. The dashboard is provided in Appendix 1. This dashboard shows data from 1 April 2018 onwards.

There were 84 deaths recorded in Quarter 2. This includes all inpatient deaths, all deaths in the emergency department, all neonatal deaths, and all intrauterine deaths above 24 weeks gestation.

There were no potentially avoidable patient deaths recorded in Quarter 2 2018/19 (where potentially avoidable is taken to mean patient deaths with avoidability scores of between 1-3).

The dashboard shows that in Quarter 2, 52 of the 84 patient deaths were reviewed, and this was done using the national methodology issued.

32 patient deaths out of 84 deaths in Q2 (38%) were not systemically reviewed, but the majority of those (31 out of 34) involved category B deaths. Two category A patient deaths were not reviewed; these were deaths in patients under the following team; care of the older person (COOP) (2). Departments and teams are reminded when category A reviews are outstanding but further work is needed and is ongoing to embed the support structures, including project management support to ensure that the risk category A reviews being overlooked is minimalised.

The dashboard outlines the avoidability of death judgement scores for inpatient deaths in Quarter 2, 2018/2019 and this is summarised below, in table 2. There were no deaths in patients with learning disabilities this quarter.

One patient death was given an avoidability death judgement score of 4; this death was fully investigated as an internal root cause analysis investigation.

Table 2 – Avoidability of death judgement scores for Q2: 2017/18

Avoidability of death judgement scores (of deaths reviewed)	Number of patients with each avoidability score
1 - Definitely avoidable	0
2 - Strong evidence of avoidability	0
3 - Probably avoidable, more than 50/50	0
4 - Possibly avoidable but not very likely, less than 50/50	1
5 - Slight evidence of avoidability	1
6 - Definitely not avoidable	50

5. Themes from Mortality Reviews

i) Key areas for improvement

a) In some clinical areas and teams, improvements are still required in the standard of documentation in the notes to record the degree to which patients have been kept informed, engaged in shared decision making and given the opportunity to express their wishes. This has also been highlighted in the 7 day services audit.

b) 2 mortality reviews found evidence of medicine safety incidents such as missed doses of antimicrobials which had not been reported, the level of harm in those two incidents was low. This does support the view that there is still some underreporting of medicines safety incidents across the organisation
c) Again there were only 2 instances when a palliative care referral was not sent early enough in patient care. These have been shared with the EoL Group but this is an improvement compared to 2018/19 where this figure had been between 5-7 per quarter.
d) The mortality review process found 7 accounts in which the reviewers felt that there had been delays in investigating the patient, escalating a change in the patient's condition, or making an appropriate referral to another team. In each case the concerns of the reviewers were shared with the relevant clinical departments so that the learning could be appropriately disseminated and discussed. One of these delays was associated with harm and this was reported through the patient safety incident system, Datix.
e) Other similar sized trusts have a defined bereavement service for adult patients' carers and families that provide support and information. Whittington Health does have a defined service in Womens' Health ICSU that is highly regarded. In the opinion of the EoL Group and the Mortality Leads, the lack of a defined bereavement service for adults is a gap within our services at Whittington Health. We have shared our ambitions with Haringey and Islington clinical commissioning groups as part of ongoing work to improve the care given to families and carers.
f) Now that the mortality review departmental process is fully established, it is clear that there is a need to recognise within Mortality Lead job plans the time needed to act as a lead, as well as ensuring that other reviewers, including trainee doctors and other clinicians, have time for this important work. There is also a need to identify appropriate project management capacity and time to support both the departmental and Trust mortality review process. This will reviewed as part of changes ahead of the introduction of the medical examiner system in April 2020.

ii) Notable practice

a) As the mortality review process has grown, most teams have developed a focus on using the reviews through existing or new education structures to share learning. This education and learning is generally highly multi-disciplinary, and gives prominence to trainees in leading on the dissemination of learning.
b) Trainee doctors and senior nurses have been recruited as reviewers – they are bringing very valuable skills and insight to this role, while at the same time being trained in safety and governance processes.
c) There is good evidence of documented patient, family and carer involvement in EoL decision-making by most teams.
d) The reviews have highlighted themes around EoLC that have directly led to a quality improvement project that involves collecting the views of bereaved families. This initiative was launched on 1 July 2018.
e) The trust has improved in linking the learning from mortality reviews to discussions at Grand Rounds and other educational events in order to share learning.
f) We are starting to network with other NHS trusts in sharing learning from the Trust's mortality review processes.
g) The Trust's mortality review process has led to an improved sharing of expertise between teams. Examples of this are discussion about safe gentamicin prescribing, earlier planning around patient treatment escalation and earlier referrals to appropriate specialist clinical teams.
h) The Trust's mortality review process is now being formally linked in with other quality and safety governance processes. Examples of this include amendments to refine and improve clinical guidelines (for instance on VTE prevention and palliative care), feeding back to

trainee doctors and other staff at the Patient Safety Forum and triangulating with the Complaints/Patient Advice and Liaison (PALs) team and legal team to improve learning and feedback to families.

i) The EoLC lead working with a third sector organisation has managed to secure the funding for 2 end of life care facilitators which will enhance the experience of this important area for both patients, families and our staff.

6. Potentially Avoidable Deaths

In 2016/17 there were probably 7 potentially avoidable deaths; we did not score deaths using a structured judgement scoring system so cannot directly compare data.

In 2017/18 there was one potentially avoidable death in Quarter 1, one potentially avoidable death in Quarter 2, none in Quarter 3 and 2 in Quarter 4. In total for 2017/2018 there were four potentially avoidable deaths; all these deaths were investigated as SIs and learning shared widely.

In Q1 and Q2 2018/2019 (1 April 2018 - 30 June 2018) there have been no potentially avoidable deaths reported.

7. Summary

This paper provides assurance that we now have a robust mortality review process, and that we meet our local targets in terms of the proportion of inpatient deaths that are being reviewed.

Recent verbal feedback from NHSI (London) suggests acute trusts in the region are managing to review between 10% and 70% of inpatient deaths, so we appear to be clearly at the higher end of this performance range.

This process has highlighted the need to improve our bereavement support to families, and our need to find out more about family and carer experience of EoL care and this has led to the planned quality improvement initiatives that have been described. It is hoped our third sector collaboration work with 2 EoLC facilitators will be invaluable in this area.

As this has now become a recurrent and permanent process, with a significant workload associated with it, we now need to develop and embed sustainable support for its continuation, both in terms of recognising this work in job plans, and in providing the administrative/project management capacity to support it. This enhanced capacity would also support the expansion of the pilot looking at mortality reviews in patients that die 30 days post discharge. This will be reviewed as part of the introduction of the medical examiner system as a statutory system in April 2020.

This paper provides the evidence that this process is now established and continues to make a positive and significant contribution to the patient safety culture of this trust.

Appendix 1: NHS England Trust Mortality Dashboard

NHS Whittington Health: Learning from Deaths Dashboard - September 2018-19

Department of Health

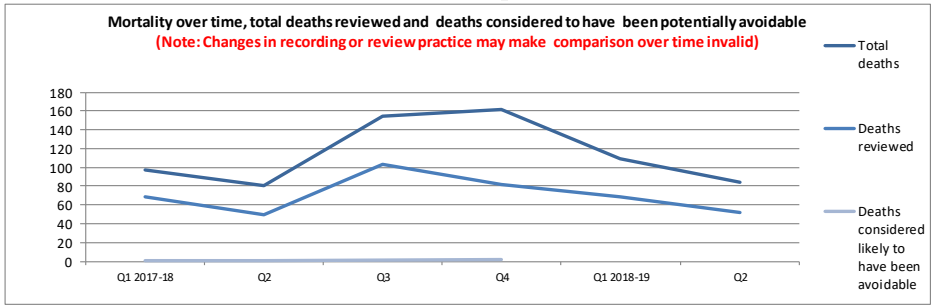
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
29	29	16	22	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
84	109	52	69	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
193	494	121	304	0	4

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

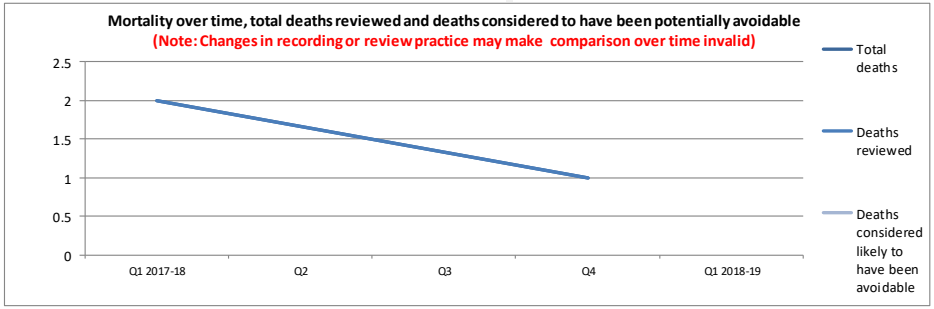
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	6.3%	This Month	0	0.0%	This Month	15	93.8%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	1.9%	This Quarter (QTD)	1	1.9%	This Quarter (QTD	50	96.2%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	3	2.5%	This Year (YTD)	14	11.6%	This Year (YTD)	104	86.0%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	3	0	3	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Meeting title	**Trust Board – public meeting**	**Date: 20 May 2019**
Report title	**Integrated performance report**	**Agenda Item: 13**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Hester de Graag, Risk and Quality Manager	
Executive summary	The report for May Trust Board is in a new format which includes the following: • a clearer process for monitoring and exception reporting • the complaints' indicator covers complaints requiring a substantive response for both 25 and 40 days, depending on their complexity • the definition for reporting pressure ulcers has changed to record all category 3 and 4 pressure ulcers attributable to Whittington Health • community waiting times and cancer, by tumour site, have been moved to the appendix • a new workforce metric, ' Time to Hire' **Areas to draw to Board members' attention are:** **Emergency Department (ED) four hours' wait:** Overall performance against the national 95% 4 hour standard for April 2019 was 84.6% (5.4% below NHS Improvement standard of 90%). **Non elective re-admission within 30 days:** Performance was 6.41% against the standard of less than 5.5%. Action is being taken include audit of readmissions to establish any patterns or trends in relation to clinical presentations and ward, i.e. starting with Care of the Elderly speciality.	
Purpose:	Review and assurance of Trust performance compliance	
Recommendation(s)	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan	
Risk Register or Board Assurance Framework	The following BAF entries are linked: Quality 1; Quality 2; Quality 3; People 1; and, People 2.	
Report history	28 May 2019, Trust Management Group	
Appendices	None	

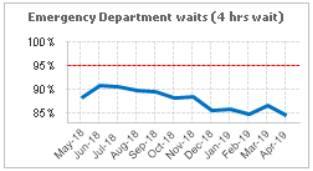
Performance Report

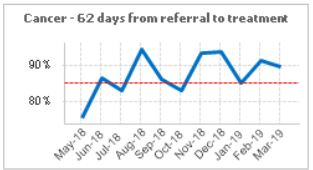
May 2019

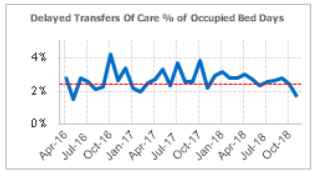
Month 1 (2019 – 2020)

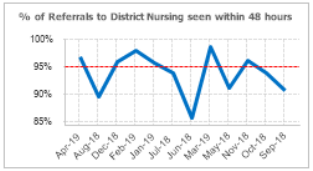
Summary

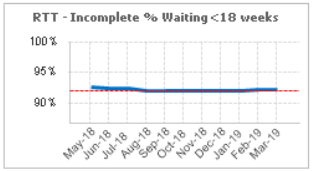
Category	Indicator	17_18 Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019-2020	
ED	Emergency Department waits (4 hrs wait)	>95%	88.1%	90.6%	90.4%	89.8%	89.3%	88.0%	88.5%	85.4%	85.7%	84.6%	86.4%	84.4%	84.4%	!
Cancer	Cancer - 14 days to first seen	>93%	97.5%	94.4%	94.4%	93.1%	90.1%	89.6%	93.7%	97.9%	95.9%	94.8%	96.2%			
Cancer	Cancer - 62 days from referral to treatment	>85%	75.5%	86.5%	82.9%	94.2%	86.2%	83.1%	93.3%	93.8%	85.2%	91.1%	89.6%			
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.09%	6.62%	5.89%	6.97%	5.93%	5.42%	4.91%	5.86%	5.48%	5.92%	6.33%	6.41%	6.41%	!
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.7%	2.3%	2.6%	2.7%	2.8%	2.5%	1.7%	2.0%	4.1%	1.3%	1.3%			
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.6%	92.4%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.1%	92.3%	92.2%			
Outpatients	Outpatients - FFT % Positive	>90%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	90.5%	90.5%	
Community	Community - FFT % Positive	>90%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.8%	96.8%	
Staff	Staff - FFT % Recommend Care	>70%		77.3%			77.4%			65.9%			74.0%			
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	91.4%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	94.1%	94.1%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	91.1%	85.7%	93.8%	89.7%	90.8%	93.8%	96.1%	95.9%	95.7%	98.1%	98.7%	96.8%	96.8%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	91.7%	91.9%	88.3%	90.3%	90.9%	90.1%	90.3%	89.8%	91.9%	95.2%	93.4%			
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	94.1%	90.9%	97.5%	95.3%	96.1%	93.1%	93.0%	92.9%	95.4%	91.6%	94.6%			

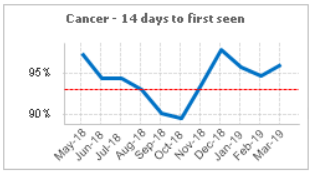


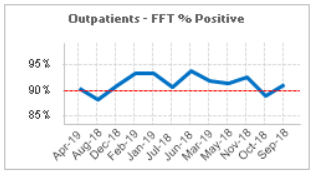












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Indicator	19_20 Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019-2020	Performance
Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI C Difficile	<16	2	0	0	2	2	1	1	3	1	0	0	0	0	
Actual Falls	400	52	33	33	26	28	36	31	35	44	43	34	42	42	
Category 3 or 4 Pressure Ulcers	0												7	7	
Harm Free Care %	>95%	93.0%	91.0%	92.6%	92.3%	93.2%	94.5%	92.3%	93.5%	90.1%	91.2%	94.2%	93.5%	93.5%	
Non Elective C-Section % Rate	<19%	19.9%	18.1%	25.9%	19.9%	19.2%	18.8%	21.5%	25.4%	20.1%	22.3%	24.7%	24.0%	24.0%	
Medication Errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	0	1	1	
MRSA Bacteraemia Incidences	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Proportion of reported Patient Safety Incidents Causing Harm	N/A	18.4%	16.6%	16.9%	16.6%	17.0%	19.1%	16.7%	21.0%	20.9%	18.4%	22.4%	18.8%	18.8%	
Serious Incidents	0	8	3	1	1	2	2	4	2	1	1	1	4	4	
VTE Risk Assessment %	>95%	95.1%	95.0%	97.2%	96.1%	96.7%	95.2%	96.9%	95.3%	95.3%	95.2%	95.9%			
Mixed Sex Accomodation Breaches	0	7	0	0	0	0	1	0	0	2	2	0	0	0	
Hospital Standardised Mortality Ratio (HSMR)	100	70.5	80.2	102.3	85.9	91.6	67.2	85.8	80.6						
Summary Hospital Level Mortality Indicator (SHMI)	1.14		0.76			0.77			0.78						

**Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Category 3 or 4 Pressure Ulcers attributed to Whittington health: Total number recorded. Category 3 = 5 Category 4 = 2 **Standard:** 10% reduction in the total number of attributable PUs during 2019/20 compared to 2018/19 including a breakdown of Pressure Ulcers by category	Pressure ulcer measurement and definitions changed in England from April 2019, following implementation of the NHSI definition and pressure ulcer measurement recommendations. The changes are: 1. All pressure ulcers which are attributed to Whittington health, therefore all Pressure ulcers developed whilst under Whittington Health care will be recorded on the quality indicators. 2. Pressure ulcers data will no longer be split into avoidable or unavoidable. 3. The monthly narrative will focus on those that have service delivery issues identified. **Variance against Plan:** One category 4 pressure ulcer within the district nursing had service delivery issues identified. This incident is being investigated further as a serious incident. The initial investigation identified that the patient was identified at high risk and required equipment which was ordered and delivered. The patient was not transferred onto the equipment for several weeks and developed multiple pressure ulcers. **Action to Recover:** To work with Adult community services and district nursing leads to identify, develop and implement a process and information sheet on how to transfer patient onto equipment within the home who are bed bound.	**Named Person:** Jane Preece, Lead Nurse Tissue Viability Service **Time Scale to Recover Performance:** WH will seek to reduce serious pressure ulcer incidence amongst its service users. A trajectory will need to be agreed once denominator has been worked out. This will be completed before the next Performance report.
Harm Free Care %: Percentage of patient with no harm on the Safety Thermometer (this includes old and new harm)	**Variance against Plan:** All Harm Free 93.5%, New Harm Free 97.13%.	**Named Person:** Breeda McManus, Deputy Head of Nursing

Standard: 95%	**Action to Recover:** 1. New Falls Mandatory training for both corporate induction and mandatory updates will be rolled out in May 2019 and will be delivered jointly with Moving and Handling training. There will be a Falls awareness week with an audit of all wards and relaunch of Baywatch with a stall in atrium and toolkits of Stop falls for wards. There is currently as project reviewing our enhanced care policy and process which will mitigate our high risk of falls 2. The tissue viability team continue to provide pressure ulcer prevention education and awareness across Whittington health. The pressure ulcer prevention and management policy is being reviewed and finalised incorporating the NHSI recommendations. We have introduced a leaflet '5 key tips for nutrition and pressure ulcer prevention', new categorisation posters and reporting process and will be reviewing our carer/patients package in the next 3 months. The District nursing teams have introduced a "Day of the week" focus on PUs**.**	Maria Lygoura, Lead Nurse for Safer Care **Time Scale to Recover Performance:** 1. May 2019 2. August 2019
Non Elective C-Section Rates: % of all deliveries where the method of delivery is a non - elective (unplanned) caesarean section **Standard:** Less than 19%	**Variance against Plan:** Emailed Shahida/Elly on leave till Monday **Action to Recover:** Multi-Disciplinary Team meeting to review all non - elective (unplanned) caesarean to commence Thursday 23.05.19	**Named Person:** Elly Tsoi, Consultant in Obstetrics and Fetal Medicine **Time Scale to Recover Performance:** Feedback June 2019
Serious Incidents: The number of Serious Incidents declared by the Trust this month.	4 SIs were declared in April 2019. 1. 2019.8029 – ACS - Pressure ulcer meeting SI criteria 2. 2019.8646 – EIM - Disruptive/ aggressive/ violent behaviour meeting SI criteria (Staff assaulted by patient). 3. 2019.9259 – S&C –Possible inadequate treatment 4. 2019.9470 – ACS - Pressure ulcer meeting SI criteria	**Named Person:** Jayne Osborne, Quality Assurance & Serious Incident Officer

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Indicator	19_20 Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019-2020	Performance
ED - FFT % Positive	>90%	80.4%	81.9%	83.7%	83.5%	82.8%	80.9%	82.3%	81.0%	82.8%	78.3%	75.6%	78.6%	78.6%	
ED - FFT Response Rate	>15%	14.1%	14.1%	12.2%	14.1%	12.8%	13.1%	11.9%	12.0%	13.2%	11.9%	11.7%	10.3%	10.3%	
Inpatients - FFT % Positive	>90%	96.4%	98.4%	97.0%	97.9%	97.0%	96.8%	97.8%	98.1%	95.5%	96.3%	98.4%	96.6%	96.6%	
Inpatients - FFT Response Rate	>25%	22.2%	17.7%	18.1%	15.6%	13.6%	12.4%	20.5%	18.1%	14.1%	21.7%	23.5%	15.1%	15.1%	
Maternity - FFT % Positive	>90%	92.8%	93.2%	95.9%	95.3%	95.5%	95.3%	92.8%	92.9%	95.6%	96.5%	94.0%	95.1%	95.1%	
Maternity - FFT Response Rate	>15%	49.4%	45.2%	53.2%	67.2%	49.3%	40.0%	42.9%	48.9%	53.1%	50.7%	52.4%	31.1%	31.1%	
Outpatients - FFT % Positive	>90%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	90.5%	90.5%	
Outpatients - FFT Responses	400	445	348	310	223	138	328	484	233	423	389	421	419	419	
Community - FFT % Positive	>90%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.8%	96.8%	
Community - FFT Responses	1500	1181	1148	869	890	1122	1159	998	622	1014	1028	953	842	842	
Staff - FFT % Recommend Care	>70%		77.3%			77.4%			65.9%			74.0%			
Complaints responded to within 25 or 40 working days	>80%												75.0%	75.0%	
Complaints (including complaints against Corporate division)	N/A	0	0	0	0	0	0	0	0	0	0	0	20	20	

**Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - FFT % Positive Response and Response Rate: number of responses and satisfactory/ positive responses achieved for ED. **Standard:** 15% of responses and 90% satisfactory/ positive responses	**Variance against Plan:** Recommend rates have been dropping since January 2019. Response rates have also been in decline across the same period. **Action to Recover:** The patient experience manager has been working with ED on their patient experience action plan. The patient experience manager will be meeting with the wider ED team to identify causes for the decline in reporting, and to update the action plan.	**Named Person:** James Connell, Patient Experience Manager **Time Scale to Recover Performance:** End of Q4 2019/20
Inpatients FFT Response Rate: number of responses achieved for Inpatients. **Standard:** 25%	**Variance against Plan:** Response rates in inpatient areas had been improving (22% and 24% for February and March 2019), but there was a drop again in April to 15%. **Action to Recover:** Patient experience manager is attending NMEC in May to discuss issues with senior nursing team.	**Named Person:** James Connell, Patient Experience Manager **Time Scale to Recover Performance:** End of Q3 2019/20
Community FFT Responses: number of responses a month for Community. **Standard:** 1500	**Variance against Plan:** The Trust has always exceeded the recommend rate KPI in Community, but has not attained the response total target of 1,500 over the past two years. **Action to Recover:** Patient experience team has been supporting community teams with improving FFT collection. • FFT links to be imbedded within SMS links for community adult dietetics The meridian hierarchy has been updated to accurately include the community adult dietetics teams. The FFT link	**Named Person:** James Connell, Patient Experience Manager **Time Scale to Recover Performance:** End of Q3 2019/20

	that will be sent to patients has been created. Actions ongoing: The patient experience manager and Dietitian Service Manager have contacted the information team to ask for support in imbedding these links into Radar reports. Deadline: May-June 2019 • Launch of tailored survey for Haringey Learning Disability team The patient experience team have been working with Meridian and the local service manager to draft LD accessible surveys. Actions ongoing: The patient experience manager will confirm a final version of the survey with Haringey LD team. Deadline: May 2019 • St Ann's iPad The iPad has been installed at the Child Development Centre in St Ann's. Actions ongoing: The local team have reported issues with the iPad. This has been escalated to the IT team. The patient experience manager will liaise with IT to agree a deadline to this work. Deadline: tbc	
Complaint responses: to respond to all complaints within allocated timeframe (25 or 40 days depending on complexity) **Standard:** 80%	**Variance against Plan:** Performance for April 2019 was 75% (15/20 responses) – three of these were '25' day complaints and two were '40' day complaints. Related to S&C (2) and EIM (3) ICSUs **Action to Recover:** The Chief Nurse emailed ICSU leads on 7.5.19 requesting what actions are being taken to ensure responses are delivered on time and to encourage seeking support from Complaints Team moving forward.	**Named Person:** Paul Macpherson, PALS & Complaints Manager **Time Scale to Recover Performance:** Review end May 2019

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Indicator	19_20 Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019-2020	Performance	
Hospital Cancelled Operations	0	5	1	4	1	2	8	10	4	5	14	7				!
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	1	2	0	0	1	0				
Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0				
Theatre Utilisation	>85%	83.6%	82.5%	78.2%	82.3%	82.1%	80.7%	79.6%	80.9%	80.4%	78.5%	77.5%	81.5%	81.5%		!
Breastfeeding Initiated	>90%	93.4%	94.2%	91.2%	91.5%	91.7%	93.2%	93.2%	89.2%	91.3%	92.4%	93.9%	90.7%	90.7%		
Mortality rate per 1000 admissions in-months	14.4	7.7	6.4	5.3	4.7	5.0	5.5	6.6	8.4	7.7	6.0	9.0	8.1	8.1		
Community DNA % Rate	<10%	8.1%	8.0%	8.5%	8.1%	7.7%	7.8%	7.5%	8.0%	7.5%	7.3%	6.7%	7.6%	7.6%		
Community Services - Provider Cancellations	<8%	6.5%	6.1%	6.3%	6.3%	5.9%	6.1%	6.6%	7.4%	6.3%	6.0%	6.3%	6.2%	6.2%		
Acute DNA % Rate	<10%	11.6%	10.2%	10.4%	10.8%	10.6%	10.5%	10.5%	10.2%	10.0%	10.6%	9.8%	10.5%	10.5%		
% of GP Referrals that were completed via ERS		73.7%	79.6%	82.6%	82.9%	84.8%	87.4%	89.0%	85.5%	87.6%	87.6%	88.3%	88.3%	88.3%		
Outpatients New:FUp Ratio	2.3	1.82	1.89	1.94	1.98	1.93	1.92	1.88	1.94	1.97	1.85	1.93	1.99	1.99		
Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.7%	2.3%	2.6%	2.7%	2.8%	2.5%	1.7%	2.0%	4.1%	1.3%	1.3%				
Non Elective Re-admissions within 30 days	<5.5%	6.09%	6.62%	5.89%	6.97%	5.93%	5.42%	4.91%	5.86%	5.48%	5.92%	6.33%	6.41%	6.41%		!
Rapid Response - % of referrals with an improvement in care							18.0%	92.4%	89.4%	84.1%	90.2%	80.8%	89.1%	89.1%		

! **Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Hospital Cancellations Operations : The number of patients operation cancelled on the day **Standard:** 0	**Variance against Plan:** Seven (7) operations were cancelled on the day in March 2019. Three target/urgent; 2 in Gynaecology (Theatre list overran) and 1 in Urology (Different procedure needed under different consultant) There were 4 non target/urgent patients cancelled on the day. Two in T&O (Incorrect disposable kit supplied by company) and two in General Surgery (1 – session started late as anaesthetist not available and 1 – admin error patient booked under incorrect consultant) **Action to Recover:** Theatre Improvement programme in place which is driven by improvements in pre-operative assessment and booking office issues. Theatre lists are signed off in advance by clinicians however timing of lists can be improved with guide standard times, booking team has been completely reviewed with new staff and significantly increased training and this should eradicate the administrative errors. Working to get anaesthetists employed to full establishment to reduce risk of non-availability.	**Named Person:** Otilia Beres, General Manager Theatres, ITU, POA & Admissions **Time Scale to Recover Performance:** Being reviewed every 2 weeks via Theatre Improvement Group. Expect to see reduction in number of cancellations for admin error down to zero by end of May 2019 as a priority, with overruns the next to be targeted.
Theatre Utilisation % Rates: Percentage of theatre slots filled. **Standard:** > 85%	**Variance against Plan:** Performance was 81.5% against an internal standard of 85%. This is the highest value for six months. Urology & gynaecology are both under 80% performance **Action to Recover:** Continue the Theatre Improvement programme focus on Pre-operative assessment and booking office. Balanced scorecards are being developed for each area to track delivery throughput and patient experience. Recording of reasons for low throughput now also being collated to inform the Productivity project.	**Named Person:** Otilia Beres, General Manager Theatres, ITU, POA & Admissions **Time Scale to Recover Performance:** Performance is to remain over 80% going forward with 85% by September 2019.

Non Elective Re-Admission within 30 days: Percentage of re-admitted patient's to hospital as an emergency within 30 days **Standard:** < 5.5%	**Variance against Plan:** 0.91% **Action to Recover:** • Conduct an audit of readmissions to establish any patterns or trends in relation to clinical presentations and ward, i.e. starting with the Care of the Elderly Wards (Getting It Right Fist Time) • Following the audit an action plan will be developed to work to reducing non-elective readmissions to within the national target	**Named Person:** Nicola Stephenson, Interim Director of EIM Kevin Gilbride, Matron EIM **Time Scale to Recover Performance:** End of Q1

Indicator	18_19 Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019-2020	Performance
Emergency Department waits (4 hrs wait)	>95%	88.1%	90.6%	90.4%	89.8%	89.3%	88.0%	88.5%	85.4%	85.7%	84.6%	86.4%	84.4%	84.4%	
ED Indicator - median wait for treatment (minutes)	<60 mins	87	79	74	64	75	79	88	91	85	93	97	91	91	
Ambulance handovers waiting more than 30 mins	0	41	16	18	9	12	18	15	23	18	53	28			
Ambulance handovers waiting more than 60 mins	0	0	1	0	10	2	0	0	2	2	14	7			
12 hour trolley waits in A&E	0	0	0	2	0	0	0	0	1	0	1	0	1	1	
Cancer - 14 days to first seen	>93%	97.5%	94.4%	94.4%	93.1%	90.1%	89.6%	93.7%	97.9%	95.9%	94.8%	96.2%			
Cancer - 14 days to first seen - breast symptomatic	>93%	96.3%	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Cancer - 62 days from referral to treatment	>85%	75.5%	86.5%	82.9%	94.2%	86.2%	83.1%	93.3%	93.8%	85.2%	91.1%	89.6%			
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%					89.5%	81.4%	93.3%	90.6%	88.9%	90.2%	89.6%			
Cancer ITT - % of Pathways sent before 38 Days	>85%					62.5%	60.0%	81.8%	50.0%	100.0%	40.0%	75.0%			
Cancer - % Pathways received a Diagnosis within 28 Days of Refer...		61.9%	50.0%	93.0%	93.0%	80.4%	83.6%	86.1%	93.9%	88.3%	88.2%	83.3%			
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%			
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%				
Cancer - 62 Day Screening	>90%			100.0%	100.0%		100.0%	75.0%	60.0%						
DM01 - Diagnostic Waits (<6 weeks)	>99%	99.0%	99.0%	99.1%	97.7%	99.0%	99.1%	99.1%	99.0%	99.0%	99.0%	99.0%	99.2%	99.2%	
RTT - Incomplete % Waiting <18 weeks	>92%	92.6%	92.4%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.1%	92.3%	92.2%	92.1%	92.1%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	1	1	0	0	0	0	0	0	
% seen <=2 hours of Referral to District Nursing Night Service	>80%	91.4%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	94.1%	94.1%	
% seen <=48 hours of Referral to District Nursing Service	>95%	91.1%	85.7%	93.8%	89.7%	90.8%	93.8%	95.6%	95.9%	95.7%	98.1%	98.7%	96.8%	96.8%	
Haringey New Birth Visits - % seen within 2 weeks	>95%	91.7%	91.8%	88.3%	90.3%	90.9%	90.1%	90.3%	89.8%	91.9%	95.2%	93.8%			
Islington New Birth Visits - % seen within 2 weeks	>95%	94.1%	90.9%	97.5%	95.3%	96.1%	93.1%	93.0%	92.9%	95.0%	91.6%	94.6%			

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - 4 Hour Waits: Percentage of A&E Attendances seen within 4 hours **National standard:** 95% **NHSI Standard:** 90%	**Variance against Plan:** 84.6% (5.4% below NHSI standard) **Action to Recover:** • Relaunch of the first 60 minutes imitative • Implementation of the revised front of house model i.e. streaming, redirection, triage & RAT. • Reviewing the current structure of CDU and restructuring CDU pathways to include direct access to CDU • Review and implement the internal professional standards in relation to speciality responses • Increase direct patient pathways to AEC to fully optimise AEC capacity • LAS conveyances and alternative care pathways i.e pilot LAS direct access to AEC for appropriate patients	**Named Person:** Michelle Scully, Interim ED Manager **Time Scale to Recover Performance:** Expect to see recovery to start by the end August 2019 once processes are fully embedded. Target for August is 92%
ED – median wait for treatment: The median wait for the number of patients waiting for more than 60 minutes to be seen. **Standard:** 60 minutes	**Variance against Plan:** 31 minutes (median wait in April is 91 minutes) **Action to Recover:** • Implementation of the revised front of house model i.e. streaming, redirection, triage & RAT. • Dedicated RAT registrar and EDA at the front of house 7 days per week	**Named Person:** Michelle Scully, Interim ED Manager **Time Scale to Recover Performance:** Expect to see recovery to start by the end of August 2019, once improved processes are embedded.
ED – ambulance handover 30 and 60 minutes: There should be zero patients waiting for more than 30 or 60 minutes for ambulance handover to ED. **Standard:** 30 and 60 minutes	**Variance against Plan:** 28 waiting more than 30 minutes and 7 more than 60 minutes. **Action to Recover:** • Pilot LAS direct access to AEC from front of house • Re-establish direct access to UTC for patients with minor illness that come via LAS	**Named Person:** Michelle Scully, Interim ED Manager **Time Scale to Recover Performance:** Expect to see recovery to

		start by the end of August 2019, once improved processes are embedded
ED – 12 Hour Trolley Waits: Patients that have a decision to admit and waited on a trolley for more than 12 hours. **Standard:** 0	**Variance against Plan:** April 2019 – 1 x 12 hour trolley breach **Action to Recover:** • ECIST mental health deep drive on the 17th June to review current escalation, breach reasons, common presenting teams and internal and external mental health response times • Optimise utilisation of the mental health suite for lower acuity of non-admitted patients • 90% of patients in ED referred to MHLT assessed within 60 minutes of arrival.	**Named Person:** Michelle Scully, Interim ED Manager **Time Scale to Recover Performance:** N/A

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Indicator	19_20 Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019-2020	Performance	
Appraisals % Rate	>90%	70.8%	71.5%	73.6%	73.2%	74.7%	77.0%	76.0%	73.2%	72.7%	72.4%	72.6%	71.3%	71.3%		!
Mandatory Training % Rate	>90%	83.0%	82.8%	82.5%	83.7%	82.2%	82.4%	81.1%	80.7%	80.8%	80.8%	80.8%	80.2%	80.2%		!
Permanent Staffing WTEs Utilised	>90%	87.2%	86.2%	86.3%	86.7%	86.4%	87.3%	87.2%	88.0%	88.1%	88.0%	88.0%	87.3%	87.3%		!
Staff FFT % recommended work	>50%		60.8%			64.4%			57.4%			61.8%				
Staff FFT response rate	>20%		16.5%			8.0%			47.8%			16.5%				
Staff sickness absence %	<3.5%	3.47%	3.41%	3.52%	3.10%	3.52%	3.92%	3.81%	3.35%	3.71%	3.69%	3.49%				
Staff turnover %	<10%		14.0%	13.5%	13.1%	12.8%	12.7%	12.7%	12.0%	11.7%	11.4%	10.8%	10.6%	10.6%		!
Vacancy % Rate against Establishment	<10%	12.8%	13.8%	13.7%	13.3%	13.6%	12.7%	12.8%	12.0%	11.9%	12.0%	12.0%	12.7%	12.7%		!
Average Time to Hire (Days)	<61 Days											63	65	65		
Nursing Staff Average % Day Fill Rate - Nurses		79.7%	84.3%	82.7%	83.4%	82.3%	76.8%	76.7%	74.9%	89.3%	87.4%	86.1%				
Nursing Staff Average % Day Fill Rate - HCAs		141.9%	121.9%	120.2%	134.2%	139.9%	130.4%	130.4%	125.3%	112.6%	117.1%	112.6%				
Nursing Staff Average % Night Fill Rate - Nurses		86.4%	87.9%	86.8%	87.9%	86.6%	85.3%	85.3%	79.2%	92.2%	90.8%	88.6%				
Nursing Staff Average % Night Fill Rate - HCAs		145.1%	116.0%	114.1%	140.5%	138.0%	79.6%	83.0%	131.1%	134.5%	124.4%	115.7%				
Safe Staffing Alerts - Number of Red Shifts		8	0	1	1	2	0	0	0	0	2	1	0	0		
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		9.3	9.4	10.0	9.0	8.8	9.2	8.8	10.2	9.0	9.0	9.1				

! **Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Appraisals % Rate: 90% of appraisals should be in date. **Standard:** 90%	**Variance against Plan:** Current Trust compliance rate is 71.3%. **Action to Recover:** ICSU's and Divisions rates are assessed monthly at local Board level, and quarterly at Performance reviews. Work is ongoing in workforce to improve quality of data, and appraisal and mandatory training 'surgeries' are underway. **New guidance** has been created and is provided on the intranet by the Workforce Information team to enable people to load appraisal dates into ESR **New simpler appraisal documentation** has been created to improve the quality of appraisals to help managers hold quality coaching conversations, and the training has been tailored to this	**Named Person:** Helen Kent, Assistant Director, Learning & Organisational Development) **Time Scale to Recover Performance:** October 2019
Mandatory Training % Rate: 90% of members of staff should have completed their mandatory training. **Standard:** 90%	**Variance against Plan:** Current Trust compliance rate is 81%. **Action to Recover:** ICSU's and Divisions rates are assessed monthly at local Board level, and quarterly at Performance reviews. Work is ongoing in workforce to improve quality of data, and appraisal and mandatory training 'surgeries' are underway. **A task and finish group** comprising L&D, OD, Workforce Information, IT, Communications and our ESR account manager will focus on • Working with ESR functionality to set a timetable for any new functionality not yet enabled • Working with IT to ensure we are maximising use of the available functionality • Providing accessible communications on using the new functionality **L&OD restructure** increases capacity for L&D to provide support to ESR users	**Named Person:** Helen Kent, Assistant Director, Learning & Organisational Development) **Time Scale to Recover Performance:** October 2019

Permanent Staffing WTEs Utilised: 90% of post should be filled. **Standard:** 90%	**Variance against Plan:** 87.3% **Action to Recover:** Vacancy rate has improved month on month in the last quarter, and continues to be reviewed in line with vacancy rate reviews, staff turnover and recruitment and retention planning.	**Named Person:** Kate Wilson, Deputy Director of Workforce **Time Scale to Recover Performance:** December 2019
Staff Turnover %: The Trust should have less than 10% of staff who have left the Trust within the last 12 months. **Standard:** 10%	**Variance against Plan:** 10.61% **Action to Recover:** Turnover has continually reduced over the past 3 months. Work is ongoing with NHSI to improve retention, and results are being seen with the reduction in turnover.	**Named Person:** Kate Wilson, Deputy Director of Workforce **Time Scale to Recover Performance:** December 2019
Vacancy % Rate against Establishment: The Trust should have less than 10% unfilled posts. **Standard:** 10%	**Variance against Plan:** 12.37% **Action to Recover:** The vacancy rate has remained steady for the past three months. A new recruitment dashboard has been in place since April, which provides the ICSU's and Corporate services with information regarding recruitment, to identify any blockers to recruitment and to take appropriate action. The nurse recruitment has been expanded on a temporary basis to look at HCA recruitment. We are partnering with local borough networks to provide outplacements for school leavers and those with disabilities.	**Named Person:** Kate Wilson, Deputy Director of Workforce **Time Scale to Recover Performance:** December 2019
Time to hire: Time taken from resignation/creation of new post to confirmed start date **Standard:** 8 weeks	**Variance against Plan:** 8.9 weeks **Action to Recover:** A new recruitment dashboard has been in place since April, which provides the ICSU's and Corporate services with information regarding recruitment, to identify any blockers to recruitment and to take appropriate action. HR Business Partners and Recruitment Advisers meet monthly with ICSU's/Corporate Services to review the dashboard and take appropriate action.	**Named Person:** Kate Wilson, Deputy Director of Workforce **Time Scale to Recover Performance:** September 2019

Appendix 1. Community Performance Dashboard

Indicator	18_19 Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019-2020	Performance
IAPT Moving to Recovery	>50%	53.4%	59.0%	52.4%	55.7%	57.0%	62.5%	57.4%	58.2%	62.3%	65.1%	59.1%			
Haringey - 8wk Review % carried out before child aged 8 weeks		78.3%	79.8%	82.1%	82.3%	80.4%	89.1%	86.2%	92.1%	84.1%	91.9%	88.6%			
Haringey - HR1 % carried out before child aged 15 months		73.3%	66.2%	70.5%	62.4%	71.3%	70.9%	72.3%	74.4%	76.7%	78.1%	80.0%			
Haringey - HR2 % carried out before child aged 30 months		62.8%	59.0%	65.1%	66.9%	64.0%	61.6%	59.9%	62.5%	68.2%	70.7%	72.0%			
Islington - 8wk Review % carried out before child aged 8 weeks		86.4%	92.3%	91.8%	95.1%	96.5%	96.7%	92.5%	90.7%	86.5%	90.8%	91.9%			
Islington - HR1 % carried out before child aged 15 mths		80.6%	76.5%	82.5%	79.3%	87.4%	77.8%	80.8%	82.7%	74.1%	74.3%	83.3%			
Islington - HR2 % carried out before child aged 30 mths		75.1%	78.3%	79.5%	79.7%	81.4%	80.2%	82.0%	86.3%	76.8%	75.1%	73.2%			
% of MSK pts with a significant improvement in function (PSFS)	>75%	74.0%	69.5%	76.5%	81.7%	68.5%	83.0%	82.6%	75.7%	85.1%	92.9%	92.9%	89.3%	89.3%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	77.4%	84.8%	84.8%	90.0%	77.8%	83.7%	95.1%	81.5%	89.7%	90.0%	86.2%	78.8%	78.8%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	86.7%	80.2%	75.5%	70.5%	78.0%	71.2%	80.0%	75.3%	73.8%	71.9%	78.5%	80.6%	80.6%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	93.8%	93.2%	94.8%	94.5%	94.0%	89.4%	96.9%	95.3%	93.3%	95.7%	93.5%	98.7%	98.7%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	100.0%	85.7%	57.1%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	
Nutrition and Dietetics - % Weight Loss Achieved at Discharge	>65%	100.0%	0.0%	100.0%	60.0%	66.7%	66.7%	100.0%	71.4%	33.3%	76.9%	100.0%	81.8%	81.8%	
Nutrition and Dietetics - % Weight Maintained or Gained at Discharge	>70%	60.0%	100.0%	87.5%	78.6%	80.0%	91.7%	93.3%	72.7%	77.8%	100.0%	90.0%	100.0%	100.0%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 we...	>45%					47.9%			47.8%						
Islington Self-Management - Average Increase in PAM Score	>=9								11						
Haringey Self-Management - Average Increase in PAM Score	>=9								13						

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Appendix 2. Community Waiting Times Dashboard

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Feb-19	Mar-19	Apr-19	Avg Wait (Apr-19)	No of Pts First Seen	% Target	Target Weeks	Feb-19	Mar-19	Apr-19	Avg Wait (Apr-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12	43.80%	57.10%	66.70%	9.5	15	>95%						0
ACS	Community Matron	>95%	6	90.00%	97.40%	97.80%	1.3	45	>95%	2	100.00%		0.00%	4.6	1
ACS	Adult Wheelchair Service	>95%	8	91.70%	100.00%	100.00%	3.8	31	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	71.60%	83.90%	90.00%	5.3	150	>95%	2	54.20%	90.00%	57.60%	2.3	33
ACS	ICTT - Other	>95%	12	97.90%	91.40%	92.10%	4.9	254	>95%	2	69.70%	54.30%	48.30%	2.8	60
ACS	ICTT - Stroke and Neuro	>95%	12	87.00%	71.80%	70.00%	7.3	50	>95%	2	52.90%	36.40%	45.50%	2.7	22
ACS	Intermediate Care (REACH)	>95%	6	97.40%	97.30%	95.10%	2.9	123	>95%	2	86.90%	89.90%	84.40%	1.1	64
ACS	Paediatric Wheelchair Service	>95%	8	100.00%	100.00%	92.30%	5.5	13	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	42.50%	52.00%	46.40%	17	110	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	87.60%	86.10%	72.50%	4.8	538	>95%				100.00%	0.3	1
ACS	Musculoskeletal Service - Routine	>95%	6	83.50%	80.10%	70.40%	4.7	1498	>95%	2					0
ACS	Nutrition and Dietetics	>95%	6	99.50%	100.00%	98.70%	2.6	224	>95%	2					0
ACS	Podiatry (Foot Health)	>95%	6	92.60%	91.90%	78.50%	4.6	609	>95%	2	0.00%	100.00%	100.00%	0.1	2
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	3.5	23	>95%						0
ACS	Tissue Viability	>95%	6	88.30%	89.30%	87.70%	2.6	73	>95%						0
ACS	Cardiology Service	>95%	6	95.50%	100.00%	96.60%	2.7	29	>95%	2	83.30%	100.00%	100.00%	0.6	2
ACS	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.9	69	>95%	2	0.00%				0
ACS	Respiratory Service	>95%	6	95.70%	100.00%	94.00%	3	67	>95%	2	100.00%	100.00%	100.00%	0.1	1
ACS	Spirometry Service	>95%	6	78.80%	77.30%	15.40%	7.4	26	>95%	2					0

