Whittington Health
NHS Trust

TRUST BOARD
IN PUBLIC

14:00-17:00
Wednesday
26 June 2019

Room 7
Whittington Education Centre

Meeting	**Trust Board – Public meeting**
Date & time	**26 June 2019: From 1400hrs**
Venue	**Whittington Education Centre, Room 7**

Non-Executive Director members:	**Executive Director members:**
Steve Hitchins, Chair Deborah Harris-Ugbomah David Holt Professor Naomi Fulop Tony Rice Anu Singh Yua Haw Yoe	Siobhan Harrington, Chief Executive Dr Clare Dollery, 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
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(s)	Action
Standing items			
1	1400	**Patient story** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Presentation
2	1425	**Welcome and apologies** *Steve Hitchins, Chair*	Verbal
3	1426	**Declaration of interests** *Steve Hitchins, Chair*	Verbal
4	1427	**29 May 2019 public meeting draft minutes, action log, matters arising** *Steve Hitchins, Chair*	Approve
5	1435	**Chairman's report** *Steve Hitchins, Chair*	Review verbal update
6	1445	**Chief Executive's report** *Siobhan Harrington, Chief Executive*	Review
Quality & patient safety			
7	1455	**Eliminating mixed gender inpatient accommodation annual declaration**	Approve

Item	Timing	Title and lead(s)	Action
		Michelle Johnson, Chief Nurse & Director of Patient Experience	
8	1505	**Serious incidents – May 2019** *Dr Clare Dollery, Medical Director*	Review
9	1515	**2019 Heatwave plan** *Carol Gillen, Chief Operating Officer*	Review
10	1520	**Assurance of Seven Day Services** *Dr Clare Dollery, Medical Director*	Approve
Performance			
11	1530	**Performance dashboard – May 2019** *Carol Gillen, Chief Operating Officer*	Review
12	1540	**Emergency Department improvement plan** *Carol Gillen, Chief Operating Officer*	Review
13	1550	**Financial performance – May 2019** *Stephen Bloomer, Chief Finance Officer*	Review
Workforce			
14	1605	**Staff story** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Presentation
Governance			
15	1625	**2018/19 Trust Annual Report & Accounts** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs and Stephen Bloomer, Chief Finance Officer*	Approve
16	1630	**2019/20 Risk management strategy review and risk appetite statement** *Michelle Johnson, Chief Nurse & Director of Patient Experience and Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Approve
17	1645	**Questions from the public on agenda items** *Steve Hitchins, Chair*	Approve
18	1650	**Any other business** *Steve Hitchins, Chair*	Verbal

Minutes of the Whittington Health Trust Board's meeting held in public on 29 May 2019

Present:

Steve Hitchins	Chairman
Carol Gillen	Chief Operating Officer (items 1-19)
Naomi Fulop	Non-Executive Director
Siobhan Harrington	Chief Executive
Deborah Harris-Ugbomah	Non-Executive Director
David Holt	Non-Executive Director
Michelle Johnson	Chief Nurse & Director of Patient Experience
Tony Rice	Non-Executive Director
Anu Singh	Non-Executive Director
Yua Haw Yoe	Non-Executive Director

In attendance:

Janet Burgess	Councillor, London Borough of Islington
Kevin Curnow	Operational Director of Finance
Norma French	Director of Workforce
Kate Green	Personal Assistant to Director of Workforce
Sarah Humphery	Medical Director, Integrated Care
Darren Marsh	Dietitian & Service Manager for Nutrition and Dietetics (item 1)
Swarnjit Singh	Trust Corporate Secretary

1.	**Patient Story**
1.1	James Connell, Patient Experience Manager, introduced Kinga, who had agreed to recount her experience as a patient of the Trust's community services.
1.2	Kinga began by saying that she had suffered from bulimia for many years, but was only diagnosed a few years ago. After completing a course of therapy her life had improved, but she still had an unhealthy relationship with food. She therefore sought advice from her GP, who had referred her to a mental health dietitian. Feeling that she had tried several forms of treatment with only a limited degree of success, Kinga approached the appointment fairly stressed and not too hopeful of any positive resolution.
1.3	Kinga described the dietitian she saw as 'amazing'. She was treated holistically, with an emphasis on her relationship both with her body and with food. She was aware that her dietitian was working extra hours in order to give her additional time, and the treatment she received made her feel hopeful as she felt she was being treated like a human being, something she had not felt prior to this course of treatment. She cited one example, explaining that the dietitian had helped her to relax about the way she felt about fruit. She had also been advised that a further course of cognitive behavioural therapy might prove beneficial.
1.4	Kinga had seen many specialists and had frequently felt she was a burden to

	them, but this dietitian had really helped her. She had remained in touch with a few people from her bulimia therapy group, and like her, they had been unaware that such services existed.
1.5	In answer to a question from James Connell about whether there were any steps that could be taken to improve the service, Kinga replied that she had been 'over the moon' with the service and couldn't praise it highly enough. If pressed, she would have to say that there were occasional problems with communications; for example, receiving texts rather than letters meant that full details of appointments were not given therefore she was in danger of missing them.
1.6	Steve Hitchins asked how widely the service was known to local GPs, and Darren Marsh replied that there was still work to do on this. Sarah Humphery offered to help by featuring the service in her GP Connect newsletter. Siobhan acknowledged that this had not been an easy subject for Kinga to talk about in a public meeting, and it had been good to hear about the holistic care she had received. Darren Marsh explained the training all staff received when starting work, saying that his own personal practice had changed as a result. It was also noted that waiting times for the service had recently improved and the only barrier to offering additional services was the shortage of specialist staff.
1.7	Kinga informed the Board that a friend of hers planned to take part in a charity run in order to raise money for the service which she felt had done so much for her.
1.8	**On behalf of the Board, Steve Hitchins thanked Kinga for sharing her story and wished her well. The Board also noted that Sarah Humphery would promote the dietetic service and its links to the Improving Access to Psychological Therapy within primary care services.**
2.	**Welcome and apologies**
2.1	Steve Hitchins welcomed everyone to the meeting, and thanked Kevin Curnow for attending in place of Stephen Bloomer.
2.2	Apologies for absence had been received from Stephen Bloomer and Jonathan Gardner.
3.	**Declaration of conflicts of interest**
3.1	Siobhan Harrington informed Board colleagues that her son had recently married a pharmacist who worked at Whittington Health.
4.	**Minutes, matters arising & action log**
4.1	The minutes of the previous meeting were agreed as a correct record, subject to the amendment on the final question asked by a member of the public in section 20 to read as: "Were there any objections arising as part of the procurement process?"
4.2	There were no matters arising other than those already scheduled for discussion.
4.3	The following updates were received on open action log items: • The final draft of the Accountability Framework would be discussed at the 11 June meeting of the Trust Management Group

	• A date for the opening ceremony for the new obstetric theatre was being agreed and would happen in June
5.	**Chairman's report**
5.1	Steve Hitchins reported that he had recently visited Gateshead as part of the Care Quality Commission's 'well led' inspection team, and was struck by the similarities between the Trust there and Whittington Health. He had circulated an account to Board colleagues.
5.2	Other events Steve Hitchins had attended and visits made since the last Board meeting included: • a reception at the House of Lords hosted by Ambitious about Autism where Whittington Health had been cited as an example of good practice • the visit by the Bishop of London to the Trust, which Steve described as a great initiative by the Chaplaincy • the international nurses' day, where he had been particularly impressed by their ambition to reach the status of 'outstanding' – the atmosphere had been really good, and he felt tribute should be paid to Michelle for her part in this • the forum event run by Emergency Department Consultant Heidi Edmundson, which, as well as being great entertainment, had provided much to think about • Camden & Islington NHSFT's first London NHS Choir Festival, which had featured Whittington Health's 'Sing for your Lungs' choir • a visit by the Rt. Hon. Jeremy Corbyn MP and Tom Hughes-Hallet to promote NHS volunteers' organisation, Helpforce • together with Adrien Cooper, Director of Environment, a meeting at Simmons House to discuss the screening of the premises to ensure patients' privacy • the inauguration ceremony for the new Mayor for the London Borough of Haringey • a meeting with the Tottenham Health Foundation to discuss their engagement with the Trust around school nursing • his sixty-fifth Appointments Advisory Committee, in his sixty-fifth month as Trust Chairman • visits to Health Visiting, Lifeforce, the Family Nurse Partnership and several wards at the hospital
5.3	Steve Hitchins explained that, during June, he planned to spend four days visiting all of the Trust's community dental services.
5.4	Steve Hitchins informed Board colleagues that Eileen Willis, Personal Assistant to the Chief Executive, was retiring in June, and everyone was welcome to sign her card and attend her retirement event on 14 June. She had worked at the Trust for twenty-seven years and would be greatly-missed. Steve Hitchins also thanked Julie Andrews for acting as Medical Director over recent months, saying that she had done a fantastic job for which the Trust was hugely grateful.
5.5	Several members of staff had taken part in the London Marathon to raise money for the Whittington Health charitable funds. The Board expressed thanks to the

	following successful runners: Stuart Richardson; Joe Heaney; Sophia Hicks; Brendan Heaney; Nickhi Gill; Hannah Wailoo; Johnny Collin and Nick Burnage. Tony Rice added that the London 10km run was due to take place shortly and encouraged Board members to join with him in participating.
6.	**Chief Executive's report**
6.1	Siobhan Harrington updated Board colleagues on the Trust's Emergency Department performance which was 84.6% during April. While this was below target, it needed to be set against an increase in attendance of 7% compared with the corresponding period in 2018. She explained that all trusts in London were facing similar pressures, and overall, Whittington Health's performance was seventh best in London. NHS Improvement's Emergency Care Intensive Support Team (ECIST) had carried out several visits, and the department's focus was on two main areas: first, flow through the whole hospital (there had just been a 'Perfect Week', the results of which would be fed back in due course); and secondly, looking at how the emergency care package might work differently, in future.
6.2	David Holt felt that this was an appropriate time for the Trust to look at what steps were being taken and recalibrate accordingly. Carol Gillen agreed, saying that much work had been done on same day emergency care. Updates were discussed by the A&E Delivery Board and a report of progress would be brought to the next Trust Board meeting.
6.3	In terms of financial performance, Siobhan Harrington reminded the Board that month one was traditionally a difficult month to report on. She confirmed that, at the end of April, the Trust reported a deficit of £1.5m, an adverse variance of £1m against its planned position. However, income was ahead of plan, which was extremely positive at this stage of the year.
6.4	The most recent round of Integrated Clinical Service Unit (ICSU) performance reviews had taken place and resulted in two ICSUs being offered enhanced support. The first round of corporate performance reviews also took place in April, and the second was being scheduled. Norma French commented on how useful these had been.
6.5	At 10.6%, the Trust's staff turnover outcome was extremely good in April and was the lowest in North Central London. The move to Bank Partners had taken place as planned on 20 May and the first week had gone well. In answer to a question about whether this meant that payment rates had now been standardised across the NCL sector, Norma French replied that medical rates were, but nursing less so, however, information was openly shared between neighbouring organisations and across the collaborative.
6.6	Siobhan Harrington drew the Board's attention to the programme of cultural work taking place across the organisation. The recent workshop led by Professor Michael West was a great success, and he had led a tailored masterclass using the Trust's values and objectives which was attended by a cross-section of staff. The branding for the cultural work had been the subject of a Trust-wide consultation, with the most popular strapline being 'Caring for those who care'.

6.7	Estates work continued as planned: in addition to the completion of the new obstetrics theatre and refurbishment of the post-natal ward, the next phase (starting in June) would see the demolition of the Waterlow building, in preparation for the building of the replacement Whittington Education Centre.
6.8	The Islington & Haringey Wellbeing Partnership was now moving into its next iteration, and the first borough partnership meetings had taken place.
6.9	Siobhan Harrington concluded her report by informing the Board that two colleagues had been nominated for that month's staff excellence awards – Rainelle See, Cavell Ward Manager, and Ali Gung or from the Housekeeping Team.
6.10	Steve Hitchins referred back to the Camden & Islington development on the Whittington site, and asked how much influence the Trust would have over the design of the building. Siobhan Harrington replied that the relationship between the two trusts was extremely positive, and she was due to meet with the Chief Executive and Medical Director at Camden & Islington NHSFT the following week and joint meetings would continue to be held about both the estates work and the working relationship between the two trusts and how they could best support one another. A further update would be provided at the Board seminar in two weeks' time.
6.11	Anu Singh asked about the Wellbeing Partnership and the Trust's ambitions to become an Integrated Care System (ICS). Siobhan Harrington replied that this was now part of a strategic approach across London whereby local authorities became the 'engine rooms'.
6.12	Naomi Fulop asked when the NCL medium term financial strategy would be considered by the Board. Siobhan Harrington explained that this was still in development and would be brought to the Board once available.
6.13	**The Board:** **i. received and reviewed the Chief Executive's report;** **ii. agreed that the Emergency Department's improvement plan would be brought to the June meeting; and** **iii. agreed that the NCL sector's medium term financial strategy would be reviewed and approved at a future Board meeting.**
7.	**Trust Wellbeing Guardian**
7.1	Norma French explained that this initiative had come from the NHS Health and Wellbeing Framework published last year and followed up this year with a set of recommendations. She explained that, as Director of Workforce she was the operational lead for Health and Wellbeing, and recommended that the Board lead was the Chief Executive. David Holt enquired whether other Trusts followed this model, and Siobhan replied that Dido Harding, NHS Improvement's Chair, had made it clear that staff health & wellbeing was ultimately the responsibility of the Board, with Chief Executives expected to take an active lead.
7.2	David Holt also asked whether the Guardian would be submitting reports to the Board and Norma French confirmed that reporting would be to the Workforce

	Assurance Committee, which in turn would feed back to the Board. Yua Haw Hoe enquired how the Pulse surveys would link in, and Norma French explained that they had been combined with the staff Friends & Family Test, and all such initiatives ultimately came under the 'Caring for those who care' cultural work aegis. Anu Singh felt there was still a need for further work to map and brand this agenda.
7.3	Tony Rice informed Board colleagues that, by 1 July, companies were required to have employee engagement measures in place. For some, this meant co-opting employees onto Boards; but more generally, this meant getting the voices of employees heard in the Boardroom. Norma French added that presenting a staff story to the Board was an effective method of staff engagement, and it was noted that this had already been agreed and built into the Board programme. Tony Rice was confident that this type of initiative was very effectively addressed by the Trust.
7.4	**Board members agreed the following recommendations:** **I. The Trust's Health & Wellbeing Group would continue to drive implementation of the Trust's Health & Wellbeing strategy and to report formally to the Workforce Assurance Committee every six months and annually to the Trust Board and these would be captured in the Committee's and Board's forward plans;** **ii. All Board Directors would actively promote health and wellbeing and lead by example through visibly participating in interventions, health and wellbeing planning and setting the culture they wanted to see across the organisation;** **iii. The Director of Workforce would be the Trust's lead with operational responsibility for occupational health and wellbeing; and** **iv. The Chief Executive would be the named Board member responsible for staff health and wellbeing planning as Wellbeing Guardian.**
8.	**Quality Assurance (CQC Compliance Update)**
8.1	Michelle Johnson presented the quarterly assurance report on CQC compliance, which had three key components: • compliance with previous inspection recommendations • progress made towards moving from 'good' to 'outstanding', and • the response to the Mental Health Act monitoring visit to Simmons House.
8.2	In terms of the implementation of previous inspection recommendations, she was confident they had either been fully addressed or had ongoing work plans against them. Michelle Johnson confirmed she had met with the new CQC relationship manager, and her team was engaged in preparatory work for the next inspection. Moving to the ambition to achieve 'outstanding' status, Michelle Johnson drew attention to the 'Better never stops' hub, saying that services should operate as if a CQC inspection might take place any day, with the emphasis that aspirant standards should reflect business as usual. The CQC had visited Simmons House to look at the Trust's compliance with the Mental Health Act, and feedback had been broadly positive.
8.3	Michelle Johnson informed the Board that the Trust was currently expecting a

	review of haemaglobinopathies which would be carried out by the national specialised commissioning team. The Trust had visited North Middlesex University Hospital (NMUH) and Barts Health NHS Trust to exchange experiences of inspections. David Holt asked about the reciprocal visits referred to at a previous Board meeting, saying that these should be taking place twice each year. Michelle Johnson explained that a visit had been planned for July, but was postponed due to the announcement of a formal CQC inspection at NMUH. One visit of our staff had already taken place to NMUH and proved a very worthwhile experience for the fourteen staff who participated.
8.4	Anu Singh enquired about the patient safety 'huddles', in which Board members used to participate, and Michelle Johnson replied that these did still take place but were led by the ICSUs. Siobhan Harrington said that exec attendance should be revived and she would take this forward.
8.5	**The Board:** **i. reviewed the work undertaken to monitor the delivery of actions identified in previous inspections;** **ii. approved the preparation methodology;** **iii. took assurance that there was appropriate attention and preparation activity taking place ahead of any announced inspection; and** **iv. agreed that the use of patient safety walkabouts and huddles be reviewed along with Non-Executive Director participation.**
9.	**Serious incidents**
9.1	Julie Andrews informed the Board that four serious incidents had been declared during April. Two were related to pressure ulcers, one to an attack by a mental health patient on Emergency Department staff, and the fourth to additional surgery being required for a patient with recurrent breast cancer. Two investigations were being undertaken by the Healthcare Safety Investigation Branch. A table setting out last year's incidents had also been included for comparative purposes.
9.2	Julie Andrews explained the changes that had recently taken place with regard to the reporting of pressure ulcers. Asked by Tony Rice what 'good' would look like in terms of performance, Michelle Johnson was clear that the aim remained to have zero pressure ulcers. In answer to a question from Janet Burgess about the numbers reported, Julie Andrews replied that thresholds were unlikely to change but it was possible there would be an increase in the number reported.
9.3	**The Board reviewed the serious incidents' report and agreed that the assurances contained within it demonstrates that the serious incident process was managed effectively and that lessons learnt were shared widely following the completion of investigations.**
10.	**2018/19 Quality Account**
10.1	Michelle Johnson informed the Board that the 2018/19 Quality Account had been widely shared, including having been taken to a Board seminar, Executive Team meeting and the Trust Management Group. Comments made at the Quality Committee meeting had also been incorporated, and external engagement had been sought. Feedback from Haringey and Islington Clinical Commissioning Groups (CCGs) had been positive, and comments were awaited from KPMG and