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Appendix 2. Community Waiting Times Dashboard

Haringey

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Feb-19	Mar-19	Apr-19	Avg Wait (Apr-19)	No of Pts First Seen	% Target	Target Weeks	Feb-19	Mar-19	Apr-19	Avg Wait (Apr-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12	0.00%				0	>95%						0
ACS	Community Matron	>95%	6	71.40%	100.00%	93.30%	2.1	15	>95%	2					0
ACS	Adult Wheelchair Service	>95%	8	91.30%	100.00%	100.00%	3.8	31	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12		100.00%	100.00%	3.1	1	>95%	2					0
ACS	ICTT - Other	>95%	12	98.20%	92.20%	92.90%	4.9	239	>95%	2	71.00%	55.10%	47.50%	2.9	59
ACS	ICTT - Stroke and Neuro	>95%	12	88.90%	74.30%	66.70%	7.5	45	>95%	2	51.60%	38.90%	47.10%	2.7	17
ACS	Intermediate Care (REACH)	>95%	6	100.00%	100.00%			0	>95%	2	100.00%	100.00%	100.00%	0.1	2
ACS	Paediatric Wheelchair Service	>95%	8	100.00%	100.00%	92.30%	5.5	13	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	37.00%	51.90%	51.20%	17.7	43	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	92.50%	91.40%	83.80%	4.3	278	>95%				100.00%	0.3	1
ACS	Musculoskeletal Service - Routine	>95%	6	81.20%	78.80%	68.90%	4.6	826	>95%	2					0
ACS	Nutrition and Dietetics	>95%	6	99.10%	100.00%	100.00%	2.6	138	>95%	2					0
ACS	Podiatry (Foot Health)	>95%	6	91.50%	89.50%	81.20%	4.7	298	>95%	2	0.00%		100.00%	0.1	1
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	3.5	11	>95%						0
ACS	Tissue Viability	>95%	6	87.50%	100.00%	96.20%	2.1	26	>95%						0
ACS	Cardiology Service	>95%	6	90.00%	100.00%	94.10%	2.8	17	>95%	2	50.00%		100.00%	0.6	1
ACS	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.9	46	>95%	2	0.00%				0
ACS	Respiratory Service	>95%	6	100.00%	100.00%	95.50%	2.9	22	>95%	2					0
ACS	Spirometry Service	>95%	6	78.10%	77.30%	15.40%	7.4	26	>95%	2					0

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Appendix 2. Community Waiting Times Dashboard

Islington

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Feb-19	Mar-19	Apr-19	Avg Wait (Apr-19)	No of Pts First Seen	% Target	Target Weeks	Feb-19	Mar-19	Apr-19	Avg Wait (Apr-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12	50.00%	42.90%	37.50%	13.3	8	>95%						0
ACS	Community Matron	>95%	6	95.70%	96.30%	100.00%	0.8	30	>95%	2	100.00%		0.00%	4.6	1
ACS	Adult Wheelchair Service	>95%	8	100.00%				0	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	71.50%	85.00%	89.70%	5.4	145	>95%	2	56.50%	90.00%	57.60%	2.3	33
ACS	ICTT - Other	>95%	12	100.00%	85.70%	50.00%	7.7	4	>95%	2	100.00%	0.00%	100.00%	0.1	1
ACS	ICTT - Stroke and Neuro	>95%	12	100.00%	50.00%	100.00%	3.3	2	>95%	2	100.00%	0.00%			0
ACS	Intermediate Care (REACH)	>95%	6	97.20%	97.10%	94.70%	2.9	114	>95%	2	85.50%	89.20%	83.90%	1.1	62
ACS	Paediatric Wheelchair Service	>95%	8					0	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	60.90%	55.10%	35.00%	19.5	40	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	82.30%	78.90%	59.90%	5.3	252	>95%						0
ACS	Musculoskeletal Service - Routine	>95%	6	87.80%	83.60%	73.50%	4.7	551	>95%	2					0
ACS	Nutrition and Dietetics	>95%	6	100.00%	100.00%	96.70%	2.8	60	>95%	2					0
ACS	Podiatry (Foot Health)	>95%	6	94.30%	94.00%	76.20%	4.6	307	>95%	2		100.00%	100.00%	0.1	1
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	3.4	12	>95%						0
ACS	Tissue Viability	>95%	6	100.00%	95.50%	90.90%	2.4	11	>95%						0
ACS	Cardiology Service	>95%	6	100.00%	100.00%	100.00%	2.5	12	>95%	2	100.00%	100.00%	100.00%	0.7	1
ACS	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.7	23	>95%	2					0
ACS	Respiratory Service	>95%	6	92.90%	100.00%	93.30%	3.1	45	>95%	2	100.00%	100.00%	100.00%	0.1	1
ACS	Spirometry Service	>95%	6	100.00%				0	>95%	2					0

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Children's Community Waits Performance

	Routine Referral Urgency							Urgent Referral Urgency						
Team Group	% Target	Target Weeks	Feb-19	Mar-19	Apr-19	Avg Wait (Apr-19)	No of Pts First Seen	% Target	Target Weeks	Feb-19	Mar-19	Apr-19	Avg Wait (Apr-19)	No of Pts First Seen
CAMHS Core - Islington	>95%	4	32.10%	41.00%	34.50%	8.8	113	>95%	2	93.30%	78.60%	70.00%	1.5	10
CAMHS NDT / ADHD - Islington	>95%	8	36.40%	12.50%	18.20%	28.9	11	>95%	2					0
CAMHS Schools - Islington	>95%	8	75.00%	80.00%	68.40%	7.9	19	>95%	2					0
Community Children's Nursing - Haringey	>95%	2	100.00%	100.00%	0.00%	149.6	2	>95%	1					0
Community Children's Nursing - Islington	>95%	2	81.30%	77.40%	83.50%	1.3	97	>95%	1	100.00%	100.00%	100.00%	0.1	10
Community Paediatrics - Haringey (SCC)	>95%	12	14.30%	0.00%	11.10%	39.4	18	>95%	1	0.00%	0.00%	0.00%	72.9	1
Community Paediatrics - Haringey (NDC)	>95%	12	72.20%	48.50%	93.10%	9.5	29	>95%	1	0.00%				0
Community Paediatrics - Haringey (Child Protection)	>95%	12	100.00%	100.00%	100.00%	1.2	17	>95%	1					0
Community Paediatrics - Haringey (Other)	>95%	12	66.70%	85.70%	100.00%	1.4	2	>95%	1					0
Community Paediatrics - Islington	>95%	12	73.30%	71.40%	33.30%	17	30	>95%	1	100.00%				0
Family Nurse Partnership - Haringey	>95%	12	78.60%	77.80%	90.00%	5.2	10	>95%						0
Family Nurse Partnership - Islington	>95%	12	87.50%	83.30%	80.00%	5.4	5	>95%						0
Haematology Service - Islington	>95%	12	89.70%	100.00%	100.00%	0.7	7	>95%						0
IANDS	>95%	14	75.00%	50.00%	50.00%	6.5	4	>95%						0
IANDS - SCT	>95%	20	18.20%	28.60%	8.30%	27.5	12	>95%						0
Looked After Children - Haringey	>95%	4	55.60%	29.40%	63.20%	4.7	19	>95%						0
Looked After Children - Islington	>95%	4	57.10%	81.80%	100.00%	1.8	4	>95%						0
Occupational Therapy - Haringey	>95%	8	47.80%	26.70%	31.60%	10.8	19	>95%	2			0.00%	4.9	1
Occupational Therapy - Islington	>95%	8	50.00%	35.00%	30.00%	10.1	10	>95%	2					0
Paediatrics Nutrition and Dietetics - Haringey	>95%	8	100.00%	100.00%	100.00%	1.8	6	>95%						0
Paediatrics Nutrition and Dietetics - Islington	>95%	8	92.30%	84.00%	72.70%	5.9	11	>95%				0.00%	4	1
Physiotherapy - Haringey	>95%	8	52.40%	70.00%	86.70%	4.9	45	>95%						0
Physiotherapy - Islington	>95%	8	88.90%	98.20%	93.00%	5.1	57	>95%			0.00%			0
PIPS	>95%	12	100.00%	100.00%	100.00%	4.6	13	>95%						0
SALT - Haringey	>95%	8	33.30%	38.40%	28.70%	11.6	80	>95%	2	0.00%	100.00%	33.30%	6.5	3
SALT - Islington	>95%	8	34.60%	30.80%	54.30%	6.9	35	>95%	2					0
SALT - MPC	>95%	18	80.90%	99.20%	100.00%	5.2	66	>95%	2					0
School Nursing - Haringey	>95%	12	86.00%	86.50%	87.30%	5.2	63	>95%						0
School Nursing - Islington	>95%	12	100.00%	91.40%	97.10%	4.2	34	>95%						0

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Appendix 3. Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 62 Day Performance by Tumour Group

Indicator	17_18 Target	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Q3 Dec-18	Q4 Jan-19	Q4 Feb-19	Q4 Mar-19	Q1 Apr-19	2019-2020	Performance
Breast	>85%	100.0%	100.0%	90.5%	100.0%	86.7%	100.0%	93.3%	100.0%	100.0%	100.0%	100.0%			
Gynaecological	>85%		40.0%		100.0%	66.7%	100.0%	66.7%	100.0%	66.7%	0.0%	100.0%			
Haematological (Excluding Acute Leukaemia)	>85%	50.0%	100.0%	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%		100.0%	0.0%			
Lower Gastrointestinal	>85%	66.7%		71.4%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%			
Lung	>85%	50.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%		100.0%	85.7%	100.0%			
Other	>85%			100.0%						100.0%		100.0%			
Skin	>85%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%			
Testicular	>85%	100.0%			100.0%						100.0%				
Upper Gastrointestinal	>85%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%		75.0%	100.0%		100.0%			
Urological (Excluding Testicular)	>85%	58.8%	81.8%	68.4%	77.8%	100.0%	44.4%	100.0%	66.7%	64.7%	80.0%	76.9%			
Sarcoma	>85%									100.0%					

Appendix 3. Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2 week wait Performance by Tumour Group

Indicator	17_18 Target	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Q3 Dec-18	Q4 Jan-19	Q4 Feb-19	Q4 Mar-19	Q1 Apr-19	2018-2019	Performance
Breast	>93%	98.7%	97.3%	98.2%	97.5%	96.4%	94.0%	97.3%	98.6%	98.5%	93.7%	96.0%		96.9%	
Childrens	>93%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%		100.0%	
Gynaecological	>93%	97.7%	100.0%	100.0%	98.0%	97.4%	95.6%	96.4%	97.8%	97.1%	91.8%	96.6%		97.1%	
Haematological	>93%	70.0%	91.7%	11.1%	37.5%	62.5%	92.9%	91.7%	95.0%	100.0%	91.7%	100.0%		82.2%	
Lower Gastrointestinal	>93%	96.6%	96.5%	87.2%	88.2%	82.4%	73.0%	87.3%	98.3%	92.8%	94.2%	95.8%		90.8%	
Lung	>93%	100.0%	92.9%	92.0%	100.0%	90.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%		95.4%	
Other	>93%														
Skin	>93%	97.8%	94.6%	99.5%	98.8%	97.4%	98.0%	97.5%	98.6%	97.6%	99.3%	96.2%		97.8%	
Upper Gastrointestinal	>93%	97.6%	78.3%	72.4%	55.0%	20.6%	59.6%	89.2%	98.0%	87.2%	98.2%	98.9%		80.9%	
Urological	>93%	98.0%	89.0%	89.8%	94.7%	97.4%	97.9%	86.4%	94.9%	91.8%	92.4%	92.1%		93.1%	

Meeting title	**Trust Board – public meeting**	**Date: 29 May 2019**
Report title	**April (Month 1) 2019/20 – Financial Performance**	**Agenda item: 14**
Executive director lead	Stephen Bloomer, Chief Financial Officer	
Report author	Kevin Curnow, Operational Director of Finance	
Executive summary	The Trust is reporting a deficit of £1.5m for the first month of the year (month 1) which is behind plan by £1m. The Trust has not assumed any Provider & Sustainability Funding relating to its financial performance against control total. Income performance is marginally ahead of plan including High Cost Drugs over performance offset by PSF income behind plan. Pay costs are in excess of budget by £0.3m. Bank spend in month is £1.8m with agency spend £0.9m. Agency staffing costs need to be tightly managed to ensure the Trust remains within the NHS Improvement annual agency ceiling of £8.8m. Non pay expenditure is £0.7m overspent in month. The Trust is forecasting Cost Improvement Programme (CIP) delivery of £0.1m in month against a £1m target. The Trust is not reporting any capital expenditure in month 1 due to the prioritisation on the annual accounts preparation. The planned spend is £1.1m.	
Purpose:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends	
Recommendation(s)	To note the financial results relating to performance during April 2019 recognising to need to improve income delivery, reduce agency spend and improve the delivery of run rate reducing CIP plans	
Risk Register or Board Assurance Framework	BAF risk – Sustainable 1	
Report history	Trust Management Group, 28 May 2019	
Appendices	1 – month 1 finance report	

Appendix 1: April (Month 1) 2019/20 – Financial Performance

Financial Overview

The Trust is reporting a £1.5m deficit in April, which is a negative variance to plan of £1m for the month.

In month, income is broadly on plan. There was a £0.1m positive income variance relating to High Cost Drugs with a corresponding adverse variance in expenditure. The largest negative variance to plan is Maternity services which is underperforming against plan by £0.1m. Due to the current adverse financial variance the Trust has reduced the expected PSF income figure by 70% and only assumed PSF income relating to the Emergency Department metric.

Non-pay is overspent in month by £0.7m, £0.1m relating to High Cost Drugs and the balance relating to the unachieved CIP schemes.

The pay spend in April is inflated by £0.6m due to the budgeted one off payment to employees at the top of Agenda for Change pay bands. Agency spend is £0.9m against the plan of £0.7m. The agency ceiling for the year is set at £8.785m.

The EIM ICSU has the largest adverse position at month 1 with a variance of £0.9m. Almost £0.6m of this variance relates to pay where there is an over-establishment of 89 WTEs.

The table below shows the summary position for the April.

Statement of comprehensive income

2019/20, Month 1 (April 2019)

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	Full year Budget (£000s)	Full Year Actuals (£000s)	Variance (£000s)	FULL YEAR BUDGET (£000s)
Clinical Income	24,091	24,373	282	24,091	24,373	282	290,479
Other Non-Patient Income	2,076	1,854	(222)	2,076	1,854	(222)	24,921
High Cost Drugs	665	793	128	665	793	128	7,984
Total Income	**26,832**	**27,020**	**188**	**26,832**	**27,020**	**188**	**323,384**
Pay	(19,652)	(19,942)	(290)	(19,652)	(19,942)	(290)	(232,207)
Non-Pay (excl HCD)	(6,034)	(6,617)	(582)	(6,034)	(6,617)	(582)	(72,407)
High Cost Drugs	(668)	(807)	(139)	(668)	(807)	(139)	(8,011)
Total Operating Expenditure	**(26,354)**	**(27,366)**	**(1,012)**	**(26,354)**	**(27,366)**	**(1,012)**	**(312,625)**
	478	**(346)**	**(824)**	**478**	**(346)**	**(824)**	**10,759**
Depreciation	(620)	(593)	27	(620)	(593)	27	(7,481)
Dividends Payable	(432)	(432)	(0)	(432)	(432)	(0)	(5,187)
Interest Payable	(271)	(268)	3	(271)	(268)	3	(3,238)
Interest Receivable	9	22	13	9	22	13	156
P/L on Disposal of Assets	0	0	0	0	0	0	0
Total	**(1,314)**	**(1,271)**	**43**	**(1,314)**	**(1,271)**	**43**	**(15,750)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**(836)**	**(1,616)**	**(780)**	**(836)**	**(1,616)**	**(780)**	**(4,991)**
Provider Sustainability Fund (PSF)	259	78	(181)	259	78	*(181)*	*4,946*
Net Surplus / (Deficit) - before IFRIC 12	**(577)**	**(1,539)**	**(962)**	**(577)**	**(1,539)**	**(962)**	**(45)**
Add back							
Impairments	0	0	0	0	0	*0*	0
IFRS & Donate	2	6	4	2	6	*4*	45
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(575)**	**(1,532)**	**(957)**	**(575)**	**(1,532)**	**(957)**	**0**

Income and activity

The Trust's reported income position is broadly on plan in month.

Total clinical income over performed by £410k, of which £350k relates to critical care stays over month end.

Outpatients underperformed by 6% in activity terms, giving an adverse variance of £107k. Income performance has improved across all ICSUs, including Surgery and Cancer, which was over plan by £12k.

Day cases and Electives activity over-performed by 5%, a variance of £23k. This was driven by a favourable variance for Electives of £40k and an adverse variance for Day case of £17k, Gastroenterology is the main reason for the over-performance with a favourable variance of £72k, £65k within day case due to endoscopy insourcing. Spinal Surgery was behind plan by £31k. This is due to elective underperformance of 4 patients. Gynaecology also underperformed £24k.

A&E, UCC and ambulatory care performance is on plan, with a favourable variance of £14k.

Clinical Support Services all over-performed; with Direct access pathology and outpatient imaging over-performing offsetting the underperformance in Direct access Imaging.

Combined Maternity Pathways/Deliveries activity under-performed by 6%, £79k.

As the months financial control total not met, only 30% of PSF has been accrued, therefore under achieved £181k.

Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	1,370	1,384	14	1,370	1,384	14	8,932	9,079	147	8,932	9,079	147
Ambulatory Care	419	407	(12)	419	407	(12)	1,640	1,631	(9)	1,640	1,631	(9)
Adult Critical Care	578	548	(30)	578	548	(30)	1,166	869	(297)	1,166	869	(297)
Community Block	3,010	3,010	0	3,010	3,010	0	0	0	0	0	0	0
Day Cases	1,222	1,205	(17)	1,222	1,205	(17)	1,778	1,887	109	1,778	1,887	109
Diagnostics	286	293	7	286	293	7	2,980	3,098	118	2,980	3,098	118
Direct Access	1,049	1,048	(1)	1,049	1,048	(1)	95,315	94,484	(831)	95,315	94,484	(831)
Elective	840	881	40	840	881	40	204	200	(4)	204	200	(4)
High Cost Drugs	636	777	141	636	777	141	0	0	0	0	0	0
Maternity - Deliveries	1,136	1,039	(96)	1,136	1,039	(96)	327	308	(19)	327	308	(19)
Maternity - Pathways	740	758	18	740	758	18	680	635	(45)	680	635	(45)
Non-Elective	3,845	3,872	27	3,845	3,872	27	1,679	1,696	17	1,679	1,696	17
OP Attendances - 1st	1,038	1,031	(7)	1,038	1,031	(7)	5,774	5,519	(255)	5,774	5,519	(255)
OP Attendances - follow up	916	856	(60)	916	856	(60)	13,310	12,346	(964)	13,310	12,346	(964)
OP Procedures	546	506	(40)	546	506	(40)	2,789	2,733	(56)	2,789	2,733	(56)
Other Acute Income	749	1,612	863	749	1,612	863	6,342	6,299	(43)	6,342	6,299	(43)
CQUIN	245	253	7	245	253	7						
Total SLA	**18,624**	**19,478**	**854**	**18,624**	**19,478**	**854**	**142,915**	**140,784**	**(2,131)**	**142,915**	**140,784**	**(2,131)**
Marginal Rate	0	0	0	0	0	0						
	18,624	**19,478**	**854**	**18,624**	**19,478**	**854**						
Other Clinical Income	6,132	5,688	(444)	6,132	5,688	(444)						
Other Non Clinical Income	2,076	1,854	(222)	2,076	1,854	(222)						
Total Other	**8,208**	**7,541**	**(667)**	**8,208**	**7,541**	**(667)**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**26,832**	**27,020**	**188**	**26,832**	**27,020**	**188**	**142,915**	**140,784**	**(2,131)**	**142,915**	**140,784**	**(2,131)**
PSF	259	78	(181)	259	78	(181)						
Revised Total	**27,091**	**27,097**	**6**	**27,091**	**27,097**	**6**						

Monthly run rates – expenditure

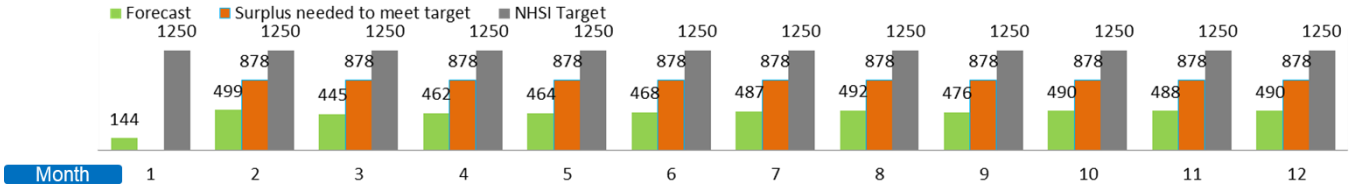
The in month combined expenditure position is £1m adverse to plan. Key points to note include:

- **Pay and Activity Correlation**
  - Total pay expenditure for April was £19.9m including £0.6m of Agenda for Change payments relating to one off payments to employees at the top of their bands in line with the national pay settlement. The £19.9m is £0.3m in excess of budget
  - Within total pay expenditure, agency costs were £0.9m. Bank spend is £1.8m. Total temporary spend in month was £2.7m.
  - Ward establishments are over staffed due to winter escalation beds and specialing/one to one care of patients. There has been increased focus by ICSUs, Chief Operating Officer and Chief Nurse to ensure appropriate staffing levels are adopted.
  - Of the pay overspend, £0.2m and 66 WTE relates to inpatient wards
  - The additional bed capacity and related staffing over-establishment threatens to derail up to £2m of 2019/20 CIP schemes.