	local Healthwatch bodies.
10.2	Siobhan Harrington commended the document and its content, but felt that a summary version would also be useful. She said that the external auditors had been happy with both the document and the process for its preparation, and this was a testament to all who had worked on it. Michelle Johnson had discussed next steps in terms of dissemination with both Jonathan Gardner and Juliette Marshall, Director of Communications.
10.3	For the 2019/20 Quality Account, Michelle outlined that she would like to see more community engagement, involving young people as well as adults. Naomi Fulop echoed this, explaining that such engagement was recognised practice for outstanding Quality Accounts. Steve Hitchins suggested that a link might be made with the relaunch of the community forum. Deborah Harris-Ugbomah recommended the inclusion of stories, which could send a powerful message. In reply to a question from Siobhan Harrington, Michelle Johnson confirmed that the monitoring of performance against the 2019/20 quality priorities' indicators would take place by the Patient Experience and Safety Committees and be reported each quarter to the Board's Quality Committee.
10.4	**The Board:** **i. reviewed and approved the 2018/19 Quality Account for submission to NHS Improvement by 29 June; and** **ii. agreed delegated authority for the Chief Executive and Chief Nurse to agree the final version for submission and inclusion on the rust's external web pages.**
11.	**Quarterly Learning from Deaths' report**
11.1	Julie Andrews reported that most departments and teams had improved the timeliness of their reporting. She confirmed that 84 deaths occurred during quarter 2 of 2018/19, of which 62% had been reviewed. The Trust had exceeded its targets for the review of both Category A and B deaths, with 93.1% of Category A deaths being reviewed against a performance target of 90%, and 45.5% of Category B deaths against a target of 25%.
11.2	Julie Andrews went on to brief the Board about the new, statutory medical examiner process, which was to come into force by April 2020. The medical examiner would be a joint appointment with the Coroner, and the Trust was currently in discussion with local CCGs to consider how best this process might work. Julie Andrews felt this initiative presented exciting opportunities, and would also bring positive benefits for families who currently underwent a lengthy wait for death certificates the average waiting time being up to five months. Naomi Fulop requested that future reports contained a summary of the process undertaken.
11.3	**The Board:** **i. recognised 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; and** **ii. was aware of the areas where remedial action was being taken to**

	improve compliance data, the sharing of learning and the systematic review of deaths of patients within 30 days of discharge.
12.	**Performance dashboard**
12.1	Carol Gillen introduced the performance report for April which was in a new clearer format following discussion at a Board seminar. Some new indicators were included, such as an additional one for response times for complaints and also for workforce to measure the 'time to hire' for new recruits.
12.2	Emergency Department (ED) performance was at 84.6% in April. The improvement plan was to be refreshed and Carol Gillen said the indications were that the department would achieve 89% in May. Non-elective procedures had been slightly over target, and a GIRFT ('Getting it Right First Time') review on Care of Older People had recently been completed. Complaints performance had improved, and a 40 day target for more complex cases had been introduced. There had been a slight improvement in theatre utilisation, which linked to the delivery of the action plan.
12.3	Within community services, there had been a very slight dip in performance in April. Carol Gillen explained there were plans to move the adult Community Services Improvement Group meetings to a bi-monthly basis, whilst continuing to hold the children and young people's group monthly. She drew attention to the reduction in waiting times for the Child and Adolescent Mental Health service (CAMHS), and added that the new clinical lead for the service was starting that week. Lesley Platt reported she had presented the results of the Haringey therapies review to the CCG and local authority. Janet Burgess commented on how pleased she was to see the reduction in waiting times for CAMHS, and Carol Gillen said that urgent cases were seen very quickly, in line with the ethos of care which was to ensure people were seen at the most appropriate place and at the right time.
12.4	Siobhan Harrington fed back positively on the format of the new report, particularly the inclusion of the statistical process control charts. She commented that the report had caused her to reflect on how far the Trust had progressed with regard to its community services' data. She was concerned, however, about the dip in performance of the Musculoskeletal service. In response, Carol Gillen explained that this had been caused at least in part by the service having been a victim of its own success –there had been an increase in demand which had not been matched with additional commissioner funding to increase the capacity of the service. She also reported that the district nursing service had also performed extremely well over recent months.
12.5	Mandatory staff training and appraisal rates continued to give cause for concern, however, Norma French said that significant work had been carried out in this area, including some 'myth busting' and data cleansing. She accepted that increasing compliance remained an important priority.
12.6	Naomi Fulop expressed her strong support for the work in hand to reduce pressure ulcers and asked whether a trajectory was available. On behalf of the Board, Steve Hitchins expressed his thanks to Hester De Graag, Quality & Risk Manager, and to Rhiannon Horton, Senior Information Analyst, for all the work they had put

	in to produce the new performance dashboard. He also suggested that future iterations might include the corporate indicators and key workforce indicators on the summary page, and that the action plan could be rag-rated.
12.7	**The Board:** **i. reviewed the performance dashboard report for April 2019;** **ii. agreed that the report for the June meeting would include a trajectory for pressure ulcers; and** **iii. agreed the next iteration of the report at June's meeting would include on the summary page all of the indicators for the delivery of the 2019/20 corporate objectives and also key workforce indicators.**
13.	**Financial report**
13.1	Kevin Curnow introduced the finance report for month one. He explained that, at the end of April, the Trust had declared a £1.5m deficit, which was £1m off plan. The key driver for that adverse variance was performance on delivery of the cost improvement programme (CIP). That said, while April was traditionally a challenging month, he was pleased to report that performance was good against the Trust's core plan with agency staffing expenditure was moving in the right direction. He also reported that pay costs were in excess of budget, and this was largely due to some staff at the top of their pay bands receiving a lump sum as part of the three year Agenda for Change pay deal; he therefore expected to see a reduction in future months. Non-pay expenditure remained broadly on track, at present.
13.2	In terms of CIP delivery, Kevin Curnow informed the Board that the Trust had delivered £0.1m in month against a target of £1m. He acknowledged, however, that the target the Trust had set itself was an extremely challenging one, and the recent CIP Delivery Board had clarified the expectations for the ICSUs and corporate directorates. David Holt highlighted the need for Board members to have early sight of the trajectory, so that they could be assured the Trust was on track to deliver by the end of the first quarter. Norma French reported that she had started her regular round of meetings with each of the ICSUs to discuss the run rate and agency ceiling cap.
13.3	**The Board reviewed the financial outturn at month one and agreed that a trajectory for CIP delivery be included in the report for the June Board meeting.**
14.	**NHS provider licence self-certification**
14.1	Siobhan Harrington explained that all NHS trusts were required to complete a self-certification on whether or not they had met the obligations set out in the NHS provider licence and publish the resulting declaration on their public websites. Swarnjit Singh and Jonathan Gardner had prepared the narrative, set out where the risks and mitigations lay, and provided evidence in support of the self-certifications in the paper's appendices. The paper had been agreed by both the Executive Team and Trust Management Group.
14.2	**The Board:** **i. approved the positive compliance statements for the annual self-certification against NHS provider licence conditions G6 and FT4;**

	ii. reviewed the assurance evidence for these conditions; and **iii. agreed delegated authority for the Chief Executive and Chair to sign off the final declarations by 31 May 2019 and them to be published on the Trust's web pages.**
15.	**Board committees' terms of reference**
15.1	Siobhan Harrington commented that the previous agenda item on provider licence self-certification sought evidence that the Board reviewed the terms of reference of all its committees. She said that Swarnjit Singh had done quite admirably in pulling together all Board committee terms of reference into a common format. Two committees (Workforce Assurance and Quality) had formally signed their updated terms of terms. In other cases, there had been consultation with respective chairs and lead executive directors; the remaining committees would ratify their updated terms of reference at their next meetings. There was discussion about the membership of the Estates Strategy Delivery Committee, and the Board recommended the Greater London Authority (GLA) representative be termed a co-optee rather than a member and similarly, patient representatives, would be co-opted on to the Quality Committee.
15.2	Steve Hitchins thanked Swarnjit Singh for the great work he had done in pulling all terms of reference together in a standard format, and for his attention to detail in doing so.
15.3	**The Board:** **i. approved the updated, terms of reference which had been standardised, where possible, subject to the co-option of a GLA representative on to the Estates Strategy Delivery Committee and the co-option of patient representatives on to the Quality Committee;** **ii. agreed the terms of reference be ratified at the next meetings of each Committee;** **iii. agreed that the Board would next complete its annual review Committees' terms of reference at its March 2020 meeting; and** **iv. agreed any crucial amendments required between reviews be delegated to Swarnjit Singh and Siobhan Harrington.**
16.	**Standing orders, standing financial instructions and scheme of reservation & delegation of powers**
16.1	As Stephen Bloomer had sent his apologies for this meeting, it was felt the whole document was required rather than just the proposed amendments.
16.2	**The Board agreed to defer this item to a future meeting.**
17.	**Minutes of the May Quality Committee meeting**
17.1	Steve Hitchins congratulated Naomi Fulop on having chaired her first Quality Committee. She drew attention to the following issues: • discussion of the Quality Account, including 2019/20 priorities • infection prevention and control, where the Trust had met all targets apart from MRSA, where the target was nil and Whittington Health had declared one • an inspiring presentation on volunteering, noting that the Trust had met its target of recruiting 124 volunteers

	• a number of policies needed reviewing and plans were in place to do this • the huge take-up of Quality (QI) Improvement training with 120 projects currently up and running and the QI celebratory event scheduled for 14 June
17.1	On the subject of volunteering, Steve Hitchins announced that there were plans for the Trust to participate in a programme called 'kangaroo care', which was designed to offer support to babies separated from their mothers through physical contact.
17.2	**The Board reviewed the minutes of the Quality Committee meeting**
18.	**Minutes of the April Workforce Assurance Committee meeting**
18.1	Anu Singh was also congratulated on chairing her first Workforce Assurance Committee. She alerted Board members to the significant amount of work going on, particularly the many different strands of the cultural agenda.
18.2	**The Board reviewed the minutes of the Workforce Assurance Committee.**
19.	**Minutes of the March Meeting of the Charitable Funds Committee**
19.1	Tony Rice reported that plans were now being made for a major campaign around maternity services. He explained that the rigorous criteria applied by the committee when considering requests meant that they turned down applications for anything they felt should come from core NHS funding.
19.2	The main focus of the meeting had been around the need to raise funds, and Tony informed the Board that the committee was recommending hiring or recruiting a professional to drive the charity forward, and he, Steve Hitchins and Siobhan Harrington would take this forward.
19.3	Naomi Fulop enquired whether any move had been made towards simplifying the process for submitting smaller bids. Tony agreed this was desirable and work on it had begun and should be completed by the following meeting.
19.4	**The Board reviewed the minutes of the Charitable Funds Committee.**
20.	**Questions from the public**
20.1	Mr Philip Richards asked three questions: Q1: In relation to item 2 (Chief Executive's report), there seemed to be three distinct threats to the recruitment of doctors and other NHS staff: Brexit; pension and taxation issues for consultants; and, staff from non-EU countries being required to pay excessive visa charges to live in the UK and charges to access NHS services. Was there any impact on the Trust from these three challenges? A: Norma French confirmed that the Trust had not lost any EU staff since the June 2016 referendum. Like other NHS providers, the Trust had participated in non-EU recruitment initiatives e.g. nursing staff from the Philippines. Its biggest vacancy issue was for middle grade emergency department doctors which was a national problem also. In addition, she would be taking a report to the Trust's Management Group on pensions and tax. Q2: Under item 11 (Quality Account), were the outpatient clinic cancellations a

	result of patients not attending? A: Michelle Johnson confirmed that these cancellations were made by the Trust. She also clarified that some of the cancellations included patient appointments which had been brought forward by half an hour.
21. 21.1	**Any other business** There were no items reported.

Public Trust Board meeting, 29 May 2019, action log

Item	Action	Lead(s)	Progress
Patient story	Promote the dietetic service and its links to Improving Access to Psychological Therapies in the next edition of the GP Connect newsletter	Sarah Humphery	Completed – a meeting is scheduled with the Dietician manager and patient who attended the May Board meeting to promote further engagement with primary care services
Action log item carried forward	Confirm to Board members this week, the date of the opening ceremony for the obstetrics theatre	Adrien Cooper	Completed - the official opening will take place in the week commencing 12 August and the exact date will be issued nearer the date
Chief Executive's report	Bring the Emergency Department's improvement plan and performance trajectory to the June Board meeting	Carol Gillen	Completed - improvement plan on agenda
Chief Executive's report	Review and approve the sector's final medium term financial strategy at a future Board meeting	Stephen Bloomer	The North Central London sector is working on the plan which will be considered by the Finance & Business Development Committee
Trust Wellbeing Guardian	Include reporting on performance against the Health & Wellbeing Framework every six months to the Workforce Assurance Committee and annually to the Trust Board in the Committee's and Board's forward plans	Norma French and Swarnjit Singh	Completed

Item	Action	Lead(s)	Progress
Quality Assurance – CQC compliance	Review the use of patient safety walkabouts and huddles and refresh the Non-Executive Director participation within them	Michelle Johnson	Our Compliance and Quality Improvement Manager in collaboration with the Patient Experience Lead and the Integrated Clinical Service Unit teams are undertaking regular service CQC peer review visits. The dates of future reviews will be shared with Non-Executive Directors to help facilitate their participation in these visits.
Quarterly learning from deaths' report	Summarise in future reports the processes and stages completed	Clare Dollery	To be included in next quarterly report due at the July Board meeting
Integrated performance report	1. Include a trajectory for pressure ulcers in the June Board report 2. Include workforce indicators on the first summary page 3. Include indicators for strategic corporate objectives	Carol Gillen Carol Gillen Carol Gillen	To be included in July's report Completed To be included in July's report
Finance report	Include recovery trajectory in the June Board report	Stephen Bloomer	Completed
Provider licence self-certifications	Delegated authority to sign the Board's self-certifications before they are posted on external webpages by 31 May 2019	Steve Hitchins and Siobhan Harrington	Completed

Item	Action	Lead(s)	Progress
Board Committee terms of reference	1. Amend Estates Strategy Delivery Committee terms of reference to say that the Greater London Authority representative would be co-opted as a member 2. Amend Quality Committee terms of reference to allow patient representatives to be co-opted members 3. Ratify agreed terms of reference at next meetings	Swarnjit Singh Swarnjit Singh Respective Board Committees	Completed – to be ratified at next committee meeting Completed – to be ratified at next committee meeting This is taking place as Board Committees meet.
Standing orders, standing financial instructions	Bring back the updated document directly to the Board	Stephen Bloomer and Jonathan Gardner	This document will be brought back to the Board following the next meeting of the Audit and Risk Committee

Meeting title	**Trust Board – public meeting**	**Date: 26 June 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 and to formally note the appointment of Dr Clare Dollery as Executive Medical Director and Responsible Officer for doctors' revalidation.	
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

Interim People Plan

1.1 The Interim NHS People Plan was published by NHS Improvement and NHS England on 3 June 2019. It has been developed with involvement from NHS employers and a wide range of other stakeholders to set out an initial approach to tackling the range of workforce challenges. Workforce supply is acknowledged as the biggest challenge facing the NHS, but it also sets out that much more needs to be done to improve staff retention and transform ways of working. It also devolves responsibility for some areas from Health Education England to regional or Sustainability and Transformation Partnership level. A substantive plan will be published following the Spending Review, which will decide key financial commitments – expected to be in the Autumn. Key themes outlined in the interim plan include:

- Making the NHS the best place to work
- Improving NHS leadership culture
- Addressing workforce shortages
- Delivering 21st century care
- Developing a new operating model for workforce

1.2 These themes tie in very well with our strategy and our existing culture plans which we will continue to evolve as more details emerge throughout the year.

NHS Chief Operating Officer

1.3 Amanda Pritchard, Chief Executive of Guy's & St Thomas' NHS Foundation Trust, has been appointed as the national Chief Operating Officer for NHS England and Improvement.

Chief Medical Director and Deputy Medical Director

1.4 On 7 June, Professor Chris Whitty, was appointed as the new Chief Medical Officer and the DHSC also confirmed that Dr Jenny Harries OBE will be the new Deputy Chief Medical Officer for England.

Public health

1.5 Following a review by the Department of Health and Social Care, the Government has confirmed that local authorities will continue to commission public health services. In addition, the review recommends that councils and the NHS work more closely to co-commission public health services, including health visiting and school nursing and also sexual and reproductive health services.

Liverpool Community Health NHS Trust

1.6 A previous review into failings at this trust was conducted by Dr Kirkup and published in February 2018[1]. Following the identification of new evidence, Stephen Hammond, Health Minister, has now commissioned a new independent investigation into the serious incidents at Liverpool Community Health NHS Trust between 2010 and 2014. This investigation will again be led by Dr Kirkup and will engage with the families of former patients and affected staff to understand their concerns and to develop recommendations. The new investigation is due to report by the end of 2020 and the lessons and recommendations will be important for all NHS providers to benchmark against.

2. Local news

Quality and safety performance

2.1 In May, overall performance against the 95% four hour standard was 88.4% (an increase from last month's 84.6 %), against a trajectory of 90% in the NHS Improvement plan. As part of the Trust's Perfect Week held between 20-29 May which focussed on dedicated support for consultants and clinical teams to improve patient flow and reduce number of patients in hospital longer than seven days, performance against this standard was 95% for five consecutive days after 31 May. There were no 12 hour trolley breaches in the Emergency Department in May. A separate agenda item on the emergency department improvement plan is being considered by Board members today.

2.2 This month we are declaring three never events. Two were identified as part of a systematic review following the national Patient Safety Alert. They happened in January 2019 and March 2018 where patients had a reconstruction plate fitted instead of a dynamic compression plate. The third happened in May regarding a patient who received a paravertebral analgesic nerve block on the unintended side. The serious incident report takes the board through the learning points and immediate actions that have been taken.

Finance

2.3 At the end of May, the Trust is reporting a year to date deficit of £1.5m which was £1.8m behind plan. The Trust has not assumed any Provider & Sustainability Funding (PSF) relating to its financial performance resulting in a negative variance of £0.3m. Income performance is marginally ahead of plan by £0.1m including the adverse variance relating to PSF.

2.4 The year to date pay costs are in excess of budget by £0.9m. Expenditure on bank staff was consistent with April's outturn at £1.8m; agency staffing expenditure was almost £1m in May, representing an increase of £50k from April. Agency trajectories have been reviewed and agreed with all ICSUs.

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1 https://improvement.nhs.uk/documents/2403/LiverpoolCommunityHealth_IndependentReviewReport_V2.pdf

2.5 Non-pay expenditure was £0.4m overspent in May and £1.1m for the year to date. The Trust is forecasting delivery of c. £0.3m in May for the Cost Improvement Programme (CIP); year to date CIP delivery is £0.4m against a £2m target. The Trust is currently liaising with NHS Improvement to confirm its capital allocation for the financial year. There is an organisation-wide focus on delivering our financial plan and papers this month discuss this in detail.

Workforce

2.6 Key workforce measures unfortunately slipped last month with appraisals at 69.8% and mandatory training at 80.1%. The performance report highlights key actions being taken, including a new simpler appraisal document, improving the electronic staff record access and functionality, and supported e-learning sessions at Crouch End.

Organisational culture and development

2.7 There are 20 team leaders being coached to take their teams on a 'team journey also based on Michael West's research which demonstrates that working in 'real teams' reduces patient mortality and improves staff engagement and efficiency. Following the development of the I.CARE behavioural framework, aligned to NHS values, the Organisational Development team have created a Staff Charter which will shortly be rolled out. A Managers' Toolkit has been created to enable managers to analyse staff survey results and discuss outcomes and actions with their teams.

2.8 We also launched the Rainbow Badge this month. The idea is that staff can show that they offer open, non-judgmental and inclusive care for patients and their families who identify as LGBT+. If patients see a member of staff wearing a badge, they know that they can talk to them about who they are, be open about their identity and how they feel. Staff who choose to wear the badge are not expected to have all of the answers but will listen and signpost to the support available, in particular for specific or ongoing issues that a patient may raise.

Estates and facilities update

2.9 The Trust has given notice on our contract with Sodexo, the current provider of both patient (on wards) and retail catering services at the Whittington Hospital site. From the end of September, patient catering will be brought in house and new approaches to take the pressure off wards will be piloted. The Trust will tender for a new retail catering supplier, but in the interim, this will also be brought in house. Affected staff are being supported and will have the opportunity to transfer to be Whittington Health employees.

2.10 As part of an initiative to standardise non-emergency patient transport across north central London, the trust has collaborated with the Royal Free, North Middlesex, Moorfields and the local CCG's to tender a single contract solution that can provide our patients with access to transport in a standardised approach across the local health network to ensure national eligibility criteria standards are consistently applied from trust to trust. The contract will be mobilised over the coming months, with Whittington going live on the 1st September.

2.11 Over the last eight months, the Trust's estates team have been working with the community dental leadership to realise a new dental facility in Hillingdon, located in central Uxbridge. The new facility opened to patients on 17 June.

2.12 The work around our longer term estates strategy continues, with various events being held with stakeholders, councillors, community groups, residents (supported by HealthWatch Islington, and Bridge Renewal Trust), and staff, to discuss our emerging priorities: new maternity and neonates buildings; improved staff accommodation; partnership in community settings; improving community children's estate; reconfiguring the Archway site to develop a health campus; and improving emergency and urgent care facilities.

New Executive Medical Director and Responsible Officer

2.13 The Trust Board extends a warm welcome to Dr Clare Dollery, our new Executive Medical Director and Responsible Officer for doctors' revalidation. Clare started on 10 June and joins us from Oxford University Hospitals NHS Foundation Trust.

Orthopaedics

2.14 The Trust is working closely with University College London Hospitals NHS Foundation Trust (UCLH) on a joint bid to host the southern hub of North Central London orthopaedics. The aim is to create a single centre of excellence across the two sites. Evidence shows that co-locating elective inpatient cases on one site with day-cases provided locally will improve outcomes and reduce cancellations for patients. Working together as a single unit will also create improvements in the ways of working as we learn from each other. The case for change is on the NCL partners in health website.

Integrated care systems

2.15 There was a great launch event in the Platform Centre this month for North Islington Locality Working, where Trust staff took part in a 'marketplace' event for services in North Islington with colleagues in the council, GPs and voluntary sector. Staff highlighted the support they provided for local people through services such as community respiratory; heart failure diabetes, district nursing, community rehabilitation, podiatry and musculoskeletal services.

Learning disability week

2.16 Learning disability week took place from 17 to 23 June with a focus this year on getting people involved in inclusive sporting activities in local communities. Trust staff took part in a range of activities, including:

- Specialist Speech and Language therapists running an introductory Makaton session
- highlighting Hospital Passports across departments to raise the profile of patients with a learning disability
- celebrating learning disability week and helping to raise awareness in partnership with colleagues from both the Haringey and Islington Learning Disability Teams, and third sector bodies - Centre 404 & the Elfrida Society

- promoting the learning disability Liaison role in Whittington Health at an event held by Middlesex Cricket Club at Highbury Fields

Healthcare People Management Association rising star award

2.17 Mala Shaunak, Organisational Development Practitioner, has been given a Guardian Rising Star Award at the annual Healthcare People Management Association Awards. Mala has been doing fantastic work in the organisational development team, including organising the masterclass on compassionate leadership with Professor Michael West last month.

2019 staff awards

2.18 Following on from the success of last year's event, the 2019 Awards will be held once again at the Royal College of Physicians on the evening of Thursday, 12 September. This year there are 12 categories open for nomination including a new category for 2019 designed to recognise the person who has done most to help us to deliver a compassionate and inclusive culture - the Caring for those Who Care Award.

Annual General Meeting

2.19 Whittington Health will hold its 2019 annual general meeting (AGM) on Wednesday, 26 September at the Whittington Education Centre at the hospital site. Residents, patients, carers and staff are encouraged to attend. The AGM will reflect on a busy 12 months and look forward to showcase work we are doing to integrate services for local people.

Staff excellence awards - Eileen Willis and Louis Menson Evans

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

- After 27 years of dedicated service in the Trust's Executive Office supporting a number of Chief Executives and Chairs, Eileen Willis retired on Friday 14 June. She displayed a huge amount of professionalism, caring and was dedicated to delivering a first class service to all she came into contact with and will be sorely missed by colleagues
- The nomination for Louis Menson Evans, Tuberculosis Clinical Support Worker, explained that he goes the extra mile for patients and staff. He sees solutions to problems and makes things happen with a positive, upbeat attitude. Louis is kind and compassionate to patients and flexible in the ways he can help facilitate a smooth and efficient patient journey. He is welcoming to new staff, enthusiastic and helpful and is such an asset to the Tuberculosis team and deserves recognition for transforming his role into facilitating a 'yes' service. Louise always puts patient care first and shows that no task is too difficult whilst remaining enthusiastic and positive – he is a great example

Meeting title	**Trust Board - public meeting**	**Date: 26 June 2019**
Report title	**Eliminating Mixed Gender Hospital Inpatient Accommodation Statement of Assurance 2019-2020**	**Agenda item: 7**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Patient Experience	
Report author	Breeda McManus, Deputy Chief Nurse	
Executive summary	This paper provides a statement of assurance that patients who require inpatient/day case care are cared for in single gender accommodation. Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. We are committed to providing every patient with same gender accommodation to help safeguard their privacy and dignity when they are often at their most vulnerable. Patients who are admitted to hospital will only share the room or ward bay where they sleep, with members of the same gender, and same gender toilets and bathrooms will be close to their bed area. There are some exceptions to this. Sharing with people of the opposite gender will happen sometimes. This will only happen by exception and will be based on clinical need in areas such as intensive/critical care units, emergency care areas and some high observation bays. In these instances, every effort will be made to rectify the situation as soon as is reasonably practicable and staff will take extra care to ensure that the privacy and dignity of patients and service users is maintained.	
Purpose:	To review and approve this paper.	
Recommendation(s)	The Board of Directors is asked to agree that: i. the statement of assurance is agreed by the Trust Board and then published onto the Trust Internet and Intranet; and ii. any monthly reporting of breaches is contained within the Trust Board Performance report, as reported to commissioners.	
Risk Register or Board Assurance Framework (BAF)	Board Assurance Framework risk 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	The information in this report is presented at the relevant Committee of the Board (Trust Board Performance Report, Quality, Audit & Risk)	
Appendices	None	

Eliminating Mixed Gender Hospital Inpatient Accommodation Statement of Assurance 2019-2020

1. Introduction

1.1 Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Whittington Health NHS Trust is committed to providing every patient with same gender accommodation because it helps to safeguard their privacy and dignity when they are often at their most vulnerable. Patients who are admitted to hospital will only share the room or ward bay where they sleep, with members of the same gender, and same gender toilets and bathrooms will be close to their bed area. Sharing with members of another gender will only happen by exception based on clinical need (for example where patients need specialist care or equipment is needed such as in the high dependency cardiac care unit (Montuschi Ward) and critical care unit or when patients choose to share for instance in chemotherapy or thalassaemia unit) or through agreement between staff and patient based on patient dignity.

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

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

2. What does this mean for patients?

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

- The ward bed bay will only have patients of the same gender
- The toilet and bathroom will be just one gender, and will be close to the bed area
- It is possible that there will be patients of different genders on the same ward but they will not share the sleeping area. Patients may have to cross a ward corridor to reach the bathroom, but patients will not have to walk through differently gendered areas
- Patients may share some communal space, such as day rooms or dining rooms, and it is very likely that they will see patients of other genders as they move around the hospital (e.g. on way to X-ray or the operating theatre)
- It is probable that visitors of another gender will come into the ward or bay this may include patients visiting each other
- It is almost certain that nurses, doctors and other staff of all genders will care for patients
- If personal assistance is required (e.g. hoist or adapted bath) then patients may be taken to a "unisex" bathroom used by people of all genders, but a member of staff will be with the patient, and other patients will not be in the bathroom at the same time
- Patients who have undergone or are undergoing a process of gender transition (trans patients) will be accommodated in the bay appropriate for the gender they are currently living in, there will be no requirement to show legal recognition in this gender

- Where there is reason to believe that a Trans patient may be more comfortable being accommodated with patients of another gender or in a side room, this will be discussed with them privately and an agreement arrived at between patient and staff. Knowledge of a patient's history of transition will not automatically lead to this question being raised where there would otherwise be no question over where a patient should be accommodated
- Patients who do not identify as male or as female will necessarily not be accommodated with other patients of the same gender or alone, but will be accommodated with either male or female patients as based on agreement between the patient and staff
- Where a patient is unable to contribute to the decision being made about their accommodation, the advice of family or carers will be sought where possible, and a decision made based on available indicators (name, manner of dress, etc.) where advice is not available, until such time as the patient can contribute to the decision being made.

3. Statement of assurance

3.1 The Whittington will not turn patients away just because a "right-gender" bed is not immediately available.

3.2 The Board is committed to on-going delivery of single gender accommodation.

3.3 To ensure that there is an on-going process in place to measure patient experience of single gender accommodation performance is provided to the Trust Board (contained within the Integrated Performance Report).

3.4 For people who sleep in shared spaces with people of the same sex, Trust staff will do everything possible to ensure dignity and privacy.

3.5 To ensure there is a process to track other mechanisms for determining patient experience of single gender accommodation, e.g. through patient complaints/comments from PALs.

3.6 Episodes of mixed gender accommodation breaches for non-clinical reasons will be reported to the Clinical Commissioning Group (CCG) through monthly performance reports and reviewed at contract meetings as required (Whittington Health Clinical Quality Review Meeting).

3.7 To provide information leaflets for patients on single gender accommodation and ensure they are used by staff in discussions with patient.

3.8 Delivery of single gender accommodation will always be considered when planning any new or refurbished estate development scheme.

3.9 If our care should fall short of the required standard, we will report it.

3.10 We have an internal monitoring process to ensure we do not misclassify any of our reports.

3.11 We will publish results alongside this declaration each month.

3.12 Where there are rare occurrences of gender mixing for non-clinical reasons, a process exists to investigate the reason and take remedial actions as required to prevent future occurrence (reported as clinical incidents).

3.13 The relevant Trust policies will refer to requirement to delivering single gender.

3.14 The Trust believes that delivering single gender accommodation should be the norm. Mixing will only occur by exception for reasons of clinical justification or patient choice.

3.15 If mixing does occur, staff will attempt to rectify the situation as soon as possible, whilst safeguarding the patient's dignity and keeping the patient informed about why the situation occurred and what is being done to address it (with an indication of how long this will take).

3.16 Issues of privacy/dignity and single gender accommodation are included in mandatory staff training and induction and the trust provides training to support the elimination of mixed gender accommodation and to promote the protection of privacy and dignity.

4. Recommendations

4.1 The Board of Directors is asked to agree that:

(i) the statement of assurance is agreed by the Trust Board and then published onto the Trust Internet and Intranet; and

(ii) any monthly reporting of breaches is contained within the Trust Board Integrated Performance report and reported to commissioners.

Meeting title	**Trust Board – public meeting**	**Date: 26 June 2019**
Report title	**Serious Incidents update – June 2019**	**Agenda item: 8**
Executive director lead	Clare Dollery, 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 May 2019. It 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.	
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 root cause analysis investigations.	
Report history	Report presented at each Public Board meeting	
Appendices	None	

Serious Incidents: June 2019 report

1. Introduction

1.1 This report provides an overview of serious incidents submitted externally via Strategic Executive Information System (StEIS) during May 2019 and 2 Never Events occurring in June are reported by exception. 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, 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 for a serious incident (as described within the NHS England Serious Incident Framework, March 2015).

3. Serious Incidents

3.1 The Trust declared one serious incident during May 2019; bring the total of reportable serious incidents to five since 1 April 2019. This incident has also been declared as a Never Event.

Table 1: Serious Incidents declared since the last report

Category	Month declared	Summary
Wrong site surgical procedure –Never Event Ref:11437	May 19	A patient received a paravertebral analgesic nerve block on the unintended side.
Wrong implant/prosthesis – Never Event Ref:12724	June 19 Reported by exception	This incident was identified as part of a systematic review following the national Patient Safety Alert NHS/PSA/D/2019/001. A patient had a reconstruction plate fitted instead of a dynamic compression plate (DCP) whilst undergoing surgery in January 2019 for a forearm fracture following a traumatic injury. Healing has been good and no further intervention is expected to be needed.
Wrong implant/ prosthesis– Never Event Ref:12735	June 19 Reported by exception	This incident was identified as part of a systematic review following the national Patient Safety Alert NHS/PSA/D/2019/001. A patient underwent surgery in March 2018 after a fall

Category	Month declared	Summary
		at home causing a forearm fracture. A reconstruction plate was fitted instead of a DCP. Healing has been good and no further intervention is expected to be needed.

Never Events

3.2 Never Events occurring in the NHS are defined as "serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers."

3.3 Never Events have the potential to cause serious patient harm or death but this does not necessarily need to have occurred to be categorised as a Never Event.

3.4 All Never Event incidents require a full root cause analysis investigation, it is important regardless of the outcome that the problems in care are identified and analysed to help understand how and why they occurred, so that effective and targeted action can be taken to prevent recurrence. It is crucial that learning from these incidents are identified and shared to prevent any future harm to patients.

3.5 All serious incidents/Never Events 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).

3.6 All serious incidents/Never Events are uploaded to the National Reporting and Learning Service (NRLS) in line with National Guidance and CQC statutory notification requirements.

3.7 The Trust this year has declared three Never Events all of which are under investigation. Immediate actions have been taken to prevent repetition.

3.8 **Wrong site surgical procedure**, where a patient received a paravertebral analgesic nerve block on the wrong side. The patient was not seriously harmed by this and therefore it was deemed to be a low harm incident.

3.8.1 The immediate actions following this incident are:

- The Royal College of Anaesthetists Guideline 'Stop before you block' is being embedded into clinical practice which includes an additional stop moment in addition to the WHO checklist, so immediately before needle insertion when performing a nerve block the anaesthetist and anaesthetic assistant must recheck the surgical site mark of the site and side of the block.
- 'Stop before you block' posters have been put up in theatres as a reminder to staff.
- Labels are being used to enable staff to document the performance of the 'Stop Before You Block'
- An audit of the stop before you block process is being undertaken to ensure compliance.

- A meeting was held with theatre staff (Anaesthetists, Anaesthetic nurses and outpatient department practitioners to discuss this incident and the lessons learned.
- The wrong-side block was included in the 'Big 4', which is a weekly message containing the 4 most important things that colleagues need to know about within the theatre complex.
- The learning from this incident was included in our spotlight on safety newsletter that is circulated to all staff via our communications department and available on our Staff Intranet Site.

3.9 **Wrong implant/prosthesis.** These **i**ncidents were highlighted following a national Patient Safety Alert - wrong selection of orthopaedic fracture fixation plates (NHS/PSA/D/2019/001) - issued by NHS Improvement in February 2019. In response to this alert the Trust Trauma and Orthopaedic team carried out a review of 287 radiographs for patients who underwent fixation of fractures with plates in the year following 01/02/2018. Two cases were identified where the unintended fixation plates were used one in January 2019 (last financial year) and one in March 2018 (FY 2017/18).