- **Non Pay**
  - Non pay expenditure for April was £7.4m, including High Cost Drugs.
  - The non-pay spend in month 1 is an adverse variance of £0.7m.
  - High Cost Drugs account for £0.1m of this variance, which is off-set in income
  - £0.5m variance relates to unachieved CIP plans

Cost Improvement Programme (CIP)

The Trust has planned CIP delivery of £1m in month 1, actually delivery is £0.1m. This is an adverse variance of £0.9m



	Forecast	Overall Target	Gap Forecast-Target	Identified but not forecasted
Total	5,406	15,067	-9,661	7,000

Next Steps

The Trust is already taking action to address the gaps identified. These actions include:

- Changes to the PMO structure to provide greater support to ICSUs to assist with the development and delivery of CIP – May 2019
- Additional support to ICSUs including operational, financial and quality, providing greater capacity and increased scrutiny
- Weekly reporting and reviews at Executive Team Meetings

Statement of Financial Position

THE WHITTINGTON HEALTH NHS TRUST

Statement of Financial Position

	Year to Date		
	As at 30 April 2019 £000	Plan 30 April 2019 £000	Plan variance 30 April 2019 £000
Property, plant and equipment and intangibles	217,099	224,084	(6,985)
Trade and other receivables	599	1,400	(801)
Total Non Current Assets	**217,698**	**225,484**	**(7,786)**
Inventories	1,463	1,355	108
Trade and other receivables	41,044	33,682	7,362
Cash and cash equivalents	27,395	19,914	7,481
Total Current Assets	**69,902**	**54,951**	**14,951**
Total Assets	**287,600**	**280,435**	**7,165**
Trade and other payables	43,944	46,119	(2,175)
Borrowings	22,269	22,269	0
Provisions	1,028	1,391	(363)
Total Current Liabilities	**67,241**	**69,779**	**(2,538)**
Net Current Assets (Liabilities)	**2,661**	**(14,828)**	**17,489**
Total Assets less Current Liabilities	**220,359**	**210,656**	**9,703**
Borrowings	34,827	39,024	(4,197)
Provisions	842	842	0
Total Non Current Liabilities	**35,669**	**39,866**	**(4,197)**
Total Assets Employed	**184,690**	**170,790**	**13,900**
Public dividend capital	66,691	66,691	0
Retained earnings	20,460	3,528	16,932
Revaluation reserve	97,539	100,571	(3,032)
Total Taxpayers' Equity	**184,690**	**170,790**	**13,900**

There are some significant variances in the balance sheet against plan, for which commentary is provided below. Overall, the value of the balance sheet is £13.9m higher from plan. The main reason is the increased surplus made by the Trust as a result of additional Provider Sustainability Funding (PSF) which materialises as cash in the bank or a debtor at 30 April. There have also been decreases in the revaluation reserve following the valuation of the Trust's land and buildings portfolio (information available after the submission of the 2019-20 operating plan), which indicated an average decrease of approximately 2%.

- **Property, Plant & Equipment (PPE) and intangible assets** are £7.0m higher than plan. This variance against plan largely arises from the revaluation of assets mentioned above.

- **Cash and cash flow:** the Trust is holding £27.4m in cash at the end of April 2019. This reflects the completion of the land sale transaction to Camden and Islington NHS FT in March 2019, and forms part of a significant level of cash that will fund a transformative Estates Strategy in future years. £20m of the balance is invested with the National Loans Fund.

  The Trust is unlikely to require any cash support during 2019/20. The Trust expects that it most significant debtor, for approximately £21.5m with NHS England for Provider Sustainability Funding (PSF) will be settled in July 2019.

- **Receivables (Debtors)** are £7.4m higher than plan. This increase is primarily driven by the additional £6.3m PSF awarded to the Trust by NHSI as a reward for meeting its financial targets in 2018-19. As stated above, the Trust expects this to be settled in July 2019.

Meeting title	**Trust Board – public meeting**	**Date: 29 May 2019**
Report title	**NHS provider licence self-certification**	**Agenda item: 15**
Executive director lead	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	
Report author	Swarnjit Singh, Trust Corporate Secretary	
Executive summary	NHS trusts are required to self-certify that they can: • meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012 • have regard to NHS Constitution requirements); and • that they have complied with governance requirements. NHS Trust Boards are now no longer required to submit the declarations to NHS Improvement but need to publish the agreed self-certifications on their web pages. Whittington Health intends to make positive confirmations on all the required declarations. The Executive Team has reviewed evidence in support of self-certification and recommends the trust declares compliance with the two conditions, based on the available guidance.	
Purpose:	Approval	
Recommendation(s)	The Trust Board is asked to: i. approve the positive compliance statements for the annual self-certification against NHS provider licence conditions G6 and FT4 contained in the self-certification statement at paragraph 2.2, the Table 1 at paragraph 2.7 and paragraph 3.1; ii. review the assurance evidence for these conditions; and iii. agree delegated authority for the Chief Executive and Chair to sign off the final declarations by 31 May 2019 to be published on the Trust's web pages.	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	Annual self-certification report to Board; Executive Team, 20 May 2019; Trust Management Group, 28 May 2019	
Appendices	Appendix 1 – Self-certification assurance evidence for condition G6(3) Appendix 2 – Self-certification assurance evidence for condition FT4(8)	

NHS provider licence self-certification

1. Background

1.1 Although NHS trusts are exempt from needing to comply with the provider licence, directions from the Secretary of State for Health & Social Care requires NHS Improvement to ensure that NHS trusts comply with conditions equivalent to the licence, as it deems appropriate.

1.2 NHS Improvement requires NHS trusts to self-certify on an annual basis whether or not they have:

NHS licence provider condition	Self-certification requirement	Deadline for Board sign-off of self-certification
Condition G6(3)	The provider has taken all precautions necessary to comply with the Licence, NHS Acts and NHS Constitution	31 May 2019
Condition FT4(8)	The provider has complied with required governance arrangements	30 June 2019

1.3 NHS Improvement's guidance[1] states there is no set process for assurance, or how conditions are met and it is at providers' discretion as to how this is carried out.

1.4 The aim of the self-certification process is for providers to carry out assurance that they are in compliance with the licence conditions and for the Board to clearly understand the Trust's position.

1.5 The Board of Directors are asked to self-certify the Trust's compliance with Conditions G6(3) and FT4(8) and to review the evidence of assurance in support of these two self-certifications contained in the respective appendices.

2. Key issues

NHS provider licence conditions

2.1 Condition G6 requires providers to:

- have effective processes and systems in place that identify risks to compliance with the conditions of the provider licence, any requirements imposed on it under the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services;
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring; and

[1] https://improvement.nhs.uk/documents/5075/Self-certification_2018_-_Consolidated_Guidance.pdf

- annually review, whether these processes and systems are effective.

2.2 The Board of Directors are invited to review the requirements of Condition G6 and confirm, or not confirm, the following self-certification statement:

> *Following a review for the purpose of paragraph 2(b) of licence condition G6[2], the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.*
>
> NB: [2]Paragraph 2(b) of licence condition G6 sets out the requirement for the Licensee to regularly review that processes and systems have been implemented and are effective

2.3 If not confirmed, the Board should agree an explanation that can be provided for the non-compliance.

2.4 Appendix 1 provides a range of assurance evidence in support of compliance with the general licence conditions. In making their declaration, the Board of Directors should take into account, in particular, the Annual Governance Statement as set out in the Annual Report 2018/19 which describes the Trust's system of internal control and the processes in place to identify, prioritise and evaluate risks to the achievement of the Trust's policies, aims and objectives and to manage any risks efficiently, effectively and economically. Key elements of the system of internal control include the Trust's Risk Management strategy, Board assurance through the Board committee structure and associated reporting lines, the Quality Improvement strategy, the annual business planning process and the Trust's approach to performance management.

2.5 Feedback from internal and external audit are also a key source of assurance on the Trust's compliance with its obligations. At the May 2019 meeting of the Audit & Risk Committee, the Trust received the Head of (Internal) Audit opinion on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes for the financial year 2018/19. The overall opinion was that partial assurance can be given that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. Action is already being taken on areas identified for improvement by internal audit e.g. the Board's risk appetite was discussed at the May Board seminar and will be further refined.

Trust governance arrangements

2.6 Condition FT4 requires providers to review whether their governance systems meet the standards and objectives in the condition; compliance requires effective Board and Committee structures, reporting lines and performance and risk management systems.

2.7 The following table (Table 1) outlines the requirements of Condition FT4. To self-certify, the Board are invited to confirm compliance, or otherwise, as at the date of the Board's review and for the future financial year (2019/20). A proposed response to each requirement ('confirmed'/'not confirmed') is set out in Table 1, along with any identified risks and mitigating actions. A summary of the evidence to support the proposed responses is provided in appendix 2.

Table 1 – Proposed self-certification responses

Condition FT4 key statement	Response	Risks/mitigating actions
1. The Board is satisfied 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.	Confirmed	The Trust is implementing internal audit recommendations.
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	Confirmed	Minimal risk – see Board Assurance Framework (BAF)
3. The Board is satisfied that the Trust 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; and c) Clear reporting lines and accountabilities throughout the organisation.	Confirmed	Minimal risk – see BAF
4. The Board is satisfied that the Trust 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 and oversight 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, the Care Quality Commission, the NHS Commissioning Board (now NHS England) and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	Confirmed	Minimal risk – see BAF

Condition FT4 key statement	Response	Risks/mitigating actions
g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.		
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Minimal risk – see BAF
6. The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Minimal risk – see BAF

3. Proposed self-certification

3.1 The proposed self-certification for the trust is shown below:

NHS provider license condition	Confirmed	Not confirmed
Condition G6(3) – the provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution	Yes	
Condition FT4(8) – the provider has complied with required governance arrangements	Yes	

4. Conclusion

4.1 The requirements of the NHS provider licence have been reviewed from corporate governance, finance and performance perspectives by the Executive Team and are deemed to have been met, as highlighted in appendices 1 and 2.

5. Recommendations

5.1 The trust board is asked to:

i. approve the positive compliance statements for the annual self-certification against NHS provider licence conditions G6 and FT4 contained in the self-certification statement at paragraph 2.2 , the Table 1 at paragraph 2.7 and paragraph 3.1;
ii. review the assurance evidence for these conditions; and
iii. agree delegated authority for the Chief Executive and Chair to sign off the final declarations by 31 May 2019 to be published on the Trust's web pages.

Appendix 1: Self-certification assurance evidence for condition G6(3) – compliance with provider licence conditions

Section 1: General licence conditions

No.	Licence condition	Explanation	Board assurance/evidence
G1	Provision of information	Licensees are required to provide NHS Improvement with any information they may require for licensing functions	The Trust has robust data collection and validation processes and has a good track record of producing and submitting large amounts of accurate, complete and timely information to regulators and other third parties to meet specific requirements
G2	Publication of information	Licensees have an obligation to publish such information as NHS Improvement may require, in a manner that is accessible to the public	The Trust is committed to operating in an open and transparent manner and is working to strengthen and develop this aspect of the Trust's governance as a corporate priority. The Board meets in public and will continue to undertake the vast majority of Trust business in public meetings; agendas, minutes and associated papers are published on our website. The Trust website contains a variety of information and referral point details providing advice to the public and referrers who may require further information about services. Copies of the Trust's Annual Report and Accounts and Quality Account are published on the website.
G3	Payment of fees to NHS Improvement	The Health & Social Care Act (2012) gives NHS Improvement the ability to charge fees each financial year and licensees are obliged to pay them upon request	No decision has yet been made by NHS Improvement to charge fees, however, any obligation to pay fees and will be accounted for within the Trust's financial planning.

No.	Licence condition	Explanation	Board assurance/evidence
			The Trust does also pay fees to other parties such as the Care Quality Commission and NHS Resolution.
G4	Fit and proper persons	This condition prevents licensees from allowing unfit persons to become or to continue as directors	All Trust Directors are required to sign an annual declaration that they are a fit and proper person, in line with organisational policy.
G5	NHS Improvement guidance	Licensees are required to pay due regard to any guidance issued by NHS Improvement	The Trust has had regard to NHSI guidance through submission of required annual and quarterly declarations, annual self-certifications and annual workforce race equality standard submissions and also when developing its annual operational and capital plans.
G6	Systems for compliance with licence conditions and regulated obligations	Licensees are expected to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements	The Trust has an approved risk management strategy in place which sets out its approach to identifying, managing and escalating risks. It also has a comprehensive and recently-reviewed Board Assurance Framework. The effective management of risks is monitored by the Trust Management Group, respective Board Committees for relevant risks and also the Trust Board. A revised risk management strategy is due to be reviewed at the June 2019 Board meeting.
G7	Registration with the Care Quality Commission (CQC)	Providers are required to be registered with the CQC and to notify NHS Improvement if registration is cancelled	The Trust is registered with the CQC for the services it provides and has no current enforcement notices in place.
G8	Patient eligibility and selection criteria	Licence holders are required to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner	The Trust publishes descriptions of the services it provides on the Trust website. Eligibility is defined through commissioners' contracts and is clear the on choose and book electronic / referral system.
G9	Continuity of services	This condition applies to all licensees. It sets out the conditions under which a service will be designated as a	Similar to the previous Mandatory Services, Commissioner Requested Services continue to be set within the contracts agreed with commissioners which

No.	Licence condition	Explanation	Board assurance/evidence
		Commissioner Requested Service. Licensees are required to notify NHSI at least 28 days prior to the expiry of a contractual obligation if no renewal or extension has been agreed. Licensees are required to continue to provide the service on expiry of the contract until NHSI issues a direction to continue service provision for a specified period or is advised otherwise. Services shall cease to be Commissioner Requested Services (CRS) if: • commissioners agree in writing that there is no longer a service need and the regulator has issued a determination in writing that the service is no longer a CRS; • three years have elapsed since the 1 April 2013 or one year has elapsed since the commencement of the license, whichever is the latter; or • the contract to provide a service has expired and the direction notice issued by NHSI specifying a further period of provision has expired. • Licencees are required under this Condition, to notify NHSI of any changes in the description and quantity of services which they are under contractual or legal obligation to provide.	are reviewed annually as part of the annual planning and contract negotiation process. No services are formally designated as Commissioner Requested Services under the terms of the License and the Trust commits to notifying NHSI as per this condition. The Trust has strong working relationships with its commissioning partners within the local health economy. The Board has a director responsible for leading on contract negotiations and Chair and executive team continually work on developing and improving stakeholder engagement. The Trust has a strong track record of delivering service transformation, efficiency and quality improvement to meet the needs of the local population.

Section 2: Pricing

No.	Licence condition	Explanation	Board assurance/evidence
P1	Recording of information	Under this condition, NHSI may oblige licensees to record information, particularly information about their costs, in line with published guidance.	The Trust notes this condition. The Trust records all of its information about costs in line with current guidance and would comply fully with any new guidance.
P2	Provision of information	Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to NHSI.	The Trust notes this condition. The Trust intends to comply fully with any new requirements to submit information to NHSI.
P3	Assurance report on submissions to NHSI	When collecting information for price setting, it will be important that the submitted information is accurate. This condition allows NHSI to oblige licensees to submit an assurance report confirming that the information that they have provided is accurate.	The Trust would comply with this condition, as the requirement arose.
P4	Compliance with the national tariff	The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the national tariff for NHS health care services. This licence condition imposes a similar obligation on licensees, i.e. the obligation to charge for NHS health care services in line with the national tariff.	The Trust complies with this condition through either following national tariff guidance or local tariff arrangements, agreed with commissioners and reported appropriately.
P5	Constructive engagement concerning local tariff modifications	The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to NHSI for a modification.	The Trust complies with this condition and engages actively and constructively with its respective commissioners.

Section 3: Choice and competition

No.	Licence condition	Explanation	Board assurance/evidence
C1	Patient Choice	This condition protects patients" rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice under the NHS Constitution, or where a choice has been conferred locally by commissioners.	The Trust complies with guidance through its policies and procedures and has made information available via the Choose and Book directory of services, NHS Choices and its website.
C2	Competition Oversight	This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct that has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	No compliance issues identified. All licensed provider organisations will be treated as ”undertakings" under the terms of the Competition Act 1998. This means that all licensed providers will be deemed to be organisations engaging in an ”economic activity" for which the provisions of the Competition Act will apply. Licensed providers therefore need to comply with the Competition Act. The Board and Executive Management team has access to expert legal advice to ensure compliance with this condition.

Section 4: Integrated Care

No.	Licence condition	Explanation	Board assurance/evidence
IC1	Enable the provision of integrated care	The licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care	The Trust is an active participant in the local health economy and is working in partnership with commissioners to take forward models of integrated care such as the NCL STP. Integrated care remains a core element of the

No.	Licence condition	Explanation	Board assurance/evidence
			Trust's 2019/24 strategy and its has a strong track record of working on integrated care pathways with other providers.

Section 5: Continuity of services

No.	Licence condition	Explanation	Board assurance/evidence
COS1	Continuing provision of Commissioner Requested Services	This condition prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provides Commissioner Requested Services, without the agreement of relevant commissioners.	The Trust complies with this condition – see G9 above.
COS2	Restriction on the disposal of assets	This licence condition ensures that licensees keep an up to date register of relevant assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain NHSI"s consent before disposing of these assets when there are concerns about the ability of the licensee to carry on as a going concern.	The Trust maintains a capital asset register for all depreciable assets, a register of all its contracts and a property and property leases' register.
COS3	Standards of Corporate Governance and Financial Management	This condition requires licensees to have due regard to adequate standards of corporate governance and financial management. The Risk Assessment Framework will be utilised by NHSI to determine compliance	The Trust has an overarching corporate governance framework through its standing orders, standing financial instructions and reservation of powers to the Board and those it has delegated. The Trust has well developed systems of corporate and financial risk management as evidenced by the annual governance statement, head of internal audit opinion, 2017/18 CQC inspection (well-led), internal and external audit reports.
COS4	Undertaking from	This condition requires licensees to put in place a	Not applicable – this licence condition does not

No.	Licence condition	Explanation	Board assurance/evidence
	the ultimate controller	legally enforceable agreement with their „ultimate controller" to stop ultimate controllers from taking any action that would cause licensees to breach the license conditions. This is best described as a „parent/subsidiary company" arrangement. **If no such controlling arrangements exist then this condition would not apply.** Should a controlling arrangement come into being, the ultimate controller will be required to put in place arrangements to protect the assets and services within 7 days.	apply as the Trust is a public benefit organisation and neither operates nor is governed by an ultimate controller arrangement
COS5	Risk pool levy	This licence condition obliges licensees to contribute, if required, towards the funding of the „risk pool" – this is like an assurance mechanism to pay for vital services if a provider fails.	The regulatory risk pool has not yet arisen. The Trust currently contributes to the NHS Resolution risk pool for clinical negligence, property expenses and public liability schemes.
COS6	Co-operation in the event of financial distress	This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with NHSI and any of its appointed persons in these circumstances in order to protect services for patients.	Financial performance is monitored by the Board, Finance & Business Development and Trust Management Committees and by NHS Improvement. The latter has assessed the Trust as in segment two of the Single Operating Framework.
COS7	Availability of Resources	This licence condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.	The Trust a forward plans and contract agreements with commissioners which cover this condition. A going concern assessment is made annually as part of the external audit review of the annual report and accounts.

Section 6: Foundation Trust conditions (NHS trusts are asked by NHSI to demonstrate how they would comply with this condition even if they are not yet Foundation Trusts)

No.	Licence condition	Explanation	Board assurance/evidence
FT1	Information to update the register of NHS Foundation Trusts.	This licence condition ensures that NHS Foundation Trusts provide required documentation to NHSI. NHS Foundation Trust Licensees are required to provide NHSI with: • a current Constitution; • the most recently published Annual Accounts and Auditor's report; • the most recently published Annual Report; and • a covering statement for submitted documents.	The Trust has a record of compliance with provided regulators with required information. Through the Audit & Risk Committee, the Board monitors the preparation and submission of the Annual Accounts, Auditor's report and the Annual Report.
FT2	Payment to NHSI in respect of registration and related costs.	If NHSI moves to funding by collecting fees, they may use this licence condition to charge additional fees to NHS Foundation Trusts to recover the costs of registration.	If NHSI required fees to be paid by the Trust, it would comply with such a condition.
FT3	Provision of information to advisory panel.	The Act gives NHSI the ability to establish an advisory panel that will consider questions brought by governors. This licence condition requires NHS Foundation Trusts to provide the information requested by an advisory panel.	Not applicable – the advisory panel has been dissolved by NHSI.
FT4	NHS Foundation Trust Governance arrangements.	This condition will enable NHSI to continue oversight of governance of NHS Foundation Trusts. In summary, licensees are required to: • have systems and processes and standards	See COS3 above also. This Trust complies with this condition as demonstrated through the annual governance statement. See fuller details of assurance/evidence

No.	Licence condition	Explanation	Board assurance/evidence
		of good corporate governance; • have regard for the guidance published by NHSI; • have effective Board Committee Structures • have clear accountabilities and reporting lines throughout the organisation and maintain appropriate capacity and capability of the Board; • comply with healthcare standards; • have effective financial management, control and decision making; and • maintain accurate information.	provided in appendix 2 overleaf.