3.9.1 One further incident was identified where the initial surgery using the wrong fixation plates took place at another Trust, however follow-up care was given at The Whittington where it was found the surgery had been unsuccessful and a further operation was required to insert the correct plate. This has been communicated to the Surgical and Executive Team at the relevant Trust.

3.9.2 <u>Immediate actions following detection of this incident.</u>

- Reconstruction plates are rarely used, however education regarding the difference between reconstruction and dynamic compression plates need to be highlighted and care taken when using either plate to ensure the appropriate one is utilised. Training is provided annually by the company who make the fixation plates. An additional session is being arranged to allow all T&O staff to become familiar with the plates.
- Reconstruction fracture plates are clearly labelled and now stored separately. All reconstruction plates were removed from the small fragment sets and will be packed into a dedicated reconstruction plate set. Sterile services are to provide tags to allow the team to send them for sterilisation (labels are awaiting delivery currently).
- Communication regarding the removal of the reconstruction plates from the small fragment sets was included in the BIG 4 (communication tool within Theatres) to inform all surgical staff of the change.
- The safety alerts, incidents and all learning is to be disseminated within the surgery team to prevent future incidents occurring.
- Further communication will be circulated to the team when changes are fully implemented.

Table 2: Other serious incidents currently under investigation

Category	Month declared	Summary
Unexpected admission to NICU Ref:30069	December 2018	A baby born in poor condition at 38 weeks and two days gestation and required resuscitation and ventilation. The baby was transferred to the tertiary

Category	Month declared	Summary
		neonatal unit for total body cooling (HSIB Investigation – clock stop for completion date).
Intrauterine death Ref: 3556	February 2019	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 (Healthcare Safety Investigation Branch-HSIB Investigation – clock stop for completion date).
Maternal death Ref: 5255	March 2019	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 2019	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 2019	A mental health patient became agitated and tense and proceeded to randomly attack staff in the ED department.
Delayed surgical intervention Ref:9259	April 2019	A patient who had recurrent breast cancer after two breast conserving operations and radiotherapy treatments required further surgical intervention (mastectomy); the patient declined initially. An agreed different procedure was carried out resulting in the patient having to return for a third surgical operation.
Pressure ulcer Ref:9470	April 2019	A community patient developed multiple pressure ulcers and sepsis resulting in patient having to be admitted to hospital.

Table 3: Serious incidents by category reported to the NELCSU between April 2016 and May 2019

SI 2019-20 Category	2016/17 Total	2017/18 Total	2018/19 Total		Apr 19	May 19	Total 19/20 YTD
Safeguarding	5	1	1		0	0	0
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	0	0		0	0	0
Confidential information leak/information governance breach	6	3	4		0	0	0
Diagnostic Incident including delay	8	7	7		1	0	1
Disruptive/ aggressive/violent behaviour	0	1	1		1	0	1
Environment Incident meeting SI criteria	0	1	0		0	0	0

Failure to source a tier 4 bed for a child	1	0	0		0	0	0
Failure to meet expected target (12 hr trolley breach)	1	0	0		0	0	0
HCAI/Infection control incident meeting SI	0	3	0		0	0	0
Maternity/Obstetric incident mother and baby (includes foetus	7	2	8		0	0	0
Maternity/Obstetric incident mother only	2	1	0		0	0	0
Medical equipment/devices/ disposables incident meeting SI	1	0	0		0	0	0
Medication Incident	0	1	1		0	0	0
Nasogastric tube	1	0	0		0	0	0
Pressure ulcer meeting SI criteria	0	0	1		2	0	2
Slip/Trips/Falls	7	6	2		0	0	0
Sub Optimal Care	4	2	1		0	0	0
Surgical/invasive procedure incident meeting SI criteria	0	0	2		0	1	1
Treatment Delay	3	4	2		0	0	0
Unexpected death	10	4	2		0	0	0
Retained foreign object	1	1	0		0	0	0
HCAI\Infection Control Incident	0	1	0		0	0	0
Total	**58**	**38**	**32**		**4**	**1**	**5**

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 May 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 one report to NELCSU during May 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.

Table 4: summary of lessons learnt and actions put in place relating to a selection of the serious incident investigation reports submitted to NELCSU

Summary	Actions taken as result of lessons learnt include:
Ref:28441	**Absconded Patient.** A patient under section absconded from a ward whilst staff were attending to another patient. The patient has not been located to date. • The Mental Health Liaison Team (MHLT) will clearly document the level of observation required at each review, as per guidance from NHSI Enhanced Care. • Patients under a mental health (MH) section will be discussed in the daily bed meetings at 08:30 and will stipulate the level of enhanced care required (i.e. 1:1 with health care assistant or mental health nurse). If 1:1 not in place local escalation procedures will be followed. This will be audited to ensure compliance. • Additional Mental Health training sessions are being arranged by Camden and Islington NHS Foundation Trust (C&I) to support and educate ward nurses on legality of MH sections and how best to support and interact with patients. • Whittington Health to audit compliance of the Enhanced Care project. This is the implementation of a new Enhanced Nursing care team (specialist team) proving therapeutic intervention to patients, reducing risk and maintaining their overall safety. • Whittington Health will audit compliance of ensuring nursing care plans are implemented and updated by the MH team, clearly stating which interventions are required to be in place to support the patient (under MH section and Deprivation of liberty safeguards (DOLS)). The interventions should clearly support the risk assessments advised by the MH team to ensure safety to the patient. • Whittington health will share with C&I the link for translated leaflets relating to information about Mental Health.

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.

6.6 Themes from serious incidents are captured in quarterly aggregated learning reports and an annual review, outlining areas of good practice and areas for improvement and trust wide learning.

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

7 Recommendation

7.1 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.

Meeting title	**Trust Board – public meeting**	**Date: 26 June 2019**
Report title	**Review of Trust Heatwave Plan**	**Agenda item: 9**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Lee Smith, Emergency Planning Officer	
Executive summary	The Trust's heatwave plan has been reviewed and updated as follows: 1) an update to references in relation to Heatwave Plan for England; 2) the addition of a "training slide set" for Service Managers/Senior Nurses to have oversight of heatwave escalation process; 3) the inclusion of an information link in references in relation to Ramadan Health Guide 4) the addition on page 16 addition of the Emergency Planning Liaison Officer (EPLO) and the Accountable Emergency Officer (AEO).	
Purpose:	Approval	
Recommendation(s)	Board members are asked to approve the updated heatwave plan	
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	Emergency Planning Steering Committee, 11 June 2019	
Appendices	None	

Whittington Health NHS

Heatwave Plan

Version and Date	5.6 01 June 2019
Valid Until	01 June 2020
Status	Live Document (1 June -15 September)
Document Purpose	This plan has been developed to ensure that the Acute and Community Services of the Trust is capable of responding to Heatwave.
Related Document	Major Incident Plan and Mass Casualty Plan Business Continuity Plan, Flu Pandemic Plan, Risk Management Policy, Fire Safety Policy.
Accountable Director	Carol Gillen Chief Operating Officer
Author	Lee Smith Emergency Planning Officer

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Distribution List

In order to comply with the requirements of being a category 1 responder under the terms of the Civil Contingencies Act 2004 the Trust has a responsibility to share its plans with partner agencies.

Internal Distribution List

Department /Role	Format
Major Incident Control Room Cupboard	Hard copy
Whittington Health Intranet Policies folder	Electronic copy
Silver and Gold dropbox	Electronic
Silver & Gold handbook (shared 'I'drive)	Electronic

External Distribution List

Organisation	Format
London Ambulance Service	Electronic Copy
NHS England (London Region)	Electronic Copy
London Borough of Islington	Electronic Copy
London Borough of Haringey	Electronic Copy

Amendment Record

No unauthorised amendments permitted.

This plan is a living document and is under constant review. A record of amendments follows any comments or suggestions for future versions are appreciated and should be directed to the Emergency Planning and Business Continuity Officer.

Change History			
version	**Date**	**Author/Editor**	**Details of Change**
22/10/08	1.0		Document created
22/03/09	2.0		Refreshed document for summer 2009 to take into account updated guidance
22/04/10	3.0		Updated to include revised national guidance from DoH Heatwave Plan
22/01/11	4.0	Mathew Boazman	Annual refresh and approval
1/10/11	5.0	Mathew Boazman	Integrated plan for ICO finalised following NHS Assurance process feedback
18/06/13	5.1	Rebecca Blake	Annual update reference to Heatwave Plan for England 2013
20/05/14	5.2	Rebecca Allsopp	Annual update reference to Heatwave Plan for England 2014
03/07/15	5.3	Lee Smith	Annual update reference to Heatwave Plan for England 2015
24/06/16	5.4	Lee Smith	Annual update reference to Heatwave Plan for England
07/04/17	5.5	Lee Smith	Annual update reference to Heatwave Plan for England
22/06/18	5.6	Lee Smith	Annual update reference to Heatwave Plan for England

24/05/2019	5.7	Lee Smith	Annual update reference to Heatwave Plan for England

1. INTRODUCTION

The Heatwave Plan for England is published by Public health England and sets out the responses required of health services and local authorities in the event of a heatwave. This plan acknowledged that climate change is becoming a serious threat to the population's health and that heatwaves are likely to become more common in England.

2. PURPOSE

The Heatwave Plan for Whittington Health NHS Trust outlines how we will work with local partners to ensure health and social care services raise awareness of the risks relating to severe hot weather and prepare organisations and individuals (especially vulnerable groups) to help reduce those risks.

Whittington Health recognise that proper preparedness is essential as in contrast to deaths associated with cold weather, the rise in mortality during a heatwave occurs very quickly – within one or two days of the temperature rising. This means that by the time a heatwave starts the window of opportunity for effective action is very short, and proper preparedness is therefore essential.

The **Department of Health and Social Care (DHSC)** is responsible for strategic leadership of both health and social care systems, but no longer has direct management of most NHS systems. **NHS England and NHS Improvement** provides national leadership for improving health care outcomes, directly commissions general practice services, some specialist services, and oversees **Clinical Commissioning Groups (CCGs)**. CCGs now commission planned hospital care, rehabilitative care, urgent and emergency care, most community health services and mental health and learning disability services. **Directors of Public Health** in Local Authorities are responsible for population health outcomes, supported by **Public Health England (PHE),** which provides national leadership and expert services to support public health.

PHE will make advice available to the public and health and social care professionals in affected regions, in preparation for an imminent heatwave, via NHS Choices, and the websites of the Met Office, PHE and the DH.

NHS Choices www.nhs.uk continues to provide reliable advice and guidance throughout the year on how to keep fit and well. It includes information on how to stay well in hot weather www.nhs.uk/summerhealth .

3. SUPPORTING DOCUMENTATION

As in previous years, the Heatwave Plan for England is also supported by a series of Information Guides published online which aim to provide an authoritative source of additional information about the effects of severe hot weather on health for:

- Making the case: the impact of heat on health now and in the future
- Looking After Yourself And Others During Hot Weather (for Individuals, families and carers);
- Supporting Vulnerable People before and during a Heatwave: Advice for Health and Social Care Professionals;
- Supporting Vulnerable People Before and During a Heatwave: Advice for Care Home Managers and Staff.

- ‘Beat the Heat’ poster: an infographic for the public with key advice for staying safe in hot weather
- ‘Beat the Heat’ poster: detailed information for the public about how to stay safe in hot weather
- ‘Beat the heat’: keep cool at home-checklist’: a checklist to help people identify situations where overheating in the home may cause harm to health, the actions to take, and how to access further help and support. This resource is aimed at members of the public as well as frontline workers (for example, health and social care staff)
- ‘Beat the heat’: keep care home residents safe and well
- Looking after children and those in early years settings during heatwaves: guidance for teachers and professionals
- **Training Slide Set** : https://app.box.com/s/60l0vg2qqlhq8ofjekwussphz1vvfexd

These supporting documents have also been updated to reflect the changing responsibilities as a result of the Health and Social Care Act (2012).

These can be found at: https://www.gov.uk/government/publications/heatwave-plan-for-england

4. BACKGROUND

The evidence about the risks to health from heatwave is extensive and consistent from around the world. Excessive exposure to high temperatures can kill. During the summer heatwave in Northern France in August 2003, unprecedentedly high day- and night-time temperatures for a period of three weeks resulted in 15,000 excess deaths. The vast majority of these were among older people.

In England that year, there were over 2,000 excess deaths over the 10 day heatwave period which lasted from 4 – 13 August 2003, compared to the previous five years over the same period.

The first Heatwave Plan for England was published in 2004 in response to this event. Since that time we have had a significant heatwave in 2006 (when it was estimated that there were about 680 excess deaths compared to similar periods in previous years). In 2009 there were approximately 300 excess summer deaths during a heatwave compared to similar periods in previous years.

Climate change means that heatwaves are likely to become more common in England. By the 2080s, it is predicted that an event similar to that experienced in England in 2003 will happen every year.

In Northern France in August 2003, unprecedentedly high day and night time temperatures for a period of three weeks resulted in 15,000 excess deaths. The vast majority of these were among older people.

Excess deaths are not just deaths of those who would have died anyway in the next few weeks or months due to illness or old age. There is strong evidence that these summer deaths are indeed ‘extra’ and are the result of heat related conditions.

Cities and urban areas tend to be hotter than rural areas, creating urban heat island effects. This is due to increased absorption and reflection of the sun on concrete compared with green or brown spaces; reduced cooling from breezes due to buildings and increased energy production from houses, industry, businesses and vehicles.

5. HEAT- HEALTH ALERT LEVEL SYSTEM

The Heat-Health Watch system operates in England from 1 June to 15 September each year. During this period, the **Met Office** may forecast heatwaves, as defined by forecasts of day and night time temperatures and their duration.

These vary from region to region but for **London** the threshold temperatures are **32 ºC (day time)** and **18 ºC (night time)** for a period of 3 or more continuous days.

The Heat-Health Watch system comprises of five main levels (Levels 0-4), which are outlined in Figure 1 below;

Figure 1: Heatwave Alert Levels

Level 0	**Long – term planning** *All year* Includes year round joint working to reduce the impact of climate change and ensure maximum adaptation to reduce harm from heat waves. This involves urban planning to keep housing, workplaces, transport systems and the built environment cool and energy efficient.
Level 1	**Heatwave and Summer Preparedness Programme** *1 June – 15 September* The heat wave plan will remain at level 1 unless a higher alter is triggered. During the summer months, social and healthcare services need to ensure that awareness and background preparedness are maintained by implementing the measures set out in the heatwave plan.
Level 2	**Heatwave is forecast – Alert and readiness** *60% risk of heatwave in the next 2-3 days* This is triggered as soon as the Met Office forecasts that there is a 60 per cent chance of temperatures being high enough on at least two consecutive days to have significant effects on health. This will normally occur 2–3 days before the event is expected. As death rates rise soon after temperature increases, with many deaths occurring in the first two days, this is an important stage to ensure readiness and swift action to reduce harm from a potential heatwave.
Level 3	**Heatwave Action** *Temperature reached in one or more Met Office National Severe Weather Warning Service Regions* This is triggered as soon as the Met Office confirms that threshold temperatures have been reached in any one region or more. This stage requires specific actions targeted at high risk groups.
Level 4	**Major Incident – Emergency Response** *Central Government will declare a level 4 alert n the event of severe or prolonged heatwave affecting sectors other than health* This is reached when a heatwave is so severe and/or prolonged that its effects extend outside health and social care, such as power or water shortages, and/or where the integrity of health and social care systems is threatened. At this level, illness and death may occur among the fit and healthy, and not just in high risk groups and will require a multi-sector response at national and regional levels.

6. HIGH RISK FACTORS

There are certain factors that increase an individual's risk during a heatwave. These include:

- Older age: especially women over 75 years old, or those living on their own who are socially isolated, or in a care home.
- Chronic and severe illness: including heart conditions, diabetes, respiratory or renal insufficiency, Parkinson's disease or severe mental illness. Medications that

potentially affect renal function, the body's ability to sweat, thermoregulation or electrolyte balance can make this group more vulnerable to the effects of heat.
- Inability to adapt behaviour to keep cool: having Alzheimer's, a disability, being bed bound too much alcohol, babies and the very young.
- Environmental factors and overexposure: living in urban areas and south facing top floor flats, being homeless, activities or jobs that are in hot places or outdoors and include high levels of physical exertion

7. MET OFFICE HEATWAVE WARNINGS

Figure 2 below summarises the Met Office service and notifications during a heatwave period for the summer of 2014.

Figure 2: Met Office service and notifications

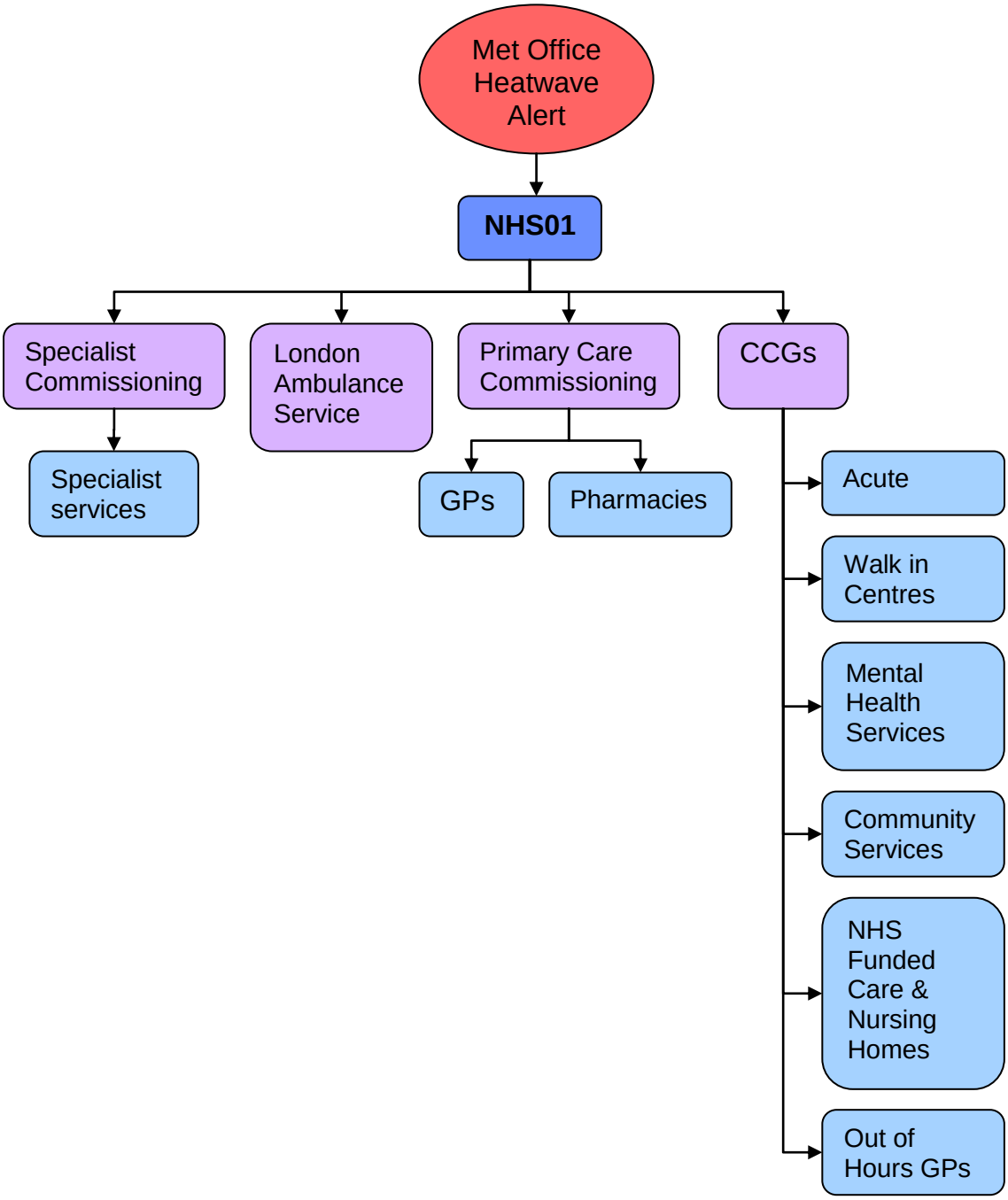
Service	Purpose	Distribution	Timing
Heatwave Warning	To provide early warning of high temperatures. The alert levels have been set with thresholds known to cause ill health from severe hot weather. They are to help ensure that healthcare staff and resources are fully prepared for hot weather periods that might impact and to raise awareness for those individuals whoa re more vulnerable to hot weather conditions	Email	Alert issued as soon as agreed threshold has been reached and when there is a change in alert level. Issued between 1 June and 15 September.
Heatwave Planning Advice	To probed advice through the summer period relating to high temperatures	Email	Twice a week (9am each Monday and Friday from 1 June to 15 September)
National Severe Weather Warning Service (NSWWS)	To provide warnings of sever or hazardous weather that has the potential to cause danger to life or widespread disruption. These warnings are issues to: • The public – to promote consideration of actions they may need to take • Emergency responders – to trigger their plans to protect the public from impacts in advance of an event, and to help them recover from any impacts after the event.	Email, web, SMS. TV, radio	When required
General Weather Forecasts	To enable the public to make informed decisions about their day to day activities	Web, TV, radio	Every day

8. ALERTING CASCADE

The response to a heatwave will be governed by the actions needed at each of the four alert actions. The Met Office will cascade a Heatwave alert to all Heat-Health Watch organisations.

The alerting cascade for London is shown in figure 3 and internally within Whittington Health seen in 8.1.

Figure 3: London Alerting Cascade



The alert levels will act as triggers for initiating internal organisational response arrangements. NHS England will request assurance from organisations as to the impact and mitigation in place during periods of sustained heatwave response at any alerting level.

In the event of a Level 4 heat-health alert being issued:

- A pager message will be cascaded to all NHS organisations directors on call via the paging system.

The pager message will read as follows:

RED from NHS01: Level 4 Heatwave – National; Emergency Declared. Confirm email address to receive further instructions to england.london-incident@nhs.net
NHS England will initiate command and control arrangements across London, and establish a reporting rhythm for situational reporting on the impacts of the incident on health organisations.

8.1 Whittington Health Alerting Cascade

Whittington Health NHS Trust receives heatwave alerts through the Emergency Planning Officer, who upon receipt of a will cascade it to all on call personnel.

Who will upon receipt of a heatwave alert will ensure the information is cascaded within their directorate/ department and in the absence of the Emergency Planning Officer, heatwave alerts will be cascaded by the Clinical Site Team.

Out of Hours this will be cascaded by the Clinical Site Team.

9. WHITTINGTON HEALTH ACTIONS

This section details the Trust responsibilities for responding at each of the levels of the Heat - Health Watch Alert System.

LEVEL 0 **LONG-TERM PLANNING**		
Includes year round joint working to reduce the impact of climate change and ensure maximum adaptation to reduce harm from heat waves. This involves urban planning to keep housing, workplaces, transport systems and the built environment cool and energy efficient.		
	Action	**Responsibility**
1	Develop systems to identify and improve resilience of high-risk individuals	
	Request an HHSRS assessment from EH for clients at particular risk.	District Nurses / health visitors
2	Encourage cycling / walking where possible to reduce heat levels and poor air quality in urban areas.	
3	Work with commissioners to develop longer term plans to prepare for heatwaves	
4	Make environmental improvements to provide a safe environment for clients in the event of a heatwave	
5	Prepare business continuity plans to cover the vent of a heatwave (e.g. storage of medicines, computer resilience, etc)	All
6	Work with partners and staff to raise awareness of the impacts of sever heat and on risk reduction awareness	EPLO
High Risk Groups **Community:** over 75, female, living on own and isolated, sever physical or mental illness; urban area, south facing top flat; alcohol and /or drug dependency, homelessness, babies and young children, multiple medications and over exertion **Care home or hospital:** over 75, female, frail, severe physical or mental illness; multiple medications, babies and young children (hospitals)		
*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions. ** Level 4: A *decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat*		

LEVEL 1 HEATWAVE AND SUMMER PREPAREDNESS PROGRAMME		
The heat wave plan will remain at level 1 unless a higher alter is triggered. During the summer months, social and healthcare services need to ensure that awareness and background preparedness are maintained by implementing the measures set out in the heatwave plan.		
	Action	**Responsibility**
1	Ensure public is aware of actions to take to minimise risk during periods of hot weather and likely high risk groups	All
2	Ensure other partners are aware of the Heatwave Plan for England 2019, actions required and public information available	All
3	Distribution of heatwave plan	Emergency Planning Officer
4	Ensure business continuity plans are in place and implement as required.	All
5	Ensure appropriate contact details are provided to Local Authorities /NHS emergency planning officers to facilitate transfer of emergency information.	Emergency Planning Officer
6	Identify individuals who are particular risk from extreme heat, especially those aged over 75 and review their medication and care plans	Community health District Nurses, /Health Visitor/ Midwives/ General Practices and Social Care to identify individuals at risk
7	Working with families and informal carers to highlight dangers of heat and promote ways to keep cool	Community health – District Nurses
8	Where individuals households are identified as being at particular risk from hot weather, request environmental health to do an assessment using the Housing Health and safety Rating System (HHSRS)	Community health in liaison with Social Care
9	Review surge capacity and the need for, and availability of staff support in the event of a heatwave especially if it lasts more than a few days.	Clinical Site Manager, Emergency Department
10	Distribution of Public Health England advice to managers of residential and nursing care homes	Community health in liaison with Social Care
11	Cool rooms or cool areas should be created. Distribution of fans within Whittington Health clinic areas should be managed via the bed management team, Labour Ward and community management leads.	Clinical leads /estate managers
12	Estates to confirm operation of air conditioning units for use during a heatwave, and temperature recording instruments	Estates Managers
13	On receipt of Met office alerts and planning guidance for London region cascade to on call personnel.	**IN HOURS (Monday to Friday 0900-1700:** Emergency Planning Officer **Weekends and Bank Holiday:** Clinical Site Team
High Risk Groups **Community:** over 75, female, living on own and isolated, sever physical or mental illness;		

urban area, south facing top flat; alcohol and /or drug dependency, homelessness, babies and young children, multiple medications and over exertion **Care home or hospital:** over 75, female, frail, severe physical or mental illness; multiple medications, babies and young children (hospitals)
*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions. ** Level 4: A *decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat*

LEVEL 2 HEATWAVE IS FORECAST - ALERT AND READINESS		
This is triggered as soon as the Met Office forecasts that there is a 60 per cent chance of temperatures being high enough on at least two consecutive days to have significant effects on health. This will normally occur 2–3 days before the event is expected. As death rates rise soon after temperature increases, with many deaths occurring in the first two days, this is an important stage to ensure readiness and swift action to reduce harm from a potential heatwave		
	Action	**Responsibility**
1	Cascade Met Office Alert and planning advice to on call personnel	**IN HOURS (Monday to Friday 0900-1700:** Emergency Planning Officer **Weekends and Bank Holiday:** Clinical Site Team
2	Distribution of advice to all those defined as at high risk living at home (key public messages in section 10)	Community Health District Nurses/ Health Visitors / Midwives
3	Call a meeting of Trust colleagues who will become the 'heatwave emergency planning team' to agree key messages and cascade alert briefing through internal and external communications channels - Implement business continuity	Emergency Planning Officer
4	Work with Trust teams and Communications to ensure that independent contractors have guidance leaflet available	Facilitates
5	Initiation of home visits as planned, where appropriate	Community Health District Nurses, /Health Visitor/ Midwives / General Practices to coordinate visiting /phones call to vulnerable patients, where appropriate
6	Prioritise current list of patients at risk	Community Health District Nurses, /Health Visitors / Midwives
7	Determine what non essential activities could cease	District Nurses / Health Visitors / Midwives
8	Make provision for surge capacity	Emergency Department, Clinical Site Managers
9	Ensure cool rooms are ready and consistently at 26°C or below	Estates/Clinical Lead / Matron/ Senior Nurse in Charge/Labour Ward
10	Check that indoor thermometers are in place and recording sheets printed to measure temperature four times a day	Estates/ Clinical Lead / Matron / Senior Nurse in Charge /Labour Ward
11	Identify particularly vulnerable individuals (those with chronic/severe illness, on multiple medications, or who are bed bound) who may be prioritised for time in a cool room	Clinical Lead / Matron / Senior Nurse in Charge
11	Consider weighing clients regularly to identify dehydration and rescheduling physio to cooler hours	Clinical Lead / Matron / Senior Nurse in Charge
13	Monitor staff welfare	Clinical Lead / Matron / Senior Nurse in Charge/ Labour Ward
14	Monitor service level to ensure staffing levels will be sufficient to cover the anticipate heatwave	Clinical Lead / Matron / Senior Nurse in Charge/ locality Managers

	period	/ Midwives
15	Obtain supplies of ice / cool water	Housekeeping/ Clinical Lead / Matron / Senior Nurse in Charge
16	Re-enforce messages on risk and protective measures to staff	Clinical Lead / Matron / Senior Nurse in Charge / Midwives
High Risk Groups **Community:** over 75, female, living on own and isolated, sever physical or mental illness; urban area, south facing top flat; alcohol and /or drug dependency, homelessness, babies and young children, multiple medications and over exertion **Care home or hospital:** over 75, female, frail, severe physical or mental illness; multiple medications, babies and young children (hospitals)		
*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions. ** Level 4: A *decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat*		

LEVEL 3 HEATWAVE ACTION		
This is triggered as soon as the Met Office confirms that threshold temperatures have been reached in any one region or more. This stage requires specific actions targeted at high risk groups.		
	Action	**Responsibility**
1	Cascade of Met Office Alert and planning advice to on call personnel	**IN HOURS (Monday to Friday 0900-1700:** Emergency Planning Officer **Weekends and Bank Holiday:** Clinical Site Team
2	Continue to distribute advice to all those defined as at high risk living at home (key public messages section 10)	Community Health District Nurses/ Health Visitors /Midwives
3	Activate plans to maintain business continuity – including a possible surge in demand	
4	Call a meeting of Trust colleagues to agree key messages and actions and cascade alert briefing through internal and external communications channels	Emergency planning officer with Emergency Management Team
5	Consider use of media to get advice out to the general public	Communications lead
6	Stop non essential activities, commence daily contact with clients at risk	District Nurse / Health Visitors / Midwives
7	Consider where appropriate, daily visits /phone calls for high risk individuals living on their own who have no regular daily contacts. This may involve informal carers, volunteers and care workers and will be targeted at defined risk groups	Community Health District Nurse / Heath Visitors General practices to coordinate visiting /phone call to vulnerable patients, where appropriate
8	Use all available resources to maximise frontline district nurse / health visitor capacity	Community Health
9	District nurses /health visitors /Midwives to make daily contact with clients at risk and provide a situation report to locality manager	Community Health District Nurse / Health Visitors
10	Upon request produce situation reports and forward summary to Emergency Planning Officer for onward report to NHS England / CSU	Locality Managers
11	Discharge planning should reflect local and individuals circumstances so that people at risk are not discharged to unsuitable accommodation or reduced care	
12	Initiation of home visits as planned, where appropriate	Community Health District Nurses, /Health Visitor/ General Practices to coordinate visiting /phones call to vulnerable patients, where appropriate
13	Prioritise current list of patients at risk	Community Health District Nurses, /Health Visitors/Midwives
14	Make provision for surge capacity	Emergency Department, Clinical Site Managers
15	Ensure cool rooms are ready and consistently at 26°C or below	Estates/ Clinical Lead / Matron / Senior Nurse in Charge /Labour Ward

16	Ensure that indoor thermometers are in place and recording sheets printed to measure temperature four times a day for all areas with patients in	Clinical Lead / Matron / Senior Nurse in Charge / Labour Ward
17	Monitor and minimise temperatures in all patient areas and take action if the temperature is a significant risk to patient safety, as high risk patients may suffer undue health effects including worsening cardiovascular or respiratory symptoms at temperatures exceeding 26ºC	Clinical Lead / Matron / Senior Nurse in Charge /Midwives
18	Continually review vulnerable individuals for prioritisation in cool rooms	Clinical Lead / Matron / Senior Nurse in Charge /Midwives
19	Continue to monitor staff welfare	Clinical Lead / Matron / Senior Nurse in Charge /Midwives
20	Continue to monitor service level to ensure staffing levels will be sufficient to cover the anticipated heatwave period	Clinical Lead / Matron / Senior Nurse in Charge/ locality Managers /Midwives
21	Implement appropriate protective factors, including a regular supply of cold drinks	Clinical Lead / Matron / Senior Nurse in Charge/ locality Managers /Midwives
22	Re-enforce messages on risk and protective measures to staff	Clinical Lead / Matron / Senior Nurse in Charge /Midwives
23	Consider moving visit hours to mornings and evenings to reduce afternoon heat from increased numbers of people	Clinical Lead / Matron / Senior Nurse in Charge /Midwives
24	Reduce internal temperatures by turning off unnecessary lights and electrical equipment	Clinical Lead / Matron / Senior Nurse in Charge/ locality Managers /Midwives
High Risk Groups **Community:** over 75, female, living on own and isolated, sever physical or mental illness; urban area, south facing top flat; alcohol and /or drug dependency, homelessness, babies and young children, multiple medications and over exertion **Care home or hospital:** over 75, female, frail, severe physical or mental illness; multiple medications, babies and young children (hospitals)		
*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions. ** Level 4: A *decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat*		

LEVEL 4 MAJOR INCIDENT - EMERGENCY RESPONSE		
This is reached when a heatwave is so severe and/or prolonged that its effects extend outside health and social care, such as power or water shortages, and/or where the integrity of health and social care systems is threatened. At this level, illness and death may occur among the fit and healthy, and not just in high risk Groups and will require a multi-sector response at national and regional levels.		
	Action	**Responsibility**
1	If a major incident is declared implement Major Incident Plan	Chief Executive / Director on Call
2	Coordinate response with NHS Health Partners	EPLO/AEO
3	All level 3 heatwave actions to continue	All
High Risk Groups **Community:** over 75, female, living on own and isolated, sever physical or mental illness; urban area, south facing top flat; alcohol and /or drug dependency, homelessness, babies and young children, multiple medications and over exertion **Care home or hospital:** over 75, female, frail, severe physical or mental illness; multiple medications, babies and young children (hospitals)		
*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions. ** Level 4: A *decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat*		

RECOVERY		
	Action	**Responsibility**
1	Hold a debrief and discuss any learning outcomes produce a report and action plan	EPLO / Emergency planning officer/ key staff
2	Amend the Trust Heat wave plan as necessary	Emergency Planning Officer

10. KEY PUBLIC HEALTH MESSAGES

Stay out of the heat:

- Keep out of the sun between 11.00am and 3.00pm.
- If you have to go out in the heat, walk in the shade, apply sunscreen and wear a hat and light scarf.
- Avoid extreme physical exertion.
- Wear light, loose-fitting cotton clothes.

Cool yourself down:

- Have plenty of cold drinks, and avoid excess alcohol, caffeine and hot drinks.
- Eat cold foods, particularly salads and fruit with high water content.
- Take a cool shower, bath or body wash.
- Sprinkle water over the skin or clothing, or keep a damp cloth on the back of your neck.