Appendix 2: Self-certification assurance evidence for condition FT4(8) – compliance with provider licence conditions

NB: *A number of the items of evidence identified cut across the key statements and the evidence list itself is not exhaustive.*

Key statement	Evidence
1. The Board is satisfied 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.	• Achieved an overall 'Good' rating following the last CQC core service inspection (2017/18) • Annual review of Board Committee terms of reference, standing orders, standing financial instructions and scheme of delegation • Annual Governance Statement, approved by Audit Committee, May 2019 • Partial assurance from the annual Head of Internal Audit opinion • An unqualified external audit opinion on the 2018/19 financial accounts and clean opinions with regard to use of resources, the content of the Quality Account • In April 2019, the Board reviewed the content and structure of the Board Assurance Framework (BAF) and strengthened this to better align with strategic objectives highlighted in the revised 2019/24 Whittington Health strategy, with the focus of Board attention, clarify ownership of risks and enable increased transparency and assurance and communication of its risk appetite • Quarterly review of the Corporate Risk Register by the Quality Committee • Risk management training provided for all new starters and Trust-wide training needs analysis identifies risk management training requirements for specific staff groups (appropriate to grade, role and location) • Annual programme of internal audit – reflective of the risks identified on the Board Assurance Framework overseen by Audit & Risk Committee • Annual clinical audit programme overseen by Quality Committee • Compliance with the requirements of the Data Protection & Security Toolkit, as reported in the Quality Account • Mechanisms in place for enabling sharing of lessons learned and review of Serious Incidents • Board of Directors' monthly review of Board Performance report, including performance against regulatory and contractual KPIs and compliance with

Key statement	Evidence
	mandatory training. The content and structure frequency of Board performance reports was reviewed in 2018/19 and a new dashboard report was introduced from May 2019 • Robust annual business planning process, including quality impact assessment of cost improvement plans and involvement of key stakeholders, and associated development of annual Operational Plan • Accountability framework for Integrated Clinical Service Units and corporate directorates is being introduced for this financial year
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	• As per Statement 1 above • Completion of well led self-assessment • Annual completion of provider self-certification • Compliance with provision B1.1.2 of the FT Code of Governance (at least half of the Board, excluding the chairperson, should comprise non-executive directors determined by the Board to be independent) • Annual Workforce Race Equality Standard submission
3. The Board is satisfied that the Trust 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; and c) Clear reporting lines and accountabilities throughout the organisation	• Board of Directors meetings focus on strategy and policy, operational performance, governance and quality, workforce and organisational development • At least an annual review of Board Committee terms of reference • Detailed governance structure in place • Audit Committee's annual self-assessment, in line with Audit Committee Handbook recommendations • Board of Directors' development programme commenced in April 2019 including a focus on the unitary Board, effectiveness, risk management, assurance and strategy • Executive and Non-Executive Director annual appraisal process (including agreement of objectives and personal development plans). • Board of Directors', Quality Governance Committee and Audit Committee annual work plans • Minutes of Board committees reviewed and ratified at next Board of Directors' meeting

Key statement	Evidence
	• Approval of Annual Governance Statement and wider Annual Report (also see Statement 1)
4. The Board is satisfied that the Trust 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 and oversight 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, the Care Quality Commission, the NHS Commissioning Board (now NHS England) and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward	• 'Clean' external audit opinion on use of resources for 2018/19 • Internal and external audit annual plan – review of completed audits by Audit & Risk Committee • Audit & Risk Committee's receipt of technical updates relating to the health sector from KPMG (external auditors) and other relevant briefings • Regular meeting of Board of Directors and Board committees, enabling timely reporting and sharing of information • Monthly performance reports to Board of Directors including performance against national and local targets, other regulatory requirements, workforce indicators, and patient and staff feedback (i.e. Friends and Family Test) • Monthly Finance reports to Board of Directors Board review of returns to NHS Improvement • Quarterly Single Oversight Framework meetings with NHS Improvement • Board of Directors' review and approval of annual capital expenditure plans with updates provided on progress • Updates to the Board on contract sign-off and future performance requirements from commissioners • Board-approved Quality Account and associated quality improvement priorities for 2019/20 with– quarterly reports on progress to Quality Committee • Board development activities – see Statement 3 above • Local anti-fraud arrangements in place with reports on progress against annual work-plan and any ad hoc anti-fraud work received by the Audit & Risk Committee

Key statement	Evidence
plans) material risks to compliance with the Conditions of its Licence; g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.	
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e) That the Trust, including its Board, actively engages on quality of care with	• Executive job descriptions with clearly defined remits/responsibilities, linked to the Trust's strategic objectives • Director appraisal process - including objective-setting and personal development planning • Board of Directors development activities. • Non-Executive and Executive Director visible leadership service visits' • Fit and Proper Persons Declarations – Board of Directors' annual self-assessment completed by Director of Workforce • Board register of interests • Complaints Annual Report to Quality Governance Committee • Annual Board reports on patient and staff survey outcomes and associated action plans • 2019/21 Patient Experience strategy agreed by Board

Key statement	Evidence
patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	
6. The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	• As per Statement 5 above i.e. pre-employment checks, Fit and Proper Persons self-assessments, appraisals and personal development plans, recommendations from Remuneration and Terms of Service Committee • Medical and nursing revalidation processes • Six monthly safe staffing report to the Board • HR policies and procedure reflect legislative and regulatory requirement and best practice

Meeting title	**Trust Board – public meeting**	**Date: 29 May 2019**
Report title	**Board Committees' terms of reference**	**Agenda item: 16**
Executive director lead	Siobhan Harrington, Chief Executive	
Report author	Swarnjit Singh, Trust Corporate Secretary	
Executive summary	Board Committees' terms of reference have been reviewed and updated with the overriding aim of standardisation under the following headings: 1. Authority 2. Role (or purpose) 3. Membership 4. Quorum and attendance 5. Frequency of meetings 6. Agenda and papers 7. Duties 8. Reporting 9. Monitoring and review The revised terms of reference for each Committee are shown at appendix 1. There has been no change to the substance of respective Board Committee's terms of reference and the content has been re-ordered as per the nine headings highlighted. Along with updated Board Committee's terms of reference, other corporate governance documents such as the standing orders, standing financial instructions and scheme of delegation and reservation of powers are being reviewed and updated, in preparation for the Care Quality Commission's well led review.	
Purpose:	Approval	
Recommendation(s)	Board members are invited to: i. approve the updated, terms of reference which have been standardised where possible; and ii. note these updated terms of reference will be ratified at subsequent Board Committee meetings.	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	None	
Appendices	Appendix 1: Updated Board Committees' terms of reference	

Appendix1: Updated Board Committees' terms of reference, May 2019

Audit & Risk Committee	
1.	**Authority**
1.1	The Board of Directors hereby resolves to establish a Committee to be known as the Audit & Risk Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.
1.2	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires for any employee, and all employees are directed to co-operate with any request made by the Committee to attend, as and when required.
1.3	The Committee is also authorised by the Board to obtain outside legal or other professional Advice, if it considers this necessary, via the Trust Secretary.
2.	**Role**
2.1	The role of the Audit & Risk Committee is to provide assurance to the Board of Directors and the Accountable Officer through a means of independent and objective review of: • the arrangements in place for governance, risk management and internal control • the comprehensiveness, reliability and integrity of assurances to meet the Board and the Accounting Officer's requirements
2.2	To support its role, the Audit & Risk Committee will have particular engagement with the work of internal and external audit and with financial reporting issues.
3.	**Membership**
3.1	The Audit & Risk Committee will be appointed by the Board of Directors. The Committee shall be made up of three, independent Non-Executive Directors of the Trust, one of whom will Chair the Committee.
3.2	The Chair of the Committee will normally also attend the Annual General Meeting prepared to respond to any questions on the Committee's activities.
3.3	The Chairman of the Trust must not be a member of the Committee.
3.4	Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.
3.5	At least one member of the Audit & Risk Committee should have recent and relevant financial experience.

4.	**Quorum and attendance**
4.1	The quorum necessary for the transaction of business shall be at least two members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by it.
4.2	The Secretary of the Committee shall maintain a register of attendance which will be published in the Trust's Annual Report.
4.3	The Chief Finance Officer will be the lead executive director for the committee.
4.4	The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report.
4.5	Other attendees include appropriate External and Internal Audit and LCFS representatives shall normally attend meetings. In addition, The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.
4.6	At least once a year, the external and internal auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.
4.7	The lead executive director for the Committee will identify a Committee Secretary who will also be attendance, along with the Trust Board Secretary.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of five meetings per financial year is suggested, with one meeting devoted to the draft annual accounts.
5.2	The external or internal auditor may request a meeting should they consider it necessary.
6.	**Agenda & papers**
6.1	Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
6.2	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft

	minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.
7.	**Duties**
7.1	The Committee should carry out the following duties for the Trust:
	Governance, risk management and internal control
7.2	The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that support delivery of Trust's strategic objectives.
7.3	In particular, the Committee will review the adequacy of: i. all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission's Judgement Framework), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors; ii. the Board Assurance Framework and underlying assurance processes that indicate the degree of the achievement of Trust's strategic objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements; iii. the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Board's Quality Committee; iv. the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority; v. the system of management for the development, approval and regular review of all trust policies, including those for ensuring compliance with relevant regulatory, legal and code of conduct requirements; vi. the financial systems; vii. the system of management of performance and finance across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; viii. the internal and external audit services, and counter fraud services; and ix. compliance with Trust's Standing Orders (SOs) and Standing Financial Instructions (SFIs).
7.4	The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following:

	i. the process for the completion and up-dating of the Assurance Framework; ii. the relevance and quality of the assurances received; iii. whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and iv. whether the Board Assurance Framework remains relevant and effective for the organisation.
7.5	The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
7.6	In relation to the management of risk, the Committee will: i. maintain an oversight of the Trust's risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements; ii. review processes to ensure appropriate information flows to the Committee from executive management and other board committees in relation to the Trust's overall control and risk management position; iii. receive reports from other Committees highlighting control risks identified during the course of their work which require further review action and outlining the action to be taken; iv. review the effectiveness and timeliness of actions to mitigate critical risks including receiving exception reports on overdue actions; and v. review the statements to be included in the Annual Report concerning risk management.
7.7	The Committee will, at least once a year, review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders, standing financial instructions and scheme of delegation.
7.8	The Committee will monitor the effectiveness of the processes and procedures used in undertaking due diligence.
7.9	In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit, the local counter fraud service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

7.10	The Committee shall review at each meeting a schedule of debtors' balances, with material debtors more than six months requiring explanations/action plans.
7.11	The Committee shall review at each meeting a report of tender waivers since the previous meeting.
	Internal audit
7.12	The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by: i. consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal; ii. review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework; iii. consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources; iv. ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; v. monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework; and vi. ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation.
	External audit
7.13	The Committee shall review the work and findings of the external auditor appointed by the Trust Board, and consider the implications and management's responses to their work. This will be achieved by: i. approval of the remuneration to be paid to the external auditor in respect of the audit services provided; ii. consideration of recommendations to the Trust Board relating to the appointment and performance of the external auditor iii. confirming the independence of the external auditor, including approval of any non-audit work and fees. iv. discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy v. discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee; and vi. review all external audit reports, including agreement of the annual

	audit letter before submission to the Board of Directors and any work carried out outside the annual audit plan, together with the appropriateness of management responses.
	Counter fraud
7.14	The Committee will review the adequacy of the Trust's arrangements by which staff may, in confidence raise concerns about possible improprieties in matters of financial reporting and control and related matters.
7.15	In particular the Committee will: i. review the adequacy of the policies and procedures for all work related to fraud and corruption as required by the NHS Counter Fraud Authority; ii. approve and monitor progress against the operational counter fraud plan; iii. receive regular reports and ensure appropriate action in significant matters of fraudulent conduct and financial irregularity; iv. monitor progress on the implementation of recommendations in support of counter fraud; and v. receive the annual report of the local counter fraud specialist.
	Raising concerns (whistleblowing) policy
7.16	The Committee will review, at least annually, the effectiveness of the Trust's raising concerns policy including any matters concerning patient care and safety.
7.17	The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.
	Other assurance functions
7.18	The Committee will also provide assurance to the Board of Directors in the following areas: i. it shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust; ii. These will include, but will not be limited to, any reviews by NHS Improvement, Department of Health & Social Care, Arm's Length Bodies or Regulators / Inspectors (e.g. Care Quality Commission, NHS Resolution.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.); iii. In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Quality Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed;

	iv. In reviewing the work of the Quality Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function at least annually; v. The Audit & Risk Committee should incorporate within its schedule a review of the underlying processes for the Data Security and Protection Toolkit and the production of annual Quality Accounts to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced; vi. The Audit & Risk Committee will oversee the work of the Health and Safety Committee and receive regular performance and assurance reports and vii. The Audit & Risk Committee will oversee the work of the Information Governance Committee and receive regular performance and assurance reports.
	Management
7.19	The Committee shall request and review reports and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.
7.20	They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.
	Financial reporting
7.21	The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. In particular, it will review: i. the Annual Report and Financial Statements, together with the external auditor's report to those charged with governance (ISA260), and recommend the accounts to the Trust Board of Directors, for formal approval and adoption, focusing particularly on the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee; ii. changes in, and compliance with, accounting policies and practices; iii. unadjusted mis-statements in the financial statements; iv. major judgemental areas; and v. significant adjustments resulting from the audit.
7.22	The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors.

	Appointment, reappointment, and removal of external auditors
7.23	The Committee shall appoint the Auditor Panel to make recommendations to the Board of Directors on its behalf, in relation to the setting of criteria for appointing, re-appointing, and removing External Auditors.
7.24	The Committee shall approve the terms of reference of the Auditor Panel, and review the function and membership of the Auditor Panel annually.
8.	**Reporting**
8.1	The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.
8.2	Members and those present should state any conflicts of interest and the Committee Secretary will minute them accordingly.
8.3	In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.
8.4	The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting thus enabling the Trust Board to oversee and monitor the work programme, functioning and effectiveness of the Committee. The Committee Chair shall draw the attention of the Board of Directors to any issues in the minutes that require disclosure or executive action.
8.5	The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement, specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements, and the appropriateness of the self-assessment against the Care Quality Commission's Judgement Framework.
8.6	The Committee will make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.
8.7	The Committee will produce an annual report to the Board of Directors reviewing its effectiveness and performance and to make any recommendations for change that it considers necessary to the Board of Directors for approval.
8.8	The Committee will receive and consider minutes from other Board Committees when requested. The Committee will also receive and consider other sources of information from the Chief Finance Officer.
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan. The

	Committee should consider holding a discussion at the end of its meetings with regards to its effectiveness, in relation to its terms of reference.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.
9.3	The Committee should consider holding a discussion at the end of some meetings with regards to the effectiveness of the committee, considering those areas highlighted within this paper.
9.4	The Committee Secretary will assess agenda items to ensure they comply with its responsibilities.
9.5	These terms of reference were approved by the Board of Directors in May 2019 and will be reviewed, at least annually.

Charitable Funds' Committee	
1.	**Authority**
1.1	Whittington Health NHS Trust, as an NHS body, holds the charitable funds in the capacity of a corporate trustee. The trustee is accountable to the Charity Commission for the proper use of the charitable funds and to the public as a beneficiary of those funds.
1.2	The Board of Directors hereby resolve to establish a Committee to be known as the Charitable Funds' Committee (the Committee) and delegate to it the powers and functions of the corporate trustee and to oversee funds for charitable purposes within the organisation. All Trust Non-Executive Directors are trustees of its charitable funds.
1.3	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires for any employee, and all employees are directed to co-operate with any request made by the Committee.
1.4	The Committee is also authorised by the Board to obtain outside legal or other professional Advice, if it considers this necessary, via the Trust Secretary.
2.	**Role**
2.1	The role of the Charitable Funds' Committee is to oversee and provide assurance to the Board of Directors on the governance of the charitable funds and discharge the delegated responsibilities from the Board.
2.2	The Committee is established to represent the interests of the Trust, as the Corporate Trustee of Whittington Hospital Charitable Funds. It will specifically: i. oversee the operation of the Charity investments owned by the Charity; ii. seek assurance that the Charity is operating in accordance with relevant legislation and with the regulations associated with its registration with the Charities Commission; and iii. raise funds for the Charity and ensure its successful contribution to the efforts of the Whittington Health Trust.
3.	**Membership**
3.1	The Charitable Funds' Committee will be appointed by the Board of Directors. The Committee shall be made up of: • three, independent Non-Executive Directors of the Trust, one of whom will Chair the Committee • Chief Finance Officer (lead executive director for the Committee) • Chief Executive Officer • Director of Nursing • One medical staff representative

	• One non-medical clinical staff representative
3.2	The Secretary of the Committee will keep a register of attendance for inclusion in the Trust's Annual Report.
4.	**Quorum and attendance**
4.1	A quorum of the committee will consist of a minimum of three members, as follows: • a Non-Executive Board Member or Trust Chairman, • the Chief Finance Officer or nominated deputy • the Chief Executive Officer or nominated deputy
4.2	All members are required to nominate a deputy to attend meetings if they cannot be present themselves. Committee membership will be reviewed by the Board as part of the annual review cycle.
4.3	The Director of Communications, Engagement & Fundraising and Head of Financial Services will also regularly attend the Committee.
4.4	The lead executive director for the Committee will arrange for a Secretary to support the Committee's administration.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. That said, there will be no less four meetings (quarterly) and the Chair will have the option to call other meetings, if required, to deal with a high volume of bids.
6.	**Duties**
6.1	The duties delegated to the Committee are as follows: i. To set the strategic framework for investments; ii. To monitor investment performance; iii. To govern, manage, regulate and plan the finances, accounts, investments, assets, business and all affairs of the charity; iv. To advise the Trustee (the Whittington Health NHS Trust Board) of their legal obligations under Charity Law; v. To seek advice from the Charity Commission and professional financial/investment advisors, where appropriate, on the investment of funds and formulate a reserves and investment policy; vi. To disseminate information and guidance to fund holders to ensure their compliance with Charity Law; vii. To monitor quarterly financial and fund activity; viii. Decide whether donations given with restrictions applied should be accepted by the Charity; ix. Approve the request to open a new fund; x. To consider recommendations for new major appeals to be taken to the Trust Board; xi. To review year end accounts of the Charitable Funds as at 31st

March and the annual report to the Charity Commission;

xii. To regularly review the expenditure of funds, the level of fund balances and ensure that the available cash is sufficient to meet the projects authorised for funding both in-pyear and multi-year;

xiii. Advise the Trust on investment strategies; ;

xiv. Review the spending plans and balances held within individual Charitable Funds;

xv. To ensure that systems are in place to provide appropriate and effective financial controls and procedures in order that the funds are operated correctly, that money is used for the appropriate purpose and the funds are not overspent;

xvi. To encourage the use of the funds for the benefit of patient and staff welfare, including professional development and training;

xvii. To review changes in legislation and approve plans for their implementation;

xviii. To consider and/or develop projects and campaigns which warrant funding, by promoting the benefits of the fund to CPFT staff members and identifying funding needs;

xix. To determine and disseminate best practice guidelines for fundraising;

xx. In conjunction with the investment managers/advice, agree an investment policy which lays down guidelines in respect of:

a. The balance required between income and capital growth
b. The balance of risk within the portfolio
c. Any categories of investment which the Trust does not wish to include in the portfolio on ethical grounds
d. Determine a policy for the distribution, or otherwise, of realised and unrealised gains on losses on investments

xxi. To raise or receive funds from community, corporate and individual donors; and

xxii. To act in accordance with the delegated powers for individual transactions as follows:

Value	Delegated powers
Up to £5,000	Fund Holder and Chief Finance Officer
£5,000 - £500,000	Charitable Funds Committee
Above £500,000	Trust Board

8. Reporting

8.1 It shall be the responsibility of the Chair to arrange for the following:

- The publication of an annual list with the dates, time and venue of each meeting.
- The agenda and relevant papers to be distributed to the Committee, at least one week prior to the meeting.

	• A record of any action points to be made and for this to be distributed to the Committee, no later than 14 days following the meeting. • Action points carried forward to a future meeting to be followed up. • Provide an exception commentary to the Board (as Trustee) as and when required. • Distribute minutes to the Chair of the Audit Committee for assurance purposes. • Liaison with Chairs of other Board Committees, raising matters of significance which need to be brought to the attention of those Committees, ensuring that the Chair and Chief Executive are aware at all times. • Timely production of minutes for the Board.
8.2	The Committee will receive the following reports: **Quarterly Reports** • Finance Report • Transactions under £5,000 approved after the previous meeting • Quarterly investment valuation and review • Details of the Charity's operational plan cash requirements • Fund balances • Details of all non-pay transactions itemising those over £25,000 in value • Details of funds highlighting those with balances in excess of £100,000 • Fundraising update • Fundraising events performance against targets **Annual Reports** • Annual Accounts and Letter of Representation signed on behalf of the Charity (for approval) • Report of the audit of the accounts and audit opinion from the external auditor • Charitable Funds Annual Report (for approval)
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.
9.3	These terms of reference were approved by the Board of Directors in May 2019 and will be reviewed, at least annually.