Keep your environment cool:

- Keeping your living space cool is especially important for infants, the elderly or those with chronic health conditions or who can't look after themselves
- Place a thermometer in your main living room and bedroom to keep a check on the temperature.
- Keep windows that are exposed to the sun closed during the day, and open windows at night when the temperature has dropped.
- Close curtains that receive morning or afternoon sun. However, care should be taken with metal blinds and dark curtains, as these can absorb heat – consider replacing or putting reflective material in-between them and the window space.
- Turn off non-essential lights and electrical equipment – they generate heat.
- Keep indoor plants and bowls of water in the house as evaporation helps cool the air.
- If possible, move into a cooler room, especially for sleeping.
- Electric fans may provide some relief, if temperatures are below 35°C.

(Longer term)

- Consider putting up external shading outside windows.
- Use pale, reflective external paints.
- Have your loft and cavity walls insulated – this keeps the heat in when it is cold and out when it is hot.
- Grow trees and leafy plants near windows to act as natural air-conditioners (see 'Making the Case')

Look out for others:

- Keep an eye on isolated, elderly, ill or very young people and make sure they are able to keep cool.
- Ensure that babies, children or elderly people are not left alone in stationary cars.
- Check on elderly or sick neighbours, family or friends every day during a heatwave.
- Be alert and call a doctor or social services if someone is unwell or further help is needed.

If you have a health problem:

- Keep medicines below 25 °C or in the refrigerator (read the storage instructions on the packaging).
- Seek medical advice if you are suffering from a chronic medical condition or taking multiple medications.

If you or others feel unwell:

- Try to get help if you feel dizzy, weak, anxious or have intense thirst and headache; move to a cool place as soon as possible and measure your body temperature.
- Drink some water or fruit juice to rehydrate.
- Rest immediately in a cool place if you have painful muscular spasms (particularly in the legs, arms or abdomen, in many cases after sustained exercise during very hot weather), and drink oral rehydration solutions containing electrolytes.
- Medical attention is needed if heat cramps last more than one hour.
- Consult your doctor if you feel unusual symptoms or if symptoms persist

11. FURTHER READING

Public Health England, Heatwave plan for England: *Protecting health and reducing harm from severe heat and heatwaves.* 2019
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/801539/Heatwave_plan_for_England_2019.pdf

Public Health England, Heatwave plan for England: *Making the case: the impact of heat on health- now and in the future.* 2015
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/429572/Heatwave_plan_-Making_the_case_-_2015.pdf

WHO Europe public health advice on preventing health effects of heat:
http://www.euro.who.int/__data/assets/pdf_file/0007/147265/Heat_information_sheet.pdf

Cochrane Review:

http://www.cochrane.org/CD009888/GYNAECA_electric-fans-reducing-health-effects-heatwaves
Beat the heat: staying safe in hot weather (leaflet) 2017:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525358/Beattheheatstayingsafeinhotweather.pdf

Beat the heat (poster) 2016:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525360/Beattheheatposter2016.pdf

Beat the heat: keep cool at home (checklist) 2016:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525361/Beattheheatkeepcoolathomechecklist.pdf

Beat the heat: keep care home residents safe and well 2017:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/615555/Beat_the_heat_care_home_overheating_2017.pdf

Public Health England, Heatwave Plan for England: *Supporting vulnerable people before and during a heatwave- advice for care home managers and staff.* 2015
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/429600/Heatwave-Care_Home_Managers.pdf

NHS: Communities in Action, Ramadan Health Guide: *A Guide to Health Fasting*
http://www.communitiesinaction.org/Ramadan%20Health%20and%20Spirituality%20Guide.pdf

Meeting title	**Trust Board – public meeting**	**Date: 26 June 2019**
Report title	**7 Day Hospital Services Self-Assessment**	**Agenda item: 10**
Executive director lead	Clare Dollery, Executive Medical Director	
Report author	Clare Dollery	
Executive summary	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	
Purpose:	NHS Improvement askes provider Boards to review self-assessment against the 7 Day Services' standards twice a year. This self-assessment is due to be submitted to the central team on 28 June 2019.	
Recommendation(s)	The Trust Board is asked to consider the 7 day hospital services self-assessment at appendix 1, in particular the green-rated performance against clinical standards 2, 5, 6 and 8 and to discuss any required changes.	
Risk Register or Board Assurance Framework	BAF risk entry 3 - Failure to hit national and local performance targets results in low quality care, financial penalties and decommissioning of services – is being reviewed and updated to include the operational performance requirements of 7 day services.	
Report history	None. The requirement is for provider Boards to review self-assessment against the standards twice a year in the spring and autumn	
Appendices	1: Self-assessment template	

7 Day Hospital Services Self-Assessment

Organisation	**The Whittington Hospital NHS Trust**
Year	**2019/20**
Period	**Spring/Summer**

The Whittington Hospital NHS Trust: 7 Day Hospital Services Self-Assessment - Spring/Summer 2019/20

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	This occurs for all emergency admissions including all surgical specilaities, medicine and COOP services, obstetric admisisons and paediatric admissions. The aasurance of this coms from 7DS audits and knowledge of rotas and work patterns and job plans. Some of our non-compliances in audit work has come from failire to document time on admission clerkings and post take ward rounds rather than actual non comliance of patients not being reviewed by a consultant post take.	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	With regards to CT there is access of off site reporting within the timeframes described although the actual scan occurs on site. There is not access to ECHO at the weekends unless a cardiology or trained ITU team member is on call which occurs about 30-40% of the time. THe assurance for this data comes from 7DS audits.	Echocardiography	Yes available on site	No the test is only available on or off site via informal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	Assurance from 7DS audits plus review of clinical pathways as part of Quality imporvement work	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available off site via formal arrangement	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	All patients in our HDU (ITU and NNU) are reviewed twice a day by a senior clinical decision maker. The assurance for this comes from 7DS audits. Previous non-compliances in this area come from non-compliance with recording times or names of senior decision maker rather than non-compliance with twice daily reviews.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10. Clinical standard 1 shared decision making fully compliant (evidence from mortality review audits and other internal audits). Clinical standard 3 MDT involvement fully compliant. Clinical standard 4 partially compliant, currrent issues with reliance on paperwork for handover but moving to electronic solutions within the next 12 months. Clinical standards 7, 9 and 10 fully compliant.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Standards met

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Meeting title	**Trust Board – public meeting**	**Date: 26 June 2019**
Report title	**Integrated performance report**	**Agenda Item: 11**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Hester de Graag, Risk and Quality Manager	
Executive summary	**Areas of performance to draw to Board members' attention:** **Emergency Department (ED) four hours' wait:** Overall performance against the national 95% 4 hour standard for May 2019 was 88.4% (1.6% below NHS Improvement standard of 90%) There were no patients waiting on trolleys in ED for more than 12 hours in May 2019. Data is now split: • 12 hour Trolley Waits – Non Mental Health • 12 hour Trolley Waits – Mental Health **Community Waiting times** A summary for both Children's, Young People and Adult Community Services has now been included on page 17.	
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 People 2	
Report history	Trust Management Group, 25 June 2019	
Appendices	None	

Performance Report

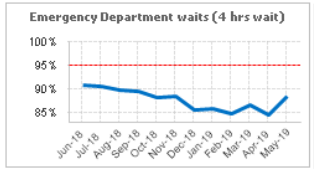
June 2019

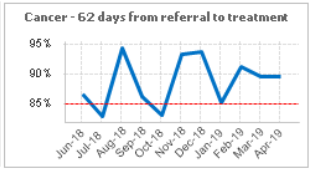
Month 2 (2019 – 2020)

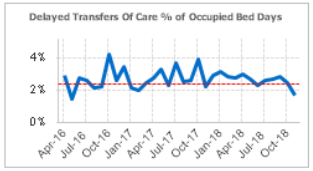
Date of production: 19/06/2019 16:22

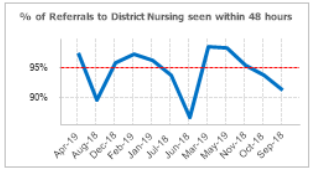
Summary

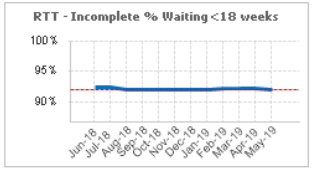
Category	Indicator	17_18 Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	2019-2020	
ED	Emergency Department waits (4 hrs wait)	>95%	90.6%	90.4%	89.8%	89.3%	88.0%	88.5%	85.4%	85.7%	84.6%	86.4%	84.4%	88.4%	86.4%	!
Cancer	Cancer - 14 days to first seen	>93%	94.4%	94.4%	93.1%	90.1%	89.6%	93.7%	97.9%	95.9%	94.8%	96.2%	95.0%		95.0%	
Cancer	Cancer - 62 days from referral to treatment	>85%	86.5%	82.9%	94.2%	86.2%	83.1%	93.3%	93.8%	85.2%	91.1%	89.6%	89.5%		89.5%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.62%	5.89%	6.97%	5.93%	5.42%	4.91%	5.86%	5.48%	5.92%	6.36%	6.39%	5.36%	5.88%	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.3%	2.6%	2.7%	2.8%	2.5%	1.7%	2.0%	4.3%	1.3%	1.3%	1.8%		1.8%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.4%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.1%	92.3%	92.2%	92.1%	92.1%	92.1%	
Outpatients	Outpatients - FFT % Positive	>90%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	90.5%	91.4%	90.8%	
Community	Community - FFT % Positive	>90%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.8%	97.7%	97.3%	
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%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	94.1%	100.0%	95.8%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	86.7%	93.8%	89.7%	91.3%	93.8%	95.6%	95.9%	96.4%	97.4%	98.7%	97.6%	98.4%	98.0%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	92.1%	88.8%	91.1%	91.1%	90.4%	90.5%	90.1%	91.9%	95.2%	94.6%	93.3%		93.3%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	91.3%	98.8%	95.3%	95.6%	93.1%	93.4%	92.8%	95.0%	91.6%	95.0%	95.7%		95.7%	
Staff	Average Time to Hire (Days)	<61 Days										63	65	69	67	!

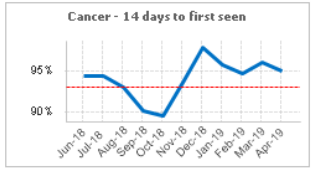


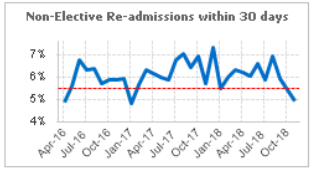


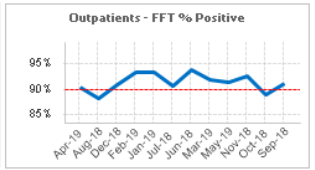












Date of production: 19/06/2019 16:22

Safe | Caring | Effective | Responsive | Well Led

Indicator	19_20 Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-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	0	0	2	2	1	1	3	1	0	0	0	0	0	
Actual Falls	400	33	33	26	28	36	31	35	44	43	34	42	38	80	
Category 3 or 4 Pressure Ulcers	0											7	16	23	
Harm Free Care %	>95%	91.0%	92.6%	92.3%	93.2%	94.5%	92.3%	93.5%	90.1%	91.2%	94.2%	93.5%	90.4%	91.9%	
Non Elective C-Section % Rate	<19%	18.1%	25.9%	19.9%	19.2%	18.8%	21.5%	25.4%	20.1%	22.3%	24.7%	24.0%	22.5%	23.3%	
Medication Errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	1	0	1	
MRSA Bacteraemia Incidences	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
Never Events	0	0	0	0	0	0	1	0	0	0	0	0	3	3	
Proportion of reported Patient Safety Incidents Causing Harm	N/A	16.6%	16.9%	16.6%	17.0%	19.1%	16.7%	21.0%	20.9%	18.4%	22.4%	18.8%	26.0%	22.5%	
Serious Incidents	0	3	1	1	2	2	4	2	1	1	1	4	1	5	
VTE Risk Assessment %	>95%	95.0%	97.2%	96.1%	96.7%	95.2%	96.9%	95.3%	95.3%	95.2%	95.9%	95.3%		95.3%	
Mixed Sex Accomodation Breaches	0	0	0	0	0	1	0	0	2	2	0	0	0	0	
Hospital Standardised Mortality Ratio (HSMR)	100	80.0	102.3	85.8	91.7	68.4	89.3	81.2	78.6						
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 = 13 Category 4 = 3 **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	**Variance against Plan:** Two patient developed Category 3 pressure ulcer within District Nursing Service (DNS) for which care and service delivery issues were identified. One had been receiving regular input from the DNS, the SSKIN checks had not been completed for more than 8 months. A Mental Capacity Assessment (MCA) was not completed when the patient declined equipment. The second patient's holistic skin assessment was not completed. **Action to Recover:** A Trust wide Pressure ulcer governance and monitoring panel will be implemented chaired by Deputy Chief Nurse. To review incidents and ensure actions are taken forward.	**Named Person:** Lead Nurse Tissue Viability Service **Time Scale to Recover Performance:** Work on the trajectory is not yet completed and is expected to be finalised in July 2019
Harm Free Care %: Percentage of patient with no harm on the Safety Thermometer (this includes old and new harm) **Standard:** 95%	**Variance against Plan:** All Harm Free 93%, New Harm Free 97%. **Action to Recover:** 1. New Falls Mandatory training for both corporate induction and mandatory updates will be rolled out in Sept 2019 and will be delivered jointly with Moving and Handling training. A Falls awareness week and relaunch of Baywatch took place on 7/6/19 with a stall in the atrium and toolkits of Stop fall for wards. Audit of all wards is in progress. 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.	**Named Person:** Deputy Chief Nurse Lead Nurse for Safer Staffing **Time Scale to Recover Performance:** 1. May 2019 2. August 2019

	The District nursing teams have introduced a “Day of the week” focus on PUs**.**	
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:** 3.5% **Action to Recover:** Multi-Disciplinary Team meeting to review all non - elective (unplanned) caesareans. The team has met 3 times so far and no immediate concerns have been identified. The reviews will continue. The team will also review the standard set.	**Named Person:** Consultant in Obstetrics and Fetal Medicine **Time Scale to Recover Performance:** Feedback September 2019
Never Events The number of Never Events Incidents declared by the Trust this month.	One Never Event was declared in November 2018 (Wrong side Surgery) Three Never Events were declared in May 2019 (one - Wrong side surgery and two – Wrong implant/prosthesis) All 4 incidents are being investigated using the Serious Incidents Framework.	**Named Person:** Quality Assurance & Serious Incident Officer
Serious Incidents: The number of Serious Incidents declared by the Trust this month.	One SI declared in Surgery in May 2019 2019.11437 - A61941 Paravertebral block for left sided rib fractures inserted on right side.	**Named Person:** Quality Assurance & Serious Incident Officer

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Indicator	19_20 Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	2019-2020	Performance
ED - FFT % Positive	>90%	81.9%	83.7%	83.5%	82.8%	80.9%	82.3%	81.0%	82.8%	78.3%	75.6%	78.6%	78.6%	78.6%	
ED - FFT Response Rate	>15%	14.1%	12.2%	14.1%	12.8%	13.1%	11.9%	12.0%	13.2%	11.9%	11.7%	10.3%	12.6%	11.5%	
Inpatients - FFT % Positive	>90%	98.4%	97.0%	97.9%	97.0%	96.8%	97.8%	98.1%	95.5%	96.3%	98.4%	96.6%	97.4%	97.1%	
Inpatients - FFT Response Rate	>25%	17.7%	18.1%	15.6%	13.6%	12.4%	20.5%	18.1%	14.1%	21.7%	23.5%	15.1%	23.3%	19.2%	
Maternity - FFT % Positive	>90%	93.2%	95.9%	95.3%	95.5%	95.3%	92.8%	92.9%	95.6%	96.5%	94.0%	95.1%	93.9%	94.4%	
Maternity - FFT Response Rate	>15%	45.2%	53.2%	67.2%	49.3%	40.0%	42.9%	48.9%	53.1%	50.7%	52.4%	31.1%	41.3%	36.2%	
Outpatients - FFT % Positive	>90%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	90.5%	91.4%	90.8%	
Outpatients - FFT Responses	400	348	310	223	138	328	484	233	423	389	421	419	233	652	
Community - FFT % Positive	>90%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.8%	97.7%	97.3%	
Community - FFT Responses	1500	1148	869	890	1122	1159	998	622	1014	1028	953	842	909	1751	
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%	92.9%	85.4%	
Complaints (including complaints against Corporate division)	N/A	0	0	0	0	0	0	0	0	0	0	20	28	48	

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

Date of production: 19/06/2019 16:22

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:** The response rate in ED increased from April to May, from 10.3% to 12.6%. This increase was achieved despite an increase in attendances. The positive recommend rate remains at 79%. **Action to Recover:** The patient experience manager has met with the lead nurse in ED. An action has been agreed to develop a Multi-Disciplinary Team (MDT) working group within the area that will meet monthly to develop and progress an action plan. Actions will include the increasing of the response and recommend rates.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** March 2020 Improving the response and recommend rate for ED has been included as a Quality Account priority for 2019/20. A working group with ED partners has been established and the first full meeting is in the first week of July 2019
Inpatients FFT Response Rate: number of responses achieved for Inpatients. **Standard:** 25%	**Variance against Plan:** Recommend rate has exceeded 90% for the 37th consecutive month. The response rate for May was 23%. This is the third time over the last four where inpatient responses have exceeded 22%, but not reached 25% **Action to Recover:** Welcome Packs are being launched in the adult inpatient wards in June and July. These contain further signposting for patients, visitors and carers to provide feedback. An increased number of volunteers are being introduced to the adult inpatient wards. The role description for these volunteers is being amended in	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** September 2019

	partnership with the ward managers and matrons. Enhancing volunteer awareness around supporting patients to complete the FFT is being included in the new role description	
Community FFT Responses: number of responses a month for Community. **Standard:** 1500	**Variance against Plan:** The recommend rate remains above 90%. The overall number of responses for May was 909, below the 1,500 KPI target. **Action to Recover:** The patient experience manager has escalated the iPad device issues at St Ann's, Bounds Green and Tynemouth Road with IT, and the Head of Haringey Children and Young People's Services. The patient experience manager is waiting for IT to arrange a meeting date to finalise actions towards rectifying the iPad device issues. The patient experience manager will be meeting with the Children's, Young People community team leads to agree actions to improving FFT responses in their areas.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** November 2019