Estates' Strategy Delivery Committee	
1.	**Authority**
1.1	The Board of Directors hereby resolves to establish a Committee to be known as the Estates' Strategy Delivery Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference and any such powers that may be directed in future by the Board.
1.2	The Estates Strategy Delivery Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.
1.3	The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.
1.4	The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.
2.	**Role**
2.1	The role of the Committee is to provide assurance to the Board of Directors on the transformation of the Whittington Health estate that will: i. support the delivery of the Whittington Health Clinical Strategy and wider local health and social care integration objectives; ii. deliver creative, innovative estate solutions to support and enhance clinical services provision, building on UK and international best practice; iii. enable improvements in: the quality, efficiency and effectiveness of the estate; reduce estate backlog and maintenance costs, environmental impact and revenue costs associated with the operation of premises; and releasing resources for investment. iv. support Trust financial sustainability; v. engage and secure support from local strategic health and social care stakeholders, including staff, the community, the Health & Wellbeing Board and the NCL STP. to deliver a transformation that meets expectations and earns support and approval; and vi. seek assurance, mitigations and recovery action plans where appropriate.
2.2	The Committee will work with the Chief Executive and executive management to ensure the organisation has the structure, resources and capacity for estate strategy that will deliver the Trust's strategic objectives.
2.3	The Board may request that the Committee reviews specific aspects of estate strategy delivery matters where the Board requires additional

	scrutiny and assurance.
3. 3.1 3.2	**Membership** The Estates' Strategy Delivery Committee shall be appointed by the Trust Board and be comprised of: • Non-Executive Directors (three) • Chief Finance Officer (lead executive director for the committee) • Director of Environment • Director of Strategy, Development & Corporate Affairs • Director of Information Technology/Chief Information Officer • Director of Procurement • Deputy Chief Operating Officer • ICSU Representation (five) • Greater London Authority representation One Non-Executive member of the Board will be appointed as the Chair of the Committee and one as the vice-Chair by the Trust Board.
4. 4.1 4.2 4.3 4.4 4.5 4.6	**Quorum and attendance** A quorum shall be three members, at least two of whom should be Non-Executive Director of the Trust Board and the lead executive director for the committee. The Committee shall be deemed to be quorate if attended by any two non-executive directors of the Trust (to include the Chair or designated alternate) and two executive or associate directors. Also in attendance will be: • Staff Side representation • A Finance Lead • A Communications Lead • A Project Manager • External Advisers The Committee may invite other Trust staff to attend its meetings for specific agenda items as appropriate. The Chief Finance Officer will ensure the provision of a Secretary to the Committee and appropriate support to the Chair and committee members. This shall include agreement of the agenda with the Chair and the Chief Finance Officer, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee on pertinent areas. The Secretary of the Committee shall maintain a register of attendance which will be published in the Trust's Annual Report.

5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. Currently, the committee meets monthly.
5.2	Additional meetings may be arranged to discuss specific issues but any such meetings should be infrequent and exceptional.
6.	**Agenda and papers**
6.1	Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
6.2	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five working days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.
7.	**Duties**
7.1	The Committee will carry out the following duties for the Trust Board: i. Establish project management arrangements for the delivery of an estate masterplan and strategic outline case; ii. Agree project budget and secure approval by the Trust Board; iii. Recruit and procure project team resources with external resources procured where required; iv. Create and maintain project risk register with mitigations; v. Identify key service models for delivery of the Trust Clinical Strategy; vi. Identify and develop partnership and development opportunities where appropriate; vii. Agree the design brief; viii. Produce the Development Control Plan (including site optimisation, design strategy, phasing approach and schedules of accommodation) for approval by Trust Board; ix. Agree engineering and energy strategy; x. Revise and secure Trust Board approval for the estates strategy as required; xi. Develop strategic outline case for NHS Improvement; xii. Develop the communications and engagement plan for Trust Board approval; xiii. Identify any agreed consultation requirements and duties; and xiv. Review Trust performance against in-year delivery of the Trust's estates strategy including contractor performance, financial controls, timetable, while recognising that the primary ownership and accountability for the Trust's rests with the full Trust Board.
7.2	In addition, the Committee will:

	i. Request and receive training and development to assist the Committee in its responsibilities. This may include sessions where appropriate from external sources; ii. Address any specific requests by the Trust Board in relation to estate development matters or requirements; iii. Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, intellectual property rights etc. related to joint ventures, commercial partnerships or incorporation of start-up companies; and iv. Examine any matter referred to the Committee by the Trust Board.
8.	**Reporting**
8.1	The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.
8.2	Draft committee minutes will be forwarded to the next private meeting of Board of Directors for noting and the minutes of all meetings shall be formally recorded and approved at the subsequent meeting. The draft minutes will be submitted to the Trust Board following each meeting to enabling the Trust Board to oversee and monitor the work programme, functioning and effectiveness of the Committee.
8.3	Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.
8.4	In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.
8.5	The Committee will also work with the Trust Management Group and Finance & Business Development Committee, as necessary.
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.
9.3	These terms of reference were approved by the Board of Directors in May 2019 and will be reviewed, at least annually.

Finance & Business Development Committee	
1.	**Authority**
1.1	The Board of Directors hereby resolves to establish a Committee to be known as the Finance & Business Development Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.
1.2	The Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.
1.3	The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.
1.4	The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.
2.	**Role**
2.1	The role of the Committee is to provide assurance to the Board of Directors through review of the financial performance, business planning, business development and investment decisions of the Trust.
2.2	The Committee will focus on assurance around risks (financial, delivery and regulatory) in both plans and delivery of plans. The Committee will seek assurances, mitigations and recovery action plans where appropriate.
2.3	The Committee will work with the Chief Executive and executive management to ensure the organisation has the structure, resources and capacity for business development that will enhance core operations.
2.4	The Board may request that the Committee reviews specific aspects of finance and/or business development matters where the Board requires additional scrutiny and assurance.
3.	**Membership**
3.1	The Committee shall be appointed by the Trust Board and be composed of: • Three Non-Executive Directors appointed by the Board • Chief Executive Officer (ex-officio) • Chief Finance Officer (lead executive director for the Committee) • Chief Operating Officer • Director of Strategy, Business Development & Corporate Affairs
3.2	One Non-Executive Director member of the Board will be appointed as the Chair of the Committee by the Trust Board.

4.	**Quorum and attendance**
4.1	A quorum shall be three members, at least two of whom should be Non- Executive members of the Trust Board.
4.2	The Secretary of the Committee shall maintain a register of attendance.
4.3	The Committee may invite other Trust staff to attend its meetings for specific agenda items as appropriate.
4.4	The Chief Finance Officer will ensure the provision of a Secretary to the Committee and appropriate support to the Chair and committee members. This shall include agreement of the agenda with the Chair and the Chief Finance Officer, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee on pertinent areas.
4.5	The following members of staff will be in attendance for committee meetings: • Operational Director of Finance • Director of Contracting & Business Development • Trust Corporate Secretary
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.
5.2	There will be six meetings per year. Additional meetings may be arranged to discuss specific issues but any such meetings should be infrequent and exceptional.
6.	**Agenda and papers**
6.1	Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
6.2	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least one week before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.
7.	**Duties**
7.1	The Committee will carry out the following duties for the Trust Board: **Finance** i. Review the Trust's annual financial plans: revenue (operating expenditure), capital (capital expenditure), working capital, investments, borrowing and key performance targets; ensuring

these are consistent with operational plans and risk assessed. Financial Plans should also be assessed against regulatory requirements and demonstrate appropriate consultation with key stakeholders, as appropriate;

ii. Gain assurance that an appropriate performance management process is in place to allow the executive to identify the need for corrective action and identify emerging risks;

iii. Oversee and evaluate the development of the Trust's financial strategy to deliver its annual business plan, incorporating a review of the risks and opportunities;

iv. Review and maintain an overview of the Trust's contract and service delivery agreements (>£5m pa) and material supplier agreements (>£1m pa) and ensure an adequate assessment of delivery risk. The Committee may wish to conduct a review of any new and innovative contract structures below the figures above;

v. Review the Trust's Information Management & Technology strategy and progress against the Fast Follower Programme;

vi. Review major investment plans (business cases) as defined by:
- Capital schemes (including leased assets and property) with an investment value in excess of £1 million.
- All revenue investment proposals with a cost implication in excess of £3 million over three years
- All proposed asset disposals where the value of the asset exceeds £1 million.

vii. Review Trust performance against in-year delivery of the financial plan (income, expenditure, capital, cash, working capital and regulatory requirements), including delivery of the Trust's cost improvement programme supporting the financial plan; while recognising that the primary ownership and accountability for the Trust's financial performance rests with the full Trust Board;

viii. Request, review and monitor any corrective action against financial plans;

ix. Oversee the development of information systems to support the business interests of the Trust, including the review and development of performance and financial reporting;

x. To oversee the development and application of service line reporting and reference costs to support operational improvement and strategic decision making;

xi. Consider key financial policies, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately;

xii. Request and receive training and development to assist the Committee in its responsibilities. This will include sessions from the Trust finance team and where appropriate from external sources; and

xiii. Address any specific requests by the Trust Board in relation to finance matters.

Business Development

i. Oversee and evaluate the development of the Trust's Business

	Development strategy, incorporating a review of consistency with the 2019/24 Trust strategy, risks (business, delivery and reputational) and market conditions; ii. Approve the resource structure, operating policies and procedures for the preparation of business development bids; iii. Receive, review and recommend to the Board proposals for new business development and existing major contracts due for renewal: market development, acquisitions, potential investments and disinvestments in order to recommend options to the Board; iv. Review the case for, and make recommendation to the Trust Board for, the establishment of any subsidiary bodies, joint ventures, strategic partnerships or other commercial partnerships (within the Trust's delegated authority under the Health and Social Care Act 2012) having regard to the risk profile and adequacy of investment requirements; v. Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, intellectual property rights etc. related to joint ventures, commercial partnerships or incorporation of startup companies; vi. Monitor the outcomes of business development initiatives. Receive regular reports and updates from management regarding progress in the achievement of the business development elements of the Strategic Plan; and vii. Examine any matter referred to the Committee by the Trust Board.
8.	**Reporting**
8.1	The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.
8.2	Draft minutes will be submitted to the Trust Board following each meeting, thus enabling the Trust Board to oversee and monitor the work programme, functioning and effectiveness of the Committee.
8.3	Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.
8.4	In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such verbal reports that the Chair of the Committee might provide.

9.3	These terms of reference were approved by the Board of Directors in May 2019 and will be reviewed, at least annually.

	Quality Committee
1. 1.1	**Authority** The Board of Directors hereby resolves to establish a Committee known as the Quality Committee (the Committee). The Committee has no executive powers other than those delegated in these terms of reference.
1.2	The Committee is authorised by the Trust Board to act within its terms of reference and provide scrutiny in terms of quality and safety for all services provided by the Trust.. The committee is authorised to obtain such internal information as is necessary to exercise its functions and discharge its duties. It is authorised to conduct deeper reviews of services with supporting evidence from all parts of the integrated care organisation and to escalate findings as necessary to the Trust Board.
1.3	The Committee is also authorised by the Board to obtain outside legal or other professional advice, if it considers this necessary, via the Trust Secretary.
2. 2.1	**Role** The role of the Quality Committee is to provide assurance to the Board of Directors on: i. the quality of services and improvement through the following key areas: ▪ Patient safety and clinical risk ▪ Clinical audit and effectiveness ▪ Patient experience ▪ Health and safety and ▪ Quality improvement ii. the establishment and maintenance of effective risk management and quality governance systems within the organization so that the Trust Board can be assured that the Trust : ▪ has adequate systems and processes in place to ensure and continuously improve patient and staff safety, quality, clinical effectiveness, and risk management ▪ has effective structures in place to measure and continuously strive to improve the effectiveness of care ▪ is responding to patients' feedback about their experiences and taking action appropriately ▪ Is promoting a culture of openness and transparency across the Trust which values innovation and improvement. ▪ has mechanisms in place to share learning and good practice in order to share learning and to raise standards ▪ effectively implements and delivers its quality improvement and patient experience strategies
3. 3.1	**Membership** The Quality Committee will be appointed by the Board of Directors. The Committee shall be made up of the following: • Non-Executive Director (Chair) • Non-Executive Director (Deputy Chair) • Non-Executive Director • Medical Director

	• Chief Nurse and Director of Patient Experience (lead executive director for the Committee) • Chief Operating Officer
3.2	The Secretary of the Committee will keep a register of attendance.
4.	**Quorum and attendance**
4.1	The Committee shall be deemed to be quorate if attended by any two Non-Executive Directors (NEDs) of the Trust (to include the Chair or designated alternate) and two executives. All NEDs can act as substitutes on all Board Committees.
4.2	In the event that an executive director member of the committee is unable to attend a meeting, they are required to send a deputy director from their directorate in their stead.
4.3	The following members of staff will be in attendance (or send a representative) at committee meetings : • Deputy Chief Nurse • Head of Clinical Governance and Risk • Integrated Clinical Service Units (ICSUs) X 7 Directors of Operations (or ICSU Clinical Directors/ Head of Nursing, to be agreed by each ICSU) • Heads of adult and children's safeguarding • Head of Patient Experience • Quality and Compliance Manager • Trust Secretary • Lay members
4.4	The committee is empowered to request any other office employed by the Trust to attend meetings for the purpose of providing advice, clarification, recommendation or explanation in respect of any matter that falls within the responsibilities of the Committee.
4.5	The Secretary of the Committee will be the Personal Assistant to the Chief Nurse & Executive Director of Patient Experience and they will keep a register of attendance for inclusion in the Trust's Annual Report.
4.6	The Quality and Compliance Manager will ensure the effective and efficient management of the Committee under the leadership of the Committee Chair and Chief Nurse.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.
5.2	Committee meetings will be held every two months, with a minimum of six per year. Additional meetings may be arranged to discuss specific issues but any such meetings should be infrequent and exceptional.
6.	**Agenda and papers**
6.1	Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.

6.2	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, one full week before the meeting. Supporting papers will also be sent out at this time.
7. 7.1	**Duties** The Committee will carry out the following duties for the Trust Board: i. monitor, review and implement quality assurance and risk management strategies and action plans, including quality assessments for all cost improvement plans; ii. fulfil the following obligations for risk management: • review the Corporate Risk Register entries (defined as risks of >15, as per the Risk Management Strategy) • seek assurance that risks to staff and patients are minimised through the application of a comprehensive risk management system • contribute to the annual review of the Trust's Risk Management Strategy iii. receive and review reports from each ICSU twice per year, with a focus on areas within the ICSU quality report which are below target, as well as areas of excellence; iv. review, recommend to the Trust Board for approval and monitor implementation of the Trust's Clinical Quality Strategy; v. review and recommend to the Trust Board, the organisation's annual Quality Account publication; vi. monitoring organisational compliance against the Care Quality Commission's Essential Standards of Quality and Safety, and providing assurance to the Trust Board that effective systems are in place to monitor compliance (i.e. internal peer review programme); vii. seek assurance on the following areas: • patient safety issues through regular reporting, including the National Safety Thermometer, learning from serious incidents, infection control, and clinical incidents • that there are robust arrangements in place for the management of safeguarding adults and children and a system in place for managing patients who are Deprived of their Liberties (DoLs) at Whittington Health. • clinical audit and effectiveness through regular reporting, including national audits, NICE guidelines, and recommendations from relevant external reports • patient experience through regular reporting, including the friends and family test, complaints, Patient Advice & Liaison Services, and equality and diversity • that appropriate action is taken in response to adverse clinical incidents, complaints and litigation • the research programme and associated governance frameworks is implemented and appropriately monitored • health and safety through regular reporting, including fire safety, health and safety assessments, medical equipment and estates • delivery of the trust's quality improvement and patient experience strategies viii. maintain oversight of all relevant national and external reports; and ix. Review annual performance against the patient/carer domains of the NHS Equality Delivery System.
8. 8.1	**Reporting** Members and those present should state any conflicts of interest and the Secretary

	should minute them accordingly.
8.2	The draft minutes of Committee meetings shall be formally recorded and presented at the next meeting of the Trust Board.
8.3	The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.
8.4	The following groups will report regularly to the Quality Committee: • Patient Safety Committee • Patient Experience Committee • Safeguarding Adults and Safeguarding Children's Committees • Health and Safety Committee • ICSU Quality and Safety Boards • Research and development
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.
9.3	These terms of reference were approved by the Board of Directors in May 2019 and will be reviewed, at least annually.

	Remuneration Committee
1.	**Authority**
1.1	The Board of Directors (the "Board") established a standing Committee of the Board known as the Remuneration Committee (the "Committee"). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.
1.2	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
1.3	The Committee is authorised by the Board to obtain outside legal or other independent professional advice through the Trust Secretary and to secure the attendance of outsiders with relevant experience if it considers this necessary.
2.	**Role**
2.1	The role of the Committee is to: • Appoint and, if necessary, dismiss executive directors • Review the performance and annual appraisal of executive directors • Establish and monitor the level and structure of total reward packages for executive directors • Provide oversight of all exit agreements and packages ensuring transparency, fairness, consistency and compliance with regulatory guidance • Review annual succession planning arrangements for executive directors • Evaluate the balance of skills, experience and knowledge of the Trust Board when vacancies arise
3.	**Membership**
3.1	The membership of the Committee will comprise all Non-Executive Directors.
3.2	The Chair of the Trust Board will be Committee Chair. In the absence of the Chair, the Senior Independent Director or Deputy Chair shall chair the meeting.
3.3	The Chief Executive shall attend Committee meetings but will withdraw from the meeting during any discussions regarding their terms of conditions of service and remuneration package.
3.4	The Director of Workforce shall be invited to relevant agenda items. Other members of staff and external advisers may attend all or part of a meeting by invitation of the Committee Chair where required.
3.5	For any decisions relating to the appointment or removal of the Board-Level directors, Committee should include the Chief Executive as required under

	Schedule 7 of the NHS Act 2006. The Chief Executive shall not be present when the Committee is dealing with matters concerning their appointment or removal.
3.6	The Secretary to the Committee will be the Trust Secretary.
4.	**Quorum and attendance**
4.1	The Committee shall be deemed to be quorate if attended by three members.
4.2	The Secretary of the Committee will keep a register of attendance for inclusion in the Trust's Annual Report.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. The Committee shall meet at least twice a year.
6.	**Agenda and papers**
6.1	Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
6.2	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five working days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.
7.	**Duties**
7.1	The Committee will carry out the following duties for the Trust Board: i. In consultation with the Chief Executive (CEO), to regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Trust Board (Board-Level Directors and Non-Executive Directors) and make recommendations to the Board with regard to any changes; ii. Give full consideration to and making plans for succession planning for the Chief Executive and other directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the board in future; iii. To ensure that Board-Level Directors and Non-Executive Directors meet the requirements of the 'Fit and Proper' Persons Regulations; iv. Before an appointment is made, evaluate the balance of skills, knowledge and experience on the Board and, in the light of this evaluation, agree a description of the role and capabilities required for a particular appointment; v. To consider any matter relating to the continuation in office of any Director at any time, including the suspension or termination of service of an individual as an employee of the NHS Trust; vi. To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its

	responsibilities; vii. To keep under review a remuneration framework for Board-Level Directors; viii. In accordance with all relevant laws, regulations and Trust policies, determine the terms and conditions of office of the Board-Level Directors, including all aspects of salary and the provision of other benefits (for example allowances or payable expenses); ix. Determine the levels of remuneration and terms of employment for Board-level Directors to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff; x. Use national guidance and market benchmarking analysis in the annual determination of remuneration of the Board-level Directors; xi. Approve the arrangements for the termination of employment of any Board-level Director and other contractual terms, having regard to any national guidance; xii. Approve contractual severance payments over £50,000 to any eligible staff; xiii. Approve any non-contractual severance payments for all staff members; xiv. The chair and another non-executive director are authorised to approve the following outside the meeting: • any redundancy/ capitalised pension cost in excess of £50,000; • salaries for newly advertised director posts. xv. Where such actions are taken, these will be reported to the next meeting of the Committee; xvi. Ensure that any proposed settlement agreement is justified and that it is drafted in such a way as not to prevent proper public scrutiny by NHS Improvement, the Department of Health & Social Care or external auditors; and xvii. Oversee the performance review arrangements for the Board-Level Directors and Non-Executive Directors ensuring that each receives an annual appraisal.
8.	**Reporting**
8.1	Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.
8.2	The minutes of the Committee meetings shall be formally recorded and a summary of the proceedings submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure, or executive action.
8.3	The Committee will report annually to the Trust Board in respect of fulfilment of its functions as set out in these terms of reference and shall ensure that the necessary disclosures in relation to appointments and remuneration are accurately reported in the required format in the Trust's annual report.
8.4	The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.
9.3	These terms of reference were approved by the Board of Directors in May 2019 and will be reviewed, at least annually.

	Workforce Assurance Committee
1.	**Authority**
1.1	The Board of Directors hereby resolves to establish a Committee to be known as the Workforce Assurance Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.
1.2	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires for any employee, and all employees are directed to co-operate with any request made by the Committee.
1.3	The Committee is also authorised by the Board to obtain outside legal or other professional Advice, if it considers this necessary, via the Trust Secretary.
2.	**Role**
2.1	The role of the Committee is to provide assurance to the Trust Board that: • there is an effective structure, process and system of control for the governance of workfoce matters and the management of risks related to them; • human resources services are provided in line with national and local standards and policy guidance and in line with the Trust's corporate objectives; • the Trust's Workforce strategy is being sucessfully implemented ; and • the Trust complies with its obligations under equality, diversity and human rights legislation.
3.	**Membership**
3.1	The membership of the Committee shall comprise: • At least two Non-Executive Directors (one of whom shall Chair this Committee); • Director of Workforce (lead executive director for the committee); • Chief Nurse and Director of Patient Experience; • Medical Director • Chief Operating Officer; • Chief Finance Officer; • Director of Integrated Care education representative.
4.	**Quorum and attendance**
4.1	The Committee shall be deemed to be quorate if attended by any two Non-Executive Directors (NEDs) of the Trust (to include the Chair or designated alternate) and two executive directors. All NEDs can act as substitutes on all Board Committees.
4.2	In the event that an executive director member of the committee is unable to attend a meeting, they are required to send a deputy director from their directorate in their stead.
4.3	The following members of staff will be in attendance at committee meetings: • Integrated Clinical Service Units' Directors of Operation (will be invited) • Assistant Director of Learning & Organsiational Development • Deputy Director of Workforce • Trust Secretary

4.4	The Secretary of the Committee will be the Personal Assistant to the Director of Workforce and they will keep a register of attendance for inclusion in the Trust's Annual Report.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. The Committee shall meet at least four times a year. The Committee Chair is able to call special meetings, if required.
6.	**Agenda and papers**
6.1	Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
6.2	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least one full week before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.
7.	**Duties**
7.1	The Committee will carry out the following duties for the Trust Board: i. Keep under review the development and delivery of the Trust's Workforce Strategy to ensure performance management is aligned to strategy implementation. The Committee will ensure that the workforce is agile and adaptable so that the Trust can respond swiftly to changes in the external environment; ii. Receive details of workforce planning priorities that arise from annual business planning processes and to receive exception reports on any significant risks or issues; iii. Ensure that effective workforce enablers are put in place to drive high performance and quality improvement; iv. Review performance scorecard indicators for workforce–related matters; v. Monitor and evaluate Trust compliance with its startutory duty to produce an annual public sector equality duty report; vi. Review annual performance against the national workforce equality standards for race and disability; vii. Review annual performance against the workforce domains of the NHS Equality Delivery System viii. Monitor delivery of the workforce culture improvement plan; ix. Advise the Board on key strategic risks relating to workforce and employment practice and review their effective mitigation; x. Receive and review regular reports on human capital management including leadership capability, workforce planning, cost management, regulation of the workforce and their health and wellbeing; and xi. Receive and review reports on the staff survey and ensure that action plans support improvement in staff experience and services to patients.
7.2	Non-Executive Director Committee members are asked to: i. Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and

	provision; ii. Review data on workforce on a regular basis and hold Executive Directors to account for ensuring that the right staff are in place to provide high quality care to patients; iii. Ensure that decisions taken at a Board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key quality and outcome measures; and iv. Understand the principles which should be followed in workforce planning, and seek assurance that these are being followed in the organisation.
8.	**Reporting**
8.1	Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.
8.2	The draft minutes of Committee meetings shall be formally recorded and presented at the next meeting of the Trust Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure, or executive action.
8.3	The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.
9.3	These terms of reference were approved by the Board of Directors in May 2019 and will be reviewed, at least annually.