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Indicator	19_20 Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	2019-2020	Performance
Hospital Cancelled Operations	0	1	4	1	2	8	10	4	5	14	7	10		10	
Cancelled ops not rebooked < 28 days	0	0	0	0	0	1	2	0	0	1	0	0		0	
Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0		0	
Theatre Utilisation	>85%	82.5%	78.2%	82.3%	82.1%	80.7%	79.6%	80.9%	80.4%	78.5%	77.5%	81.5%	85.3%	83.4%	
Breastfeeding Initiated	>90%	94.2%	91.2%	91.5%	91.7%	93.2%	93.2%	89.2%	91.3%	92.4%	93.9%	91.7%	90.5%	91.1%	
Mortality rate per 1000 admissions in-months	14.4	6.4	5.3	4.7	5.0	5.5	6.6	8.4	7.7	6.0	9.2	8.1	7.3	7.7	
Community DNA % Rate	<10%	8.0%	8.5%	8.1%	7.7%	7.8%	7.5%	8.0%	7.5%	7.3%	6.7%	7.6%	7.0%	7.3%	
Community Services - Provider Cancellations	<8%	6.1%	6.3%	6.3%	5.9%	6.1%	6.6%	7.4%	6.3%	6.0%	6.3%	6.3%	6.2%	6.3%	
Acute DNA % Rate	<10%	10.2%	10.4%	10.8%	10.6%	10.5%	10.5%	10.2%	10.0%	10.6%	9.8%	10.5%	11.4%	11.0%	
% of GP Referrals that were completed via ERS		79.6%	82.6%	82.9%	84.8%	87.4%	89.0%	85.5%	87.6%	87.5%	88.2%	88.4%	88.2%	88.3%	
Outpatients New:FUp Ratio	2.3	1.89	1.94	1.98	1.93	1.92	1.88	1.94	1.97	1.86	1.92	1.94	1.93	1.93	
Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.3%	2.6%	2.7%	2.8%	2.5%	1.7%	2.0%	4.3%	1.3%	1.3%	1.8%		1.8%	
Non Elective Re-admissions within 30 days	<5.5%	6.62%	5.89%	6.97%	5.93%	5.42%	4.91%	5.86%	5.48%	5.92%	6.36%	6.39%	5.36%	5.88%	
Rapid Response - % of referrals with an improvement in care						18.0%	92.4%	89.4%	84.1%	90.2%	80.8%	89.7%	100.0%	94.9%	

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

Date of production: 19/06/2019 16:22

<table>
<tr><th>Indicator and Definition</th><th>Commentary and Action Plan</th><th>Named Person & Date Performance will Recover</th></tr>
<tr>
<td>Hospital Cancellations Operations : The number of patients operation cancelled on the day

Target: 0
Theatre overrunning – pushing to fill lists as effectively as possible part of Theatre productivity to ensure that timings accurate although checked by Consultant and Lead Theatre Nurse for each area.
Anaesthetist unavailable – some gaps in service so being replaced as soon as possible however all Anaesthetists are as flexible as possible, unusual to be cancelled on the day.</td>
<td>Variance against Plan: There were 10 cancelled operations on the day in April 2019. None were urgent or cancer cases.

<table>
<tr><th>Speciality</th><th>Total Case</th><th>No. cancelled</th><th>Reason</th></tr>
<tr><td>T&O</td><td>7</td><td>3</td><td>No surgeon illness</td></tr>
<tr><td></td><td></td><td>3</td><td>List overran</td></tr>
<tr><td></td><td></td><td>1</td><td>Anaesthetist unavailable</td></tr>
<tr><td>Spinal</td><td>1</td><td>1</td><td>List overran</td></tr>
<tr><td>Gen Surgery</td><td>1</td><td>1</td><td>Theatre list overran Bariatrics</td></tr>
<tr><td>Urology</td><td>1</td><td>1</td><td>Equipment failure</td></tr>
</table>

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. The equipment failure has been resolved.</td>
<td>Named Person:
General Manager Theatres, ITU, POA & Admissions

Time Scale to Recover Performance:
This is reviewed on a daily basis. Part of KPI for Theatre Productivity.
Priority to reduce theatre list overrun to only 1 or 2 per month by end of June 2019.</td>
</tr>
</table>

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Indicator	18_19 Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	2019-2020	Performance
Emergency Department waits (4 hrs wait)	>95%	90.6%	90.4%	89.8%	89.3%	88.0%	88.5%	85.4%	85.7%	84.6%	86.4%	84.4%	88.4%	86.4%	
ED Indicator - median wait for treatment (minutes)	<60 mins	79	74	64	75	79	88	91	85	93	97	91	77	83	
Ambulance handovers waiting more than 30 mins	0	16	18	9	12	18	15	23	18	53	28	56		56	
Ambulance handovers waiting more than 60 mins	0	1	0	10	2	0	0	2	2	14	7	5		5	
12 hour trolley waits in A&E - Non Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
12 hour trolley waits in A&E - Mental Health	0	0	2	0	0	0	0	1	0	1	0	1	0	1	
Cancer - 14 days to first seen	>93%	94.4%	94.4%	93.1%	90.1%	89.6%	93.7%	97.9%	95.9%	94.8%	96.2%	95.0%		95.0%	
Cancer - 14 days to first seen - breast symptomatic	>93%	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%		98.0%	
Cancer - 62 days from referral to treatment	>85%	86.5%	82.9%	94.2%	86.2%	83.1%	93.3%	93.8%	85.2%	91.1%	89.6%	89.5%		89.5%	
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%				89.5%	81.4%	93.3%	90.6%	88.9%	90.2%	89.6%	89.2%		89.2%	
Cancer ITT - % of Pathways sent before 38 Days	>85%				62.5%	60.0%	81.8%	50.0%	100.0%	40.0%	75.0%	71.4%		71.4%	
Cancer - % Pathways received a Diagnosis within 28 Days of Refer...		50.0%	93.0%	93.0%	80.4%	83.6%	86.1%	93.9%	88.3%	88.2%	83.3%	89.9%		89.9%	
Cancer - 31 days to first treatment	>96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer - 31 days to subsequent treatment - surgery	>94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%		100.0%	
Cancer - 62 Day Screening	>90%		100.0%	100.0%		100.0%	75.0%	60.0%				100.0%		100.0%	
DM01 - Diagnostic Waits (<6 weeks)	>99%	99.0%	99.1%	97.7%	99.0%	99.1%	99.1%	99.0%	99.0%	99.0%	99.0%	99.2%	99.2%	99.2%	
RTT - Incomplete % Waiting <18 weeks	>92%	92.4%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.1%	92.3%	92.2%	92.1%	92.1%	92.1%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	1	1	0	0	0	0	0	0	0	
% seen <=2 hours of Referral to District Nursing Night Service	>80%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	94.1%	100.0%	95.8%	
% seen <=48 hours of Referral to District Nursing Service	>95%	86.7%	93.8%	89.7%	91.3%	93.8%	95.6%	95.9%	96.4%	97.4%	98.7%	97.6%	98.4%	98.0%	
Haringey New Birth Visits - % seen within 2 weeks	>95%	92.1%	88.8%	91.1%	91.1%	90.4%	90.5%	90.1%	91.9%	95.2%	94.6%	93.3%		93.3%	
Islington New Birth Visits - % seen within 2 weeks	>95%	91.3%	98.8%	95.3%	95.6%	93.1%	93.4%	92.8%	95.0%	91.6%	95.0%	95.7%		95.7%	

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:** 88.4% (1.6% 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:** 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:** Improved to 16 minutes (median wait in May is 76 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:** 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:** 33 waiting more than 30 minutes and 3 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	**Named Person:** Interim ED Manager **Time Scale to Recover Performance:** Expect to see recovery to

	that come via LAS	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:** There were no patients waiting on trolleys in ED for more than 12 hours in May 2019. Data is now split: • 12 hour Trolley Waits – Non Mental Health • 12 hour Trolley Waits – Mental Health **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:** Interim ED Manager **Time Scale to Recover** **Performance:** N/A

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Indicator	19_20 Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	2019-2020	Performance	
Appraisals % Rate	>90%	71.5%	73.6%	73.2%	74.7%	77.0%	76.0%	73.2%	72.7%	72.4%	72.6%	71.3%	69.8%	70.6%		!
Mandatory Training % Rate	>90%	82.8%	82.5%	83.7%	82.2%	82.4%	81.1%	80.7%	80.8%	80.8%	80.8%	80.2%	80.1%	80.1%		!
Permanent Staffing WTEs Utilised	>90%	86.2%	86.3%	86.7%	86.4%	87.3%	87.2%	88.0%	88.1%	88.0%	88.0%	87.3%	86.9%	87.1%		!
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%	3.41%	3.52%	3.10%	3.52%	3.92%	3.81%	3.35%	3.71%	3.69%	3.49%	3.27%		3.27%		
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%	10.9%	10.7%		!
Vacancy % Rate against Establishment	<10%	13.8%	13.7%	13.3%	13.6%	12.7%	12.8%	12.0%	11.9%	12.0%	12.0%	12.7%	13.1%	12.9%		!
Average Time to Hire (Days)	<61 Days										63	65	69	67		!
Nursing Staff Average % Day Fill Rate - Nurses		84.3%	82.7%	83.4%	82.3%	76.8%	76.7%	74.9%	89.3%	87.4%	86.1%	86.7%	86.2%	86.4%		
Nursing Staff Average % Day Fill Rate - HCAs		121.9%	120.2%	134.2%	139.9%	130.4%	130.4%	125.3%	112.6%	117.1%	112.6%	109.1%	115.0%	112.1%		
Nursing Staff Average % Night Fill Rate - Nurses		87.9%	86.8%	87.9%	86.6%	85.3%	85.3%	79.2%	92.2%	90.8%	88.6%	88.4%	87.2%	87.8%		
Nursing Staff Average % Night Fill Rate - HCAs		116.0%	114.1%	140.5%	138.0%	79.6%	83.0%	131.1%	134.5%	124.4%	115.7%	109.3%	114.6%	112.0%		
Safe Staffing Alerts - Number of Red Shifts		0	1	1	2	0	0	0	0	2	1	0	0	0		
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		9.4	10.0	9.0	8.8	9.2	8.8	10.2	9.0	9.0	9.1	9.0	9.1	9.0		

! **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:** -17% **Action to Recover:** Simplified 2-page appraisal to support better conversations Simplified 2-page guidance for appraises and managers Shorter, clearer screenshot guidance on loading to ESR	**Named Person:** Assistant Director, Learning & Organisational Development **Time Scale to Recover Performance:** 3 months (September 2019)
Mandatory Training % Rate: 90% of members of staff should have completed their mandatory training. **Standard:** 90%	**Variance against Plan:** -8% **Action to Recover:** Participating in Stainability and Transformation Partnerships (STP) alliance to transfer compliance data Working with internal and external partners to improve access to ESR and use of wider functionality Advertising e-learning supported sessions at Crouch End E-learning suite Improving communications and 'how to' guides for staff Creating new drop-in sessions at Archway site Involving ESR account manager in complex queries Improving reporting	**Named Person:** Assistant Director, Learning & Organisational Development **Time Scale to Recover Performance:** 6 months (December 2019)
Permanent Staffing WTEs Utilised: 90% of post should be filled. **Standard:** 90%	**Variance against Plan:** 86.92% **Action to Recover:** There has been a slight increase in permanent staffing WTE's utilised. This continues to be reviewed in line with vacancy rate reviews, staff turnover and recruitment and retention planning.	**Named Person:**, 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:** 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:** 13.08% **Action to Recover:** The vacancy rate has remained relatively steady for the past three months, while still above target. 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:** 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:** 9.9 weeks **Action to Recover:** The time to hire has increased from 8.8 weeks to 9.9 weeks, however this is due to roles being released post end of financial year. HR Business Partners and Recruitment Advisers meet monthly with ICSU's/Corporate Services to review the dashboard and take appropriate action.	**Named Person:** Deputy Director of Workforce **Time Scale to Recover Performance:** September 2019

Appendix 1. Community Performance Dashboard

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Children's community waiting times Services under Children, Young People (CYP) operate on different waiting time a target, performance is monitored monthly in the Community Service Improvement Group (CSIG); services are divided into 3 categories: Phase 1, Monitored Services and Light Touch Services. • Phase 1 – Overall, services are delivering progress against 95% target apart from Occupational Therapy (OT) Haringey due to historic clinical backlog but their average waiting time has improved since October 2018. • Monitored Services – Improvement noted in Community Paeds, School Nursing and Family Nurse Partnership (FNP). CAMHS still an area where focus is needed. Service improvement now in progress which aims to change management structure and improve patient waiting times. Improvement work around Therapy in Haringey also in progress. • Light Touch – services such as Community Paeds (CP), Parent Infant	**Overall summary:** CAMHS anticipates an overall improvement in waiting times for the next quarter. Therapy Review, further update on the impact will be reported in Q2. Community Paediatrics – NDC, CP and Com Paeds Islington show good improvement, except SCC. CYP ICSU continues to focus on reducing waiting times, a few services in CYP such as Looked After Children and FNP will continue to experience challenges which invariably can be out of the control of the services. **Action to Recover:** Revised target proposal currently under review – this will give services to work to realistic waiting times. Services to continue to address data quality and ensure that Borough Leads consistently review and monitor this.	**Named Person:** Director of Operation CYP **Time Scale to Recover Performance:** Consistent performance for light touch services; Speech and Language Therapy Michael Palin Centre will move to light touch services. Expect improvement in waiting times for CAMHS in the next quarter. Director of CYP will continue to challenge service managers to ensure data are entered correctly and services have robust grip on Patient Tracking List (PTL).

Psychology Service (PIPS), Haematology and PIPS consistently delivering 100% target.		
Adults community waiting times Adult Community Services (ACS) operate on different waiting time targets, performance is monitored monthly in the Community Service Improvement Group (CSIG)	**Overall Summary:** Adult Community Services have experienced pressures in relation to waiting times in May 2019 in Bladder and Bowel, Community Rehabilitation, ICTT, Intermediate Care, Musculoskeletal Services (MSK) and Podiatry. **Action to Recover:** There are a number of work streams underway that are being monitored through the Adult Community Service Improvement Group (CSIG). For Bladder and Bowel, the service is working closely with clinicians and commissioners to develop a Single Point of Access and streamline referral pathways to improve efficiency and signpost patients to the most appropriate service. In Community Rehabilitation, Integrated Care Therapy Team (ICTT) and Intermediate Care there is ongoing work through CSIG to reduce inappropriate referrals and maximise existing capacity. In Podiatry there have been some issues with the booking of new appointments and this is being addressed through a Central Booking Service action plan. In MSK there has been an increase in demand that is being addressed through additional capacity however this ongoing issue is being discussed with commissioners as there are resource implications associated with this increased demand.	**Named Person:** Director of Operations ACS **Time Scale to Recover Performance:** The timescale for recovery for services is 3-6 months.