Meeting title	**Trust Board – public meeting**	**Date: 29 May 2019**
Report title	**Standing orders, standing financial instructions and scheme of reservation and delegation of powers**	**Agenda item: 17**
Executive director lead	Stephen Bloomer, Chief Finance Officer	
Report author	Swarnjit Singh, Trust Corporate Secretary	
Executive summary	**Background** The Audit & Risk Committee previously reviewed this document at its meetings in 28 March 2018 and 27 March 2019. As part of the well led action plan and the agreed Board forward plan, the Trust's standing orders, standing financial instructions and scheme of reservation and delegation of powers form part of a suite of updated corporate governance framework documents presented to the May Trust Board meeting for review and approval. Only minor changes are proposed to this document, as set out overleaf. There are **no** changes proposed to the standing financial instructions' section of this document.	
Purpose:	Approval	
Recommendation(s)	The Trust Board is asked to agree the Trust's updated standing orders, standing financial instructions and scheme of reservation and delegation of powers, for the minor changes highlighted.	
Risk Register or Board Assurance Framework	Quality 1 – Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation	
Report history	None	
Appendices	1: proposed amendments to standing orders, standing financial instructions and scheme of reservation and delegation of powers	

Standing orders, standing financial instructions and scheme of reservation and delegation of powers

There are two distinct changes proposed to the Trust's standing orders:

1. **First, only minor changes to the Trust's standing orders are proposed, as follows by amending current terminology so the following terms are replaced accordingly:**

Current term	Replacement term	Page/paragraph reference/comments
Audit Committee	Audit & Risk Committee	Throughout document
Department of Health	Department of Health & Social Care	Throughout document
Secretary of State for Health	Secretary of State for Health & Social Care	Throughout document
Conflicts of interest policy	Managing conflicts of interest in the NHS policy	page 31/section 7.4.1.1
Audit Commission	Financial Reporting Council	page 38 – The Audit Commission was abolished on 31 March 2015. The National Audit Office is included in this paragraph and should remain
Strategic Health Authority (SHA)	NHS Improvement/England London office	page 39
Local Security Management Specialist and directions on security management and Counter Fraud & Security Management Service (CFSMS)	NHS Counter Fraud Authority (CFA)	pages 44, 60, 61 - The NHS Counter Fraud Authority is the successor organisation to the CFSMS and has responsibility for security management
Security Management Director	Chief Finance Officer	page 61
NHS Litigation Authority	NHS Resolution	pages 54, 95, 96
Director of Information	Chief Operations Officer (COO)	Page 53/section 27.1.3 the Freedom of Information scheme is published by the Assistant Director, Information Governance and that post holder reports to the COO

2. **Secondly, there are two areas of proposed amendments to the standing orders as follows:**

a) Seven Nolan Principles of Public Life (page 31)
It is proposed that the following text is added to this section to provide clarity on the principles and behaviours expected:

Nolan Principle	Board members' requirement
Selflessness	Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
Integrity	Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
Objectivity	In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
Accountability	Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
Openness	Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
Honesty	Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
Leadership	Holders of public office should promote and support these principles by leadership and example.

b) Integrated Business Plan (page 44)
This is mentioned on page 44 and relates to the time of the NHS Trust Development Authority when all NHS trusts were exhorted to become Foundation Trusts. It is proposed that section 13.1.1 be deleted.

Minutes
Quality Committee, Whittington Health

Date & time:	Wednesday 8th May 2019
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Naomi Fulop (NF), Non-Executive Director
Members Present:	Deborah Harris-Ugbomah (DH) Non-Executive Director Carol Gillen (CG) Chief Operating Officer Michelle Johnson (MJ) Chief Nurse & Director of Patient Experience Tony Rice (TR) Non-Executive Director
In attendance	James Connell (JC) Patient Experience Manager Colette Datt (CD) Nurse Consultant CYP Services Casey Galloway (CGa) Patient Experience Officer Fiona Isacsson (FI) Director of Operations – Surgery & Cancer Alison Kett (AK) Associate Director of Nursing Adult Community Health Services Rachel Landau (RL) Clinical Director EIM Kat Nolan-Cullen (KNC) Compliance & QI Manager Sharon Pilditch (SP) Matron for Surgery Stuart Richardson (SR) Chief Pharmacist Leanne Rivers (LRi) Patient Representative Louise Roper (LRop) Quality & Risk Manager for Surgery & Cancer Lynda Rowlinson (LRo) Interim Head of Governance and Risk Paula Ryeland (PR) – QI Lead Aisling Thompson (AT) Director of Operations ACS Swarnjit Singh (SS) Corporate Secretary Duncan Wagstaff – Researcher (observer) Carolyn Stewart (CS) Minute taker

Agenda items

1.1	Welcome & Apologies	Chair
	Naomi Fulop (NF) welcomed everyone to her first meeting as Chair of the Quality Committee and advised attendees on the re-structuring of NED membership of Trust Committees. Michelle Johnson (MJ) formally thanked Anu Singh for previously chairing and supporting the Quality Committee so well and also thanked Yua Haw Yoe for supporting the Committee. NF welcomed Tony Rice as a new member to the Committee and thanked Deborah Harris Ugbomah for remaining on the Committee. Apologies were received and recorded from: Julie Andrews (JA) Interim Medical Director Helen Taylor (HT) Clinical Director ACW Sita Chitambo (SC) Associate Director of Nursing EIM	

1.2	Declarations of Conflicts of Interests	Chair
	No conflicts of interest were noted.	

1.3	Minutes of the previous meeting	Chair
	No amendments were requested to be made to the minutes of the previous meeting held on 13th March 2019. The minutes were approved.	

Action Log – open items	Deadline	Owner
• Nursing & Midwifery Strategy Annual Report – left open	July 2019	MJ
• Management & Development of Policies – SS had reviewed draft policy and returned it to LR who assured the Committee that it will be completed by the end of May. MJ stressed the urgency for this to be completed imminently. – action left open	May 2019	LR
• Quality Improvement presentation for Trust Board Seminar – PR to liaise with SS – suggested June or July Seminar – action left open	May 2019	SS/PR
• Volunteers required for FFT on Coyle and Day Treatment Centre (DTC) – James Connell to pick this up – action left open	May 2019	JC
• Surgery and Cancer to revise timeline for QI programme within the ICSU – FI to follow up – action left open.	June 2019	FI

1.4	Matters Arising	Chair

1.4.1	DH referred to the Nursing and Midwifery Strategy annual report and queried if this was being completed and where it should impact on the annual report. As the focus was on the clinical strategy by the Nursing and Midwifery Executive Committee (NMEC) in 2018-19, MJ reported that there was no review of the nursing and midwifery strategy undertaken. MJ agreed to bring a proposal to the next meeting on the development of nursing and AHP priorities in line with the new Corporate objectives.

2.1	**Quality Account 2018/2019**
2.1.1 2.1.2	The report was taken as read. KNC advised that this is the draft Quality Account for 2018/2019. The majority of data is correct and complete although KNC asked for any omissions or accuracy changes to be sent to her by close of play the following day as the report will be going to the Audit & Risk committee. The Quality priorities for 2019/20 have been shared with the Trust Management Group and Health Watch and the CCG. L Rivers queried the result of the staff survey whereby approximately one third of staff feel bullied. MJ replied that approximately 50% of staff had completed the survey and that the Whittington Health (WH) score is average across the NHS. MJ added that a WH culture survey was carried out last July at the CEO's request in order to address this. As a result, MJ believes that staff now feel more confident to speak up. NF requested that an opening paragraph be included in the report to explain that the cultural survey was an external report that had been shared with staff. FI added that this had been discussed at the Surgery & Cancer Performance reviews and that they had addressed a lot of the problems. They had established that by increasing visible leadership, talking to leaders and ensuring that people in senior leadership positions exhibit correct behaviour, that this had a positive effect on staff. DH commented that the Audit & Risk Committee relies on the Quality Committee to do its duty and provide assurance on the report before it goes to the Audit and Risk committee and requested that it be approved, and requested discussion on the highlights of the year to provide reassurance: MJ summarised the report: 1. Chief Exec Summary will be finalised following the Audit & Risk Committee 2. Priorities for 2019/2020 (NHSI template) cover patient experience, patient safety and clinical effectiveness. • There has been shared engagement with clinical staff and managers as well as with Health Watch and the CCGs. • Patient experience: some are priorities that remain from last year. The Trust was recorded as one of the worst for patient food. The Trust will be reviewing quality of food over the next 3-6 months **(this was incorrectly reported and will not be a quality account priority for 19-20 as it will be considered through the**
2.1.3	

	nutritional steering group over this period of change. • Patient Safety quality priorities - Pressure Ulcers prevention and early identification continue to be a focus and there will be an enhanced review. AK advised that KPIs had been agreed with the CCG for a 10% reduction in grade 3 and 4 pressure ulcers. It was noted that the pressure ulcer wording should be the same for the KPI and the Quality Account. There had also been feedback from TMG that Mental Health and Learning Disabilities should not be linked together so this has been separated. MJ added that there had been good engagement across the Trust for the Learning Disability steering group led by AK. • Leanne Rivers queried the target setting at 75% for autism patients being seen within 2 hours in ED rather than 100% within 3 hours. It was stressed that this was the right period of time for people to wait rather than extending to 3 hours. • Discussion had taken place at the Trust Board Seminar regarding delivering the national clinical audit plan and it was agreed that this would now be included in our priorities. MJ reported that the Trust had achieved 100% in the national clinical audits which is a credit to the quality governance team. There has also been an increase in enrolment in clinical trials and primary research. An addition will be made to the priorities to recognise the development of nursing and AHP led research. 3. Awaiting CQUINS Q4 data from the CCGs. 4. Learning from Deaths – Q3 and 4 data not yet analysed. This information gets shared at Quality Committee and Trust Board 5. Staff feedback data – Friends and Family Test (FFT) – staff survey was discussed 6. Patient FFT – it was suggested that it would be useful to compare data for areas going back to 2017/2018. 7. VTE – awaiting data from KPMG (auditors). 8. Reporting on hospital acquired infections C-Diff – this was recognised as an area to celebrate as the Trust reported below the Trust target
2.1.4	9. Seven day services – This is reported quarterly to Trust Board 10. Part 3 – review of Quality Performance looking at 2017/18. Summary of what was achieved last year with some outstanding additions to be included. All quality Account priorities are reported to the Quality Committee.
2.1.5	Other information – performance indicators and further information from external stakeholders. The CCG will receive the report after it has been presented to the Audit & Risk Committee. CG requested an amendment on P53 with regard to the reduced cancellation by

2.1.6	3%. She advised that when appointments are brought forward or amended, it is recorded as a cancellation. CG asked for this to be portrayed in the report.
2.1.7	MJ apologised for the report being circulated at the last minute and thanked Kat for producing the report. DH stated that the Quality Account should reflect what has been discussed at Quality Committee in order to provide assurance to the Audit & Risk Committee. It was agreed that the Quality Committee has recommended the content of the Quality Account (with some late additions accepted) for approval to the Audit & Risk Committee.

Actions	**Deadline**	**Owner**
2.1.1 omissions or accuracy changes to be sent to KNC by close of play the following day	Completed	
2.1.2 NF requested that an opening paragraph be included in the report to explain that the cultural survey was an external report that had been shared with staff.	Completed	
2.1.3 It was noted that the pressure ulcer wording should be the same for the KPI and the Quality Account.	Completed	
2.1.3 An addition will be made to the priorities to recognise the development of nursing and AHP led research.	Completed	
2.1.3 Patient FFT – it was suggested that it would be useful to compare data for areas going back to 2017/2018.	Completed	
2.1.6 CG requested an amendment on P53 with regard to the reduced cancellation by 3%	Completed	

2.2	**Quality Account Priorities 2019-20: draft review**
2.2.1	The draft review of the Quality Account priorities for 2019-20 were reviewed and agreed for recommendation for approval at Audit and Risk committee and at Trust Board.

Actions	**Deadline**	**Owner**
None		

2.3	**Risk Management Strategy – 2018 - 2021**
2.3.1	LRo advised the Committee that this is the first review of the Risk Management Strategy. It includes areas of good practice and areas for improvement as a result of a recent internal audit. MJ referred to p7 relating to the Board Assurance Framework (BAF) to note the work that has gone to align the BAF to risk management.

2.3.1	DH asked if this would be going to the Audit & Risk Committee and LR confirmed this. It was agreed that the paper would go to TMG. Quality Committee agreed that this document reflects the way risks should be managed for 2019-20.

Actions	**Deadline**	**Owner**
Present to TMG	14th May 2019	MJ

3.1	**Adult Community Services (ACS)**
3.1.1	Report Highlights: • Report 4 Quarter 3/4 there were 2 reported Serious Incidents (SIs) in March 2019 in relation to attributable pressure ulcers. From 1st July 2018 to the end of February 2019 there had been no SIs in the ICSU. Both SI reports are under investigation and there has been considerable learning from this, including working with tissue viability staff. • Duty of Candour cases – the report stated 15 – 20 outstanding. This is in relation to pressure ulcers that may be attributed/not attributed to the Trust. • Risk register – 9 risks. Bladder & Bowel, Tissue Viability and Central Booking and lots of improvement work. • Risk identified at Quarter One 2019/2020 Performance review with regard to money moving into primary care which could risk business moving away from WH. Currently negotiating with Haringey & Islington CCGs, with the higher risk being evident in Haringey. MJ stressed that this is an opportunity of working with GP Federations as well as a risk. • Risk in IAPT service and increasing number of people with moderate mental health problems, adjusting waiting times for appointments. CG stressed that there is a fine margin in achieving IAPT targets and the team is meeting to look at demand and the capacity risk. • Complaints – reached 100% response rate each month. • NF – asked how the ICSU would address district nursing visiting continuity. AK replied that increasing the permanent key staff and cutting vacancies had helped considerably. There is also a one day a week focus on pressure ulcers. Good leadership and good values are also key. CG asked for continuity within the ICSU to be monitored. AK added that via e-community, the new allocation of district nursing visits system will be more focused and show continuity. The system covers over 300,000 visits per year. • Quality improvement – registering QI projects and a considerable amount of improvement work being carried out. Services are learning from each other to bring services together to improve services. • Appraisal rates – good work and increased by 15% in 4 months. Mandatory training more static at 85%. • Patient feedback requires more focus. District Nursing gets a quarter of the total FFT for the ICSU. DH referred to the patient stories and that patient engagement highlighted only bad stories and should include positive stories. NF thanked AK for presenting the report.

Actions	Deadline	Owner
Monitor District Nursing continuity within the ICUS	End of Q1	AK

2.5	Acute Patient Access, Clinical Support Service & Women's Health (ACW)
	Key aspects were in the summary: • Serious Incidents (SI) report around confidentiality finalised and actions in progress • American Airlines have supported successful promotional workshops within Women's Health • New risk & quality manager appointed to the ICSU • FFT results and patient experience in all areas of the ICSU have improved considerably over the last 6 months. Significant numbers (over 90% in maternity). • Outpatients pharmacy waiting times have improved • Mandatory training and appraisals analysis carried out to determine ways of improving compliance. Appraisal rate currently at 76% and below target. Mandatory training – similar result. • Complaints 100% compliant • Significant risks on register mainly involving estates, but maternity building works and estates building strategy underway. Organisational risks in medicine in regard to fridges. Working with estates to rectify this. NF thanked SR for presenting the report.

Actions	Deadline	Owner
None		

3.1	Aggregated Learning Quarterly Report
3.1.1	LR highlighted achievements in terms of incident reporting. Target of 30% increase for in reporting of patient safety incidents and the lowest amount of SIs for the quarter (Q4 2018/2019).
3.1.2	Review of complaints; Working to link claims/complaints together was well as incidents and engagement with patients. Learning from claims was mentioned and DH and MJ suggested a specific legal report regarding legal services and claims to tie in with the Maternity Standards CNST be submitted for the next Quality Committee**.**
3.1.3	The report currently includes complaints performance in relation to complaints response times of 25 days but will now include up to 40 days for complex cases so the performance numbers may alter the result. NF requested more triangulation of learning across the areas. LRo said this would be the next step. SS suggested that learning from the ombudsmen cases could be a topic for a Trust Board seminar.

Actions	Deadline	Owner
1. Legal Services & Claims report to be submitted to next Quality Committee	July 2019	LRo
2. Board Seminar – learning from Ombudsman	July 2019	SS

3.2	Patient Safety Quarterly Report
3.2.1	NF highlighted the positive aspect of the report. Infection control had met all targets for 2018/2019 and on also on target for the 50% reduction in e-coli septicaemia. Reporting for C-diff has now changed from 48 hours from the first symptom to test for C-diff to within 24 hours which will be more challenging. The 2017/2018 target was 16 and the Trust had declared 13 cases, coming in under target. The target for 2019/2020 is 19. There has been one case of MRSA (July 2018) which was investigated and some learning identified.

Actions	Deadline	Owner
None		

4.3	Patient Experience Report
4.3.1	JC updated the committee on the progress over the last few months with regard to gathering patient feedback (Friends and Family Test) in ED. JC is meeting with ED to discuss how to increase response rates.
4.3.2	CGa updated on volunteering and focused on 4 points: • Increased volunteer numbers, aiming for an additional 124 by the end of May. Good volunteer cover on Wards, mainly Meyrick and Cloudesley. • Improved recruitment process in signing up volunteers partly due to HR assistance. • More communication and publicity in volunteering and promoting via social media. There will be a Volunteer week of events in June, which will be publicised shortly. • Planning to update the volunteer uniforms and will use fundraise events to purchase polo shirts rather than tabards.
4.3.2	Due to timing restraints, NF asked for the slides to be circulated to the Committee members and attendees after the meeting. NF thanked JC and CGa for attending and presenting to the Committee.

Actions	Deadline	Owner
Volunteer slides to be circulated to attendees after the meeting	May 2019	JC

4	Quality Impact Assessment of Cost Improvement Plans (CIPS)
4.4.1	The Committee was advised that the current position is that there are a number of CIPS that have not been Quality Impact Assessed. CG advised that these will be progressed immediately.
4.4.2	NF requested feedback on CIPS at the next Quality Committee to seek assurance from CG that these are on track and show progress where schemes have been identified to be QIA assessed. FI raised a concern regarding bed optimisation and was assured that a QIA level 2 has been completed and mitigation has been put in.

Actions	Deadline	Owner
QIA CIPS feedback to return to Quality Committee	July 2019	CG

4.5	Quality and Safety Risk Register (risks >15)
4.5.1	• 2 risks have been closed; 1 risk has been reduced. • There has been no increase to existing risks and there have been 2 new risks. • Risk ID 970: Central booking – this has been reduced after discussion at the Trust Board.
4.5.2	The committee requested that all ICSUs ensure there is representation at the Trust Fire Safety Committee meeting and to feedback to the Committee who will be representing their ICSU and the date they attended, via LRo.

Actions	Deadline	Owner
Fire Safety ICSU attendance reassurance to QC	July 2019	LRo

4.6	Quality Assurance Report (including CQC action plan, peer review programme etc)
4.6.1	The report was taken as read. CQC Action Plan. All actions are completed or in progress and are monitored by the ICSUs.
4.6.2	Fortnightly CQC preparation meetings have been taking place. All core services to have undertaken self- assessments. Communications promoting our "Better Never Stops" campaign which is providing help for services.
4.6.3	There had been an Unannounced CQC Mental Health Act (MHA) 1983 monitoring visit of Simmons House in March 2019 where some actions had been identified around the application of the MHA

Actions	Deadline	Owner
None		

4.7	Serious Incident Report (April Board report)
4.7.1	LR presented the SI report that had been presented to the Trust board in March. 1 serious incident had been declared in March.

Actions	Deadline	Owner
None		

4.8	Trust Policies Review
4.8.1	LRo advised the Committee that a lot of policies had expired in November and December 2018. The Policy Approval Group is now meeting every 2 weeks instead of monthly to clear the backlog of out of date policies. NF asked for clarity regarding the status of the policies to be identified as to whether they have expired or are under review and it was agreed that the Quality governance team would clarify and escalate to MJ as necessary. MJ requested that it is on the agenda for the next CQC preparation meeting and that the Trust Policy Review comes back to report to the July Quality Committee as a formal paper.

Actions	Deadline	Owner
Trust Policy Review to be discussed at the CQC Prep group and feedback to Quality Committee in July as a formal paper	July 2019	LRo

4.9	Quality Improvement Update
4.9.1	PR provided a brief update to the committee and advised that she had been working with individuals and teams providing the QI Training which is very popular, with 120 projects currently up and running. One highlight described was the Frailty Pathway, which, over its first year of implementation has seen 375 patients resulting in 200 admissions being avoided and creating a financial saving of approximately £700,000. The Trust is holding a QI Celebration afternoon event on 14th June. NF thanked PR for attending and updating the Committee.

Actions	Deadline	Owner
None		

4.10	Quality Committee Annual Work Plan 2019/20
4.10.1	LRo presented the Quality Committee annual work plan. It was noted that the July and September Quality Committee agendas are full due to the annual updates from the previous year. It was agreed that these meetings should be extended by 30 minutes.
4.10.2	SS queried whether the QC risks on the BAF should be added as a standing item and the Nursing & Midwifery Strategy item be removed. He also queried whether there should be an Annual Health & Safety report included in the work plan. LRo would check these queries.

Actions	Deadline	Owner
Invitations to the July and September Quality Committee meetings to be extended by 30 minutes	May 2019	CS

4.11	Quality Committee Self- Assessment & Review of Terms of Reference
4.11.1	LRo had circulated Self- Assessment forms at the beginning of the meeting for completion.

	Regarding Membership of the Committee, MJ advised that this had been amended slightly to reflect that some attendees are only required to present their papers and do not need to attend the whole meeting. DH queried whether the internal auditors should be invited to the meetings and added to the annual business cycle The Terms of Reference were approved by the Committee with one change around internal auditors to be added as people who will be invited to meetings as required.

Actions	**Deadline**	**Owner**
Findings from self-assessment forms to be presented at next meeting	July 2019	LRo

5.	Minutes of Reporting Groups – for information only
5.1	The minutes from reporting groups were taken as read.

The meeting closed at 4.15pm
The next Quality Committee is scheduled for **Wednesday 10th July 2019** (2pm-4.30pm)
Future dates:

- 11th September 2019 (2pm – 4.30pm)
- 13th November 2019 (2pm – 4pm)

Workforce Assurance Committee – Draft minutes of the meeting held on Wednesday, 24 April 2019

Present:

Stephen Bloomer	Chief Finance Officer
Norma French	Director of Workforce
Carol Gillen	Chief Operating Officer
Michelle Johnson	Chief Nurse & Director of Patient Experience
Helen Kent	Assistant Director of Learning & OD
Anu Singh	Non-Executive Director (in the Chair)
Kate Wilson	Acting Deputy Director of Workforce
Yua Haw Yoe	Non-Executive Director

In attendance:

Lawrence Anderson	Medical HR Business Partner & Acting Head of Resources
Kate Green	PA to Director of Workforce (Minutes)
Swarnjit Singh	Trust Corporate Secretary

Apologies:

Becs Sullivan	Guardian of Safe Working

19/13 Welcome and Introductions

13.01 Anu Singh welcomed everyone to this, her inaugural meeting as Chair of the Workforce Assurance Committee, and in particular Yua Haw who was also new to the committee.

19/14 Minutes of the last meeting

14.01 The minutes of the meeting held on 18th January 2019 were approved.

14.02 It was add to include a rolling action plan, which would include dates where actions were agreed.

19/15 Matters arising

15.01 Referring to minute 04.04, Kate Wilson said that she had checked that the wording around whether staff were atheists or had no religion was indeed standard national wording.

19/16 Quarters 3 & 4 Workforce Report

16.01 Introducing this item, Kate Wilson highlighted some of the key points contained in the report as follows:

- Sickness was at 3.7% during the period covered so remained steady when compared to Quarter 2; there had been a slight increase within Emergency & Integrated Medicine, largely attributable to two members of staff who had been on long term sick leave.

- There had been a reduction in turnover from 13% to 11%, a good downward trend, and Kate mentioned the ongoing work on retention. Turnover within Procurement was higher than in Quarter 2; this was attributable to a recent restructuring exercise. There was also a restructuring exercise taking place within Payroll. A 1% reduction in nursing was explained by a reduction in an overall reduction in the establishment, with the opposite being the case for Health Care Assistants.

- Bank and Agency usage had decreased slightly during Quarters 2 and 3 but risen again in Quarter 4. It was noted that the Bank (Temporary Staffing) Office was to transfer to Bank Partners in mid-May, with the aim being to further reduce the use of agency staff, but also to improve efficiency and increase the hours the office would be open.

- Mandatory Training and Appraisal numbers continued to fluctuate.

16.02 The report now included data on recruitment, and Kate said that a great deal of work had gone into analysing performance over recent months. End to end recruitment was now taking an average of 8.9 weeks against a KPI of 8 weeks. Carol asked whether future reports might include exceptions and details of where the longest times taken to recruit were. Kate replied that she did have this data broken down by ICSU, where the most recent report showed that times were longer within the Children & Young People's ICSU. It was noted that the longest delays occurred between time of resignation and submitting Vacancy Scrutiny Panel forms, but also in shortlisting. HR Business Partners were working with their respective ICSUs to break this down still further. Kate added that for shortlisting, it unsurprisingly took far longer for those in clinical roles than those in administrative roles, and Michelle added that sometimes hundreds of applications were received with each taking on average ten minutes to review – shortlisting for one post might therefore take most of a working day. She suggested that consideration should therefore be given to 'capping' the number of applicants.

16.03 The team was also working to identify other blockers to speedy recruitment which might include but were not necessarily limited to receipt of references and Occupational Health clearance. Carol added that although she was personally in favour on on-line processes she was aware some found completing the on-line VSP forms difficult.

16.04 Anu enquired whether there was a work plan in place to address these issues, and Kate replied that there was. It was agreed she would produce a single page summary of this for the next meeting. Anu also enquired whether it might be helpful to have ICSU representation at the WAC. Norma replied that this had happened in the past, normally when the committee had wished to carry out a deep dive into a particular area, and it was agreed that the issue of representation should be discussed when the revised terms of reference were considered.

16.05 Stephen Bloomer asked about the interaction between the WAC and the Finance & Business Development (F&BD) Committee for areas such as bank and agency spend; he would expect F&BD to monitor the ongoing financial implications, but should the associated actions come to WAC? Norma replied that she held regular run rate reduction and agency ceiling meetings with each of the ICSUs, and it was at those where actions were planned and monitored. Michelle added that WAC was by its nature an assurance committee;

actions should be monitored through Trust Management Group as the executive decision-making body. Anu suggested WAC could gain further assurance through deep dives.

16.06 Expanding on mandatory training, Helen Kent informed the committee that a small group of workforce colleagues had volunteered to help answer outstanding queries. The team was currently being restructured, and one comment received had been that it would be helpful to have accommodation on the hospital site (the team currently works from Crouch End) in order to be able to offer the support they needed to complete their training. She acknowledged that ESR was not the easiest system to navigate, but took the view that it was preferable to help and support people to manage ESR rather than looking at alternatives. Using the workbooks was resource intensive; Helen pointed out that if 100 staff completed all nine modules and submitted forms for entry on the system this required 900 separate ESR transactions. The team was currently very short-staffed, and there was a backlog of queries to work through. There was no additional resource available, but time off in lieu had been offered to the volunteers who were working on it.

16.07 Carol assured the committee that all ICSUs had action plans, but wondered whether there were additional measures which could be put into place to help; could the Trust for example add a line to recruitment letters asking successful NHS candidates to bring with them proof they had recently completed their mandatory training? Norma agreed this would address new starters, but not those employed by the Trust who had become non-compliant. Helen pointed out that for new starters, induction made them compliant, although it was noted that some new starters were unable to attend induction for several weeks due to sessions being fully booked. Work on passports between Trusts also continued.

16.08 Helen also pointed out there was a need to support managers scrutinising reports, but staff were given three months' notice of the need to update their modules, and needed to take responsibility for completion themselves. It was agreed she would take a short paper to TMG setting out the current position and what actions might be taken to support the ICSUs and Directorates to increase compliance.

16.09 Moving on to appraisals, Helen informed the committee that the team had reduced and simplified the guidance making it far easier to follow and there was now a single page form for completion. She added that the staff survey results had highlighted the need to improve the quality of appraisals, and in addition to ensuring staff were able to see when their appraisals were due there was also a link with the development of assessment centres and talent management. In answer to a question from Yua Haw about whether staff were given opportunities to come back to their managers about specific points raised during appraisals, Helen said that issues should be addressed during one to one sessions which should take place frequently throughout the year. Anu thanked Helen for answering the questions raised and for taking this forward.

19/17 <u>Guardian of Safe Working Report</u>

17.01 Lawrence Anderson informed the committee that a new Guardian of Safe Working had been appointed; Care of Older People Consultant Becs Sullivan had taken on this role from 1st March 2019. Becs would in future be writing and presenting this report to the committee.

17.02 The Trust had received 384 exception reports in Quarter 4, an increase from 218 in Quarter 3, equating to 543 additional hours worked and causing a cost pressure of £5935. Although the default position was to award time off in lieu, rotation meant that this was often impossible, hence the resulting fines. It was noted however that not all fines were payable since strict guidelines were built into the junior doctors' contract. The majority of exception

reports had been submitted by F1 grades within medicine, and Lawrence explained that because two junior doctors that had been on long term sick leave would shortly be transferring specialties, it was likely that the next report would see a rise in exception reporting within surgery. Fines were payable when there had been either a breach of contract or statute, e.g. when doctors had worked in excess of the hours set out in the European Working Time Directive (EWTD). A third of the fine was payable to the doctor, and the remaining two thirds remained in a 'pot', to be used, following consultation with those affected, for improving conditions. It was noted that this was set out as part of national terms and conditions rather than through any local determination of process, with patient safety as the main ethos.

17.03 Stephen Bloomer asked whether the number of exception reports received by Whittington Health was unusual. Lawrence replied that there was no formal benchmarking process, but Guardians met quarterly and he could ask Becs to make enquiries. He did feel however that the Trust had a high number, which on one hand could be seen as positive since it meant that junior doctors felt able to report, whereas there had been coverage in the national media of areas where they felt constricted from doing so. Stephen asked what might be done to press the ICSUs to address issues contributing to junior doctors working increased hours, and Lawrence said that Becs was already working on this in Medicine, Carol added that one aspect was to spot any trends, e.g. the commonly raised issue of phlebotomy. Becs was planning to review data monthly rather than quarterly which would be helpful in identifying any such issues.

17.04 Lawrence also briefed the committee on the work being undertaken to implement the BMA's Fatigue and Facilities Charter, which he, Deslyn Bruce and Kate Green were all supporting. This was an initiative primarily designed to improve conditions for junior doctors working at night, although Whittington Health had widened the remit to include all staff working at night. Initial focus had been on improving conditions in the junior doctors' mess, overnight accommodation, and access to hot meals. Becs was also planning to become more involved in the junior doctors' forum (with support from Deslyn), and it was hoped that the new rotation of junior doctors starting in August might assist in refreshing this group.

17.05 Carol Gillen asked that the Guardian of Safe Working monthly reports be shared with the ICSUs, and was particularly keen to learn what impact the introduction of the central phlebotomy service might have had.

19/18 <u>Employee Relations Activity</u>

18.01 Kate Wilson informed the meeting that the team was continuing to hold regular case review sessions, which had served as a key driver for maintaining the 90 day performance target. They were also developing a performance dashboard for the ICSUs.

1802 There were currently eight suspensions across the Trust, all quite different in nature and in different areas. An enhanced risk assessment for suspensions had been introduced, and Kate stressed that all suspensions remained under constant scrutiny and were regularly reviewed in the light of new evidence which came to light. In answer to a question from Anu about the recording of cultural issues, Norma explained that this report related purely to formal activity.

19/19 <u>Cultural Agenda</u>

19.01 Introducing this item, Norma summarised the high amount of activity being undertaken in this area, including the ongoing work in response to Professor Lewis's report, the Trust's

response to the staff survey, and the statutory WRES (Workforce Race Equality Standard) and WDES (Workforce Disability Equality Standard) work.

NHS Staff Survey

19.02 Helen Kent began by briefing the committee on the results of the 2018 national staff survey. There had been a good response to the survey – at 48.5% the highest recorded by the Trust – but the results had been poor. This was not entirely unexpected, and it was noted that Professor Lewis had warned the Trust that such results were to be expected as staff became more vocal about the issues raised. There were however some good results from individual areas, including workforce and individual teams. An ICSU template had been prepared, which included space for celebrations, as well as implementation of 'quick wins' and strategic focus.

19.03 The ICSU quarterly performance review meetings had been held over the last few weeks, and they had all presented their individual staff survey action plan. The March Trust Board had agreed the corporate action plan, which had agreed that the main focus for the coming year should be on the eradication of bullying and harassment, and staff engagement.

Gender Pay Gap

19.04 A paper on the gender pay gap had been taken to the March Board meeting; what had been missing from that paper had been details of the actions which could be taken by the Trust to reduce that gap. Helen took the committee through the actions set out in Norma's paper to the WAC, which included the development of a strategy to ensure inclusivity and diversity across all protected characteristics.

WRES Improvement Plan Progress Report

19.05 Helen updated the committee on progress made regarding the requirements set out in the WRES improvement plan, which had included the establishment of fair treatment panels and unconscious bias training.

19.06 Anu enquired whether the Trust Board was maintaining control of this agenda, and Norma replied that the Board had delegated responsibility to the WAC to do so. That being the case, Anu felt that it was incumbent on the committee to remove WRES from the overarching cultural issues agenda and hold twice-yearly deep dives into this work. WAC members were reminded that Anu was Non-Executive Director lead for inclusion and diversity. Anu also requested that data from the Fair Treatment Panels be included within the Employee Relations activity report.

Cultural Survey Action Plan

19.07 Helen drew attention to the following pieces of work being carried out under this cultural transformation agenda, namely:

- the UCLP/NHSI cultural and leadership programme
- the Trust-wide competition on the branding of this work
- the seminar to be conducted by Michael West in May, and
- the accompanying culture fair
- the Affina 'team journey' where 18 staff are being trained to become team coaches
- the development of a staff charter

- reciprocal mediation with neighbouring Trusts
- CPD for coaches and mediators.

19.08 Given the size of this agenda, Anu enquired whether the team was able to keep track of all this work. Helen and Norma agreed this was challenging given the size of the team, and Anu enquired whether this might be placed under the aegis of the Performance Management Office (PMO). Carol replied that this could be explored, although the primary remit of the PMO was to support the service improvement agenda and CIPs. Norma added that she had fully briefed Siobhan on this work, and welcomed the support of the Board.

19.09 Referring back to the gender pay gap, Norma clarified the distinction between this and equal pay issues. She added that where new employees were employed on grades above the routinely prescribed level she had to sign them off, therefore there were robust checks and balances and an audit trail in place.

19.10 Swarnjit Singh enquired whether the Trust's WRES work programme was to be revised in response to recent national changes, and Norma replied that it would be, with a further action plan coming to the next committee.

19/20 <u>Terms of Reference for the Workforce Assurance Committee</u>

20.01 The committee reviewed the draft terms of reference which had been circulated, and Swarnjit explained that the Trust was required to have terms of reference which were consistent across all Board committees. Referring to committee membership, he explained that only directors and non-executive members were full committee members; others were either 'in attendance' or attended as required.

20.02 The committee discussed ICSU representation, and it was agreed that Directors of Operation should be invited to attend, possibly shadowed by a service manager. The Medical Director should also be added to the list of full members.

20.03 It was agreed that further discussion was required about what committees/working groups might sit beneath the WAC, and Swarnjit was asked to map a draft structure and circulate it for consideration. Carol wondered whether there might be mileage in establishing a task and finish group on mandatory training, and it was agreed that this might be included as an option in Helen's paper to TMG.

	Draft minutes of The Whittington Health Charitable Trust Committee meeting held on 26th March 2019

Present	Name	Initials	Title
	Tony Rice	TR	Non-Executive Director (Committee Chair)
	Steve Hitchins	SH	Non-Executive Director (Trust Chairman)
	Stephen Bloomer	SB	Chief Finance Officer
	Jon Ware	JW	Head of Financial Services
	Jonathan Gardner	JG	Director of Strategy, Development & Corporate Affairs
	Siobhan Harrington	SMH	Chief Executive Officer
	Juliette Marshall	JM	Director of Communications
	Linda Ellis	LE	Compton *for item 19/007*
	Dan Fletcher	DF	Kingston Smith *for item 19/008*
	Vivien Bucke	VB	Business Support Manager, Finance

Item	Discussion	Action
19/001	**Welcome, Apologies for Absence & Declarations of Interest**	
1.1	There were no apologies and no Declarations of Interest were received.	
19/002	**Approval of Minutes of the meeting held on 10th October 2018**	
2.1	The minutes were agreed as an accurate record with the exception of 36.1 amended to 'Committee'.	
19/003	**Action notes**	
3.1	In addition to those marked completed JM confirmed the Patient Leaflets & Names on website action was completed.	
19/004	**Financial Report Month 11 2018/19**	
4.1	JW reported the headlines for month 11: ▪ Income is ahead of the whole year 2017-18 at £221k ▪ Expenditure is at £1.2m, but £1m of that relates to the maternity donation, therefore spend was lower than hoped for the remaining funds. If approved the bids from the Kanitz fund brought to this meeting will bring spend in line with 2017-18. In addition: ▪ The Charity had received the final settlement for the Joyce Edith Layton at £35k higher than expected; **Action: JM to check thank you note had gone.** ▪ Balance sheet – the charity had held higher cash balances while the maternity transaction was completed so the value is expected to reduce going forward.	**JM**
4.2	MJ asked about the Friends of St. Luke's Hospital donation and JW	

	stated the instruction was for use in the community sites with a Christmas bias. **Action: MJ Community use of the donation to be reviewed**.	**MJ**
19/005	**Fund Balances**	
5.1	The paper set out the breakdown of funds by the various categories taking into account significant movements in those balances: - Unrestricted funds (general use) - £142k; - Unrestricted funds (specific use) – £566k; - Restricted funds (including postgraduate funds) - £1,981k; and - Endowment funds – £24k. JW stated that: ▪ The largest movement related to maternity and the impact of this was on the unrestricted funds, reducing the balance to £700k. ▪ Movements in the year other than maternity were small, and if this was excluded, the movement had been upward by £24k. Most of which had gone into restricted funds.	
5.2	JW reported that the merchandise fund has asked to transfer £30k of their profit to fund the play terrace. The Committee supported the virement. **Action: JW to move funds.**	**JW**
19/006	**Applications for Funding**	
6.1	JW stated there had been a number of bids to the Kanitz fund which the Trust Chair and CFO had discussed outside the cycle of meetings with the fund holders. He highlighted Appendix 3 Funding recommendations – Kanitz bequest. The table showed 14 items of which 10 were recommended for funding. As listed below 4 were not recommended and ongoing costs were not recommended for a further 2 items. SB asked for: (1) agreement to those marked Fund and this was agreed. (2) For the Committee to discuss and ratify the recommendation not to fund. The Committee concluded: a). <u>The Critical Care Annual Award Ceremony</u> overlapped with the Trust annual awards so agreed this should not be funded. b). <u>Critical Care education fund</u>. SB stated there was a need for the Committee to generally think about education. There is a view that The Trust should fund education not the Charity. MJ asked about Critical Care training and was told the charity can fund this if staff can articulate the training is over and above core ITU training. SB emphasised the need to be consistent across all groups of staff and not just nursing as the current fund balances were only for clinical training and this did not seem equitable. The committee members agreed and decided not to fund at this point. c) <u>NICOM</u> The Committee agreed not to fund as stated in the paper. d)<u>Transport Table</u> The Committee agreed not to fund as stated in the paper e) <u>LIDCO arm for calibration</u> The Committee agreed not to fund as stated	

	in the paper f) Circadian lighting system: MJ proposed to hold a workshop with the clinical leads with a view to generating an acceptable scheme. JW noted a further 4 bids had been received against the fund.	**MJ**
6.2	The Committee accepted the report.	
19/007	**General Fundraising**	
7.1	JM reported: ▪ Eddie Mitchell of Compton was now working with the Trust for 3 days a week. ▪ The trial of the contactless giving points had been successful and suggested an opportunity to use this donation route to generate more significant monies in the future. A proposal would be brought to the Committee recommending investing in the contactless giving points.	**JM**
7.2	SMH was keen to know how much had been able to be delivered in three months since Compton started. JM stated there had been a lot of work in first 6 weeks getting up and running and she would report back after a review with Compton at the next meeting.	**JM**
7.3	The committee discussed grant making capabilities and noted twenty applications had been sent out to organisations; a lot being specifically Islington funders.	
7.4	JM confirmed it would be 3-6 months to Compton initial feedback. SB raised the issue of setting a target to Compton. **Action: JM to send the target to SB and TR to agree as Chairman's action.**	**JM**
19/008	**Fundraising Strategic Review**	
8.1	Dan Fletcher joined the meeting to discuss the fundraising strategic review. Points discussed were: ▪ The Charity has a lot of untapped potential. ▪ The Charity will need to spend some money to raise more money and a well-established fundraising team should achieve 4 or 5 times the cost of the team. . ▪ DF recommended the blended option 2 – in-house led approach that would retain the knowledge and networks and take the messages out to the NHS teams. ▪ How to create something different than it already had. ▪ The need for a Head of Charity first; this role would be broader than just fundraising. However, SMH was concerned that the grading is equivalent to an Associate Director of Nursing and therefore delivery needed to reflect that. ▪ SB asked where DF saw the Trustees as giving gravitas and was enough being asked of the Trustees and the areas that work closely with the Charity because that would help with the grading issue. ▪ DF agreed that there was more of a role for trustees, but felt that developing the Charity infrastructure, strengthening the Charity's recognition rating and recruiting charity ambassadors and volunteers needed to be driven by a member of staff as the charity can always	

	take second place against the demands on Executive Directors time. ▪ DF suggested discussing the implementation of their charity with Hillingdon & Royal Surrey County Hospital. ▪ SB suggested looking at alternative models e.g. bringing in someone from another Trust for a few months as he could not justify the levels and model for this charity. ▪ The Committee agreed to discuss the detail and other models of hiring the Head of Charity. The report would be discussed at the Trust Board Seminar. It was noted that a different structure would mean revising the action plan. **Action:** Report to the Trust Board Seminar and conversations to be had with other Trusts on how they found a Head of Charity.	
19/009	**AOB**	
9.1	SHi spoke of the need for an additional NED required for the Committee. **Action: JG to assess if it was possible to bring in an external representative.**	**JG**
	Next Meeting: 26th June 2019	