Indicator	19_20 Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	2019-2020	Performance
IAPT Moving to Recovery	>50%	59.0%	52.4%	55.7%	57.0%	62.5%	57.4%	58.2%	62.3%	65.1%	59.1%	62.2%		62.2%	
Haringey - 8wk Review % carried out before child aged 8 weeks	N/A	79.8%	81.9%	82.0%	80.4%	89.1%	86.2%	92.1%	84.1%	91.9%	88.7%	90.5%		90.5%	
Haringey - HR1 % carried out before child aged 15 months	N/A	66.0%	70.4%	62.4%	71.1%	70.7%	72.0%	74.1%	76.7%	78.1%	80.6%	81.8%		81.8%	
Haringey - HR2 % carried out before child aged 30 months	N/A	59.2%	65.1%	66.9%	64.0%	61.0%	60.2%	62.5%	68.1%	70.4%	72.0%	71.3%		71.3%	
Islington - 8wk Review % carried out before child aged 8 weeks	N/A	92.3%	91.8%	95.1%	96.5%	96.7%	92.5%	90.7%	86.5%	90.3%	91.6%	93.0%		93.0%	
Islington - HR1 % carried out before child aged 15 mths	N/A	76.5%	82.4%	80.1%	87.4%	77.4%	80.8%	82.8%	74.1%	73.7%	83.3%	80.5%		80.5%	
Islington - HR2 % carried out before child aged 30 mths	N/A	78.0%	79.5%	79.2%	81.0%	80.2%	82.0%	86.3%	76.8%	75.5%	72.4%	78.2%		78.2%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	69.5%	76.5%	81.7%	68.5%	83.0%	82.6%	75.7%	85.1%	92.9%	92.9%	89.3%	96.2%	92.1%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	84.8%	84.8%	90.0%	77.8%	83.7%	95.1%	81.5%	89.7%	90.0%	86.2%	78.8%	87.1%	82.8%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	80.2%	75.5%	70.5%	78.0%	71.2%	80.0%	75.3%	73.8%	71.9%	78.5%	80.6%	74.3%	77.9%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	93.2%	94.8%	94.5%	94.0%	89.4%	96.9%	95.3%	93.3%	95.7%	93.5%	98.7%	96.2%	97.6%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	85.7%	57.1%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Nutrition and Dietetics - % Weight Loss Achieved at Discharge	>65%	0.0%	100.0%	60.0%	66.7%	66.7%	83.3%	71.4%	33.3%	76.9%	100.0%	81.8%	75.0%	80.0%	
Nutrition and Dietetics - % Weight Maintained or Gained at Discharge	>70%	100.0%	88.9%	78.6%	80.0%	91.7%	93.8%	72.7%	77.8%	100.0%	90.0%	100.0%	100.0%	100.0%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 we...	>45%				47.9%			47.8%			42.3%				
Islington Self-Management - Average Increase in PAM Score	>=9							11			18				
Haringey Self-Management - Average Increase in PAM Score	>=9							13			15				

Appendix 2. Community Waiting Times Dashboard

Haringey and Islington combined

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Mar-19	Apr-19	May-19	Avg Wait (May-19)	No of Pts First Seen	% Target	Target Weeks	Mar-19	Apr-19	May-19	Avg Wait (May-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12	57.10%	66.70%	81.00%	8.1	21	>95%						0
ACS	Community Matron	>95%	6	97.40%	97.90%	97.40%	1	39	>95%	2		0.00%			0
ACS	Adult Wheelchair Service	>95%	8	100.00%	100.00%	92.70%	4.6	41	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	83.90%	90.10%	82.10%	6.3	106	>95%	2	90.00%	57.60%	77.40%	1.6	31
ACS	ICTT - Other	>95%	12	91.40%	92.20%	96.30%	4.7	298	>95%	2	54.30%	48.30%	75.00%	1.7	44
ACS	ICTT - Stroke and Neuro	>95%	12	71.80%	70.00%	65.30%	8.8	49	>95%	2	36.40%	45.50%	61.00%	2.1	41
ACS	Intermediate Care (REACH)	>95%	6	97.30%	94.70%	83.50%	3.3	121	>95%	2	89.90%	84.40%	82.10%	1.1	56
ACS	Paediatric Wheelchair Service	>95%	8	100.00%	92.30%	100.00%	5.6	7	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	52.20%	46.40%	49.40%	15.2	164	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	86.10%	72.50%	57.80%	5.6	533	>95%			100.00%			0
ACS	Musculoskeletal Service - Routine	>95%	6	80.10%	70.40%	67.50%	4.8	1522	>95%	2			100.00%	0.4	1
ACS	Nutrition and Dietetics	>95%	6	100.00%	98.70%	98.20%	2.7	227	>95%	2			100.00%	0.1	1
ACS	Podiatry (Foot Health)	>95%	6	91.90%	78.50%	74.40%	4.8	613	>95%	2	100.00%	100.00%			0
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	2.7	19	>95%						0
ACS	Tissue Viability	>95%	6	89.30%	87.80%	83.30%	2.4	60	>95%						0
ACS	Cardiology Service	>95%	6	100.00%	96.60%	94.70%	2.1	19	>95%	2	100.00%	100.00%	88.90%	1.1	9
ACS	Diabetes Service	>95%	6	100.00%	100.00%	98.10%	2.2	53	>95%	2			0.00%	3	1
ACS	Respiratory Service	>95%	6	100.00%	94.00%	98.30%	2.7	59	>95%	2	100.00%	100.00%	100.00%	0.3	3
ACS	Spirometry Service	>95%	6	77.30%	15.40%	35.40%	6.9	48	>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	Mar-19	Apr-19	May-19	Avg Wait (May-19)	No of Pts First Seen	% Target	Target Weeks	Mar-19	Apr-19	May-19	Avg Wait (May-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12					0	>95%						0
ACS	Community Matron	>95%	6	100.00%	93.30%	90.90%	1.9	11	>95%	2					0
ACS	Adult Wheelchair Service	>95%	8	100.00%	100.00%	92.50%	4.7	40	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	100.00%	100.00%	66.70%	7.9	3	>95%	2					0
ACS	ICTT - Other	>95%	12	92.20%	92.90%	96.50%	4.6	283	>95%	2	55.10%	47.50%	70.30%	1.9	37
ACS	ICTT - Stroke and Neuro	>95%	12	74.30%	66.70%	66.00%	8.8	47	>95%	2	38.90%	47.10%	60.00%	2.1	40
ACS	Intermediate Care (REACH)	>95%	6	100.00%		75.00%	3.9	4	>95%	2	100.00%	100.00%	100.00%	0.1	1
ACS	Paediatric Wheelchair Service	>95%	8	100.00%	92.30%	100.00%	5.6	7	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	52.40%	51.20%	46.50%	15.9	71	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	91.40%	83.80%	66.00%	5.2	268	>95%			100.00%			0
ACS	Musculoskeletal Service - Routine	>95%	6	78.80%	68.90%	68.50%	4.6	799	>95%	2					0
ACS	Nutrition and Dietetics	>95%	6	100.00%	100.00%	100.00%	2.9	130	>95%	2			100.00%	0.1	1
ACS	Podiatry (Foot Health)	>95%	6	89.50%	81.20%	65.70%	5.1	283	>95%	2		100.00%			0
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	2.6	9	>95%						0
ACS	Tissue Viability	>95%	6	100.00%	96.20%	100.00%	1.2	18	>95%						0
ACS	Cardiology Service	>95%	6	100.00%	94.10%	88.90%	2.7	9	>95%	2		100.00%	100.00%	1.4	3
ACS	Diabetes Service	>95%	6	100.00%	100.00%	97.70%	2.4	43	>95%	2			0.00%	3	1
ACS	Respiratory Service	>95%	6	100.00%	95.50%	95.70%	3.1	23	>95%	2					0
ACS	Spirometry Service	>95%	6	77.30%	15.40%	34.00%	6.9	47	>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	Mar-19	Apr-19	May-19	Avg Wait (May-19)	No of Pts First Seen	% Target	Target Weeks	Mar-19	Apr-19	May-19	Avg Wait (May-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12	42.90%	37.50%	75.00%	10.2	12	>95%						0
ACS	Community Matron	>95%	6	96.40%	100.00%	100.00%	0.6	26	>95%	2		0.00%			0
ACS	Adult Wheelchair Service	>95%	8					0	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	85.00%	89.70%	82.30%	6.4	96	>95%	2	90.00%	57.60%	77.40%	1.6	31
ACS	ICTT - Other	>95%	12	85.70%	50.00%	100.00%	3.4	4	>95%	2	0.00%	100.00%	100.00%	0.7	4
ACS	ICTT - Stroke and Neuro	>95%	12	50.00%	100.00%			0	>95%	2	0.00%				0
ACS	Intermediate Care (REACH)	>95%	6	97.10%	94.30%	83.20%	3.3	113	>95%	2	89.20%	83.90%	83.00%	1	53
ACS	Paediatric Wheelchair Service	>95%	8					0	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	55.10%	35.00%	43.10%	16.9	65	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	78.90%	59.90%	47.80%	6.1	255	>95%						0
ACS	Musculoskeletal Service - Routine	>95%	6	83.60%	73.50%	66.60%	5	593	>95%	2					0
ACS	Nutrition and Dietetics	>95%	6	100.00%	96.70%	98.60%	2.4	71	>95%	2					0
ACS	Podiatry (Foot Health)	>95%	6	94.00%	76.20%	81.50%	4.6	325	>95%	2	100.00%	100.00%			0
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	2.8	10	>95%						0
ACS	Tissue Viability	>95%	6	95.50%	91.70%	94.10%	1.3	17	>95%						0
ACS	Cardiology Service	>95%	6	100.00%	100.00%	100.00%	1.6	10	>95%	2	100.00%	100.00%	83.30%	0.9	6
ACS	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.5	10	>95%	2					0
ACS	Respiratory Service	>95%	6	100.00%	93.30%	100.00%	2.5	36	>95%	2	100.00%	100.00%	100.00%	0.3	3
ACS	Spirometry Service	>95%	6					0	>95%	2					0

Children's Community Waits Performance

	Routine Referral Urgency							Urgent Referral Urgency						
Team Group	% Target	Target Weeks	Mar-19	Apr-19	May-19	Avg Wait (May-19)	No of Pts First Seen	% Target	Target Weeks	Mar-19	Apr-19	May-19	Avg Wait (May-19)	No of Pts First Seen
CAMHS Core - Islington	>95%	4	40.40%	35.00%	32.90%	10.2	140	>95%	2	78.60%	75.00%	75.00%	1.8	8
CAMHS NDT / ADHD - Islington	>95%	8	12.50%	42.10%	40.00%	25.3	10	>95%	2					0
CAMHS Schools - Islington	>95%	8	80.00%	71.40%	54.50%	6.8	22	>95%	2					0
Community Children's Nursing - Haringey	>95%	2	100.00%	0.00%	66.70%	2.3	3	>95%	1					0
Community Children's Nursing - Islington	>95%	2	78.70%	84.50%	80.20%	2.6	101	>95%	1	100.00%	100.00%	100.00%	0.4	1
Community Paediatrics - Haringey (SCC)	>95%	12	0.00%	11.10%	20.00%	24.9	15	>95%	1	0.00%	0.00%	0.00%	56	7
Community Paediatrics - Haringey (NDC)	>95%	12	48.50%	93.30%	91.40%	8.1	35	>95%	1			0.00%	14.9	1
Community Paediatrics - Haringey (Child Protection)	>95%	12	100.00%	100.00%	100.00%	0.7	27	>95%	1					0
Community Paediatrics - Haringey (Other)	>95%	12	85.70%	100.00%	100.00%	3.9	4	>95%	1					0
Community Paediatrics - Islington	>95%	12	71.40%	33.30%	63.00%	13	27	>95%	1					0
Family Nurse Partnership - Haringey	>95%	12	77.80%	90.00%	100.00%	1.7	16	>95%						0
Family Nurse Partnership - Islington	>95%	12	83.30%	80.00%	100.00%	3.6	3	>95%						0
Haematology Service - Islington	>95%	12	100.00%	100.00%	100.00%	0.7	8	>95%						0
IANDS	>95%	14	50.00%	50.00%	44.40%	8.5	9	>95%						0
IANDS - SCT	>95%	20	28.60%	8.30%	13.30%	26.3	15	>95%						0
Looked After Children - Haringey	>95%	4	27.80%	60.00%	78.90%	2.2	19	>95%						0
Looked After Children - Islington	>95%	4	81.80%	100.00%	83.30%	6.1	6	>95%						0
Occupational Therapy - Haringey	>95%	8	31.30%	31.60%	42.90%	10.4	14	>95%	2		0.00%			0
Occupational Therapy - Islington	>95%	8	35.00%	30.00%	27.30%	11.9	22	>95%	2					0
Paediatrics Nutrition and Dietetics - Haringey	>95%	8	100.00%	100.00%	100.00%	2.5	9	>95%						0
Paediatrics Nutrition and Dietetics - Islington	>95%	8	84.00%	72.70%	85.00%	4.6	20	>95%			0.00%			0
Physiotherapy - Haringey	>95%	8	70.00%	86.70%	70.30%	6.5	64	>95%						0
Physiotherapy - Islington	>95%	8	98.20%	93.00%	87.70%	4.6	73	>95%		0.00%				0
PIPS	>95%	12	100.00%	100.00%	87.50%	4.8	16	>95%						0
SALT - Haringey	>95%	8	38.40%	31.00%	23.60%	11.5	89	>95%	2	100.00%	33.30%	100.00%	0.9	2
SALT - Islington	>95%	8	30.80%	54.30%	27.10%	9.2	70	>95%	2					0
SALT - MPC	>95%	18	99.20%	100.00%	100.00%	4.7	54	>95%	2					0
School Nursing - Haringey	>95%	12	86.70%	87.50%	93.90%	2.2	114	>95%						0
School Nursing - Islington	>95%	12	91.40%	97.10%	100.00%	2.1	38	>95%						0

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

Cancer - 62D Performance by Tumour Group

Indicator	19_20 Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	2019-2020	Performance
Breast	>85%	100.0%	90.5%	100.0%	86.7%	100.0%	93.3%	100.0%	100.0%	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%	50.0%		50.0%	
Haematological (Excluding Acute Leukaemia)	>85%	100.0%	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%		100.0%	0.0%	100.0%		100.0%	
Lower Gastrointestinal	>85%		71.4%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Lung	>85%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%		100.0%	85.7%	100.0%	100.0%		100.0%	
Other	>85%		100.0%						100.0%		100.0%	100.0%		100.0%	
Skin	>85%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%		100.0%	
Testicular	>85%			100.0%						100.0%		100.0%		100.0%	
Upper Gastrointestinal	>85%	100.0%	0.0%	0.0%	100.0%	100.0%		75.0%	100.0%		100.0%	50.0%		50.0%	
Urological (Excluding Testicular)	>85%	81.8%	68.4%	77.8%	100.0%	44.4%	100.0%	66.7%	64.7%	80.0%	76.9%	88.9%		88.9%	

Cancer - 2WW Performance by Tumour Group

Indicator	19_20 Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	2019-2020	Performance
Breast	>93%	97.3%	98.2%	97.5%	96.4%	94.0%	97.3%	98.6%	98.5%	93.7%	96.0%	93.9%		93.9%	
Childrens	>93%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%		100.0%	
Gynaecological	>93%	100.0%	100.0%	98.0%	97.4%	95.6%	96.4%	97.8%	97.1%	91.8%	96.6%	94.5%		94.5%	
Haematological	>93%	91.7%	11.1%	37.5%	62.5%	92.9%	91.7%	95.0%	100.0%	91.7%	100.0%	100.0%		100.0%	
Lower Gastrointestinal	>93%	96.5%	87.2%	88.2%	82.4%	73.0%	87.3%	98.3%	92.8%	94.2%	95.8%	91.2%		91.2%	
Lung	>93%	92.9%	92.0%	100.0%	90.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Skin	>93%	94.6%	99.5%	98.8%	97.4%	98.0%	97.5%	98.6%	97.6%	99.3%	96.2%	98.0%		98.0%	
Upper Gastrointestinal	>93%	78.3%	72.4%	55.0%	20.6%	59.6%	89.2%	98.0%	87.2%	98.2%	98.9%	91.4%		91.4%	
Urological	>93%	89.0%	89.8%	94.7%	97.4%	97.9%	86.4%	94.9%	91.8%	92.4%	92.1%	98.8%		98.8%	

Meeting title	**Trust Board – public meeting**	**Date: 26 June 2019**
Report title	**Emergency Department improvement plan**	**Agenda Item: 12**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Magdalena Nikolova, Systems Resilience Programme Manager	
Executive summary	The Accident & Emergency Delivery Board Improvement plan details the programme for 2019/20 to drive improvements in order to deliver against the agreed four hour wait trajectory. The plan employs a whole system approach divided into three distinct work streams: in-flow, through flow and out-flow led by a Senior Responsible Officer.	
Purpose:	Review	
Recommendation(s)	The Trust Board is asked to receive and review the 2019/20 whole system improvement plan and to be assured that the plan will deliver the required improvements in the emergency pathway.	
Risk Register or Board Assurance Framework	Quality 2 - Failure to hit national and local performance targets results in low quality care, financial penalties and decommissioning of services – (e.g. Emergency Department (ED), community etc.) Quality 3 - Failure to provide robust urgent and emergency pathway for people with mental health care needs results in poor quality care for them and other patients, as well as a performance risk	
Report history	Presented to A&E Delivery Board	
Appendices	1: Islington/ Whittington Health Accident and Emergency Delivery Board System Improvement Programme 2019/2020	

Islington's Accident and Emergency Delivery Board (AEDB)
2019/20 Improvement Programme

Islington's A&E Delivery Board is responsible for overseeing the successful implementation of a comprehensive improvement programme that aims to improve patient experience and deliver a sustainable position against key performance targets for the Trust.

The Improvement programme is a system wide approach to managing A&E pressures and improving and standardising processes for patient assessment, admission and discharge across 7 days to achieve the four hour operational standard. Delivery of the 2019/20 Improvement Programme is managed through three distinct work streams focusing on specific priorities for the system: inflow, through flow and outflow.

Inflow
The Inflow programme focuses on managing demand in the community and reducing avoidable A&E attendances and hospital admissions.

The Inflow working group is led by Islington Clinical Commissioning Group (CCG) and has representatives from primary and urgent care, integrated care, mental health, substance misuse, public health, children's services and the London ambulance service (LAS). The working group oversees the delivery of the following priority areas:

- LAS conveyances and alternative care pathways
- Admission avoidance/rapid response (with links to frailty)
- Access to mental health services outside acute settings
- Primary care improvement works (hubs, extended access, redirection, public health communications)
- High Intensity Users/Frequent Flyers
- Integrated Urgent Care projects (direct booking, online/phone Hubs, 111 online)

The key measures of success for the Inflow programme are: reduction in avoidable A&E attendances, reduction in low acuity patients seen in A&E, reduction in GP referrals requiring no significant investigation or treatment and optimisation of the Rapid Response service supporting patients in the community and reducing A&E attendance/potential hospital admissions.

Through flow
The Through flow programme focuses on improving internal Whittington Health processes that enable staff to deliver the highest quality of care in a timely way and ensure a positive patient experience.

The Through flow working group is led by Whittington Health and oversees the delivery of the following priority areas:

- Improving LAS handover times
- Development of LAS > Ambulatory Emergency Care (AEC) pathways
- Improving patient flow away from the Emergency department by streaming to onsite services (AEC, Urgent Treatment Centre and primary care) and redirection to offsite services (such as a GP or Pharmacy)

- Embedding medically enhanced Rapid Assessment and Treatment, providing early senior assessment and treatment of patients.
- Increasing use of ambulatory care across all specialities as an appropriate alternative to hospital admission for the diagnosis, management & treatment of patients.
- Optimising existing Mental Health pathways and improving access to acute Mental Health beds for patients in ED/on acute medical ward

The key measures of success for the Through flow programme are: improved patient experience, increased number of patients assessed within 15 minutes, increased number of patients seen by a clinician/decision maker within 60 minutes, overall reduction of breaches and improved performance against the 4 hour standard.

Outflow

The Outflow programme focuses on timely and effective transfer and discharge of patients from both the Emergency Department and wards into community settings.

The Outflow working group is led by Islington Council with representatives from social care, Whittington Health, integrated care and other partners across the system. This working group oversees the following priority areas:

- Embedding clear transfer processes with partners in the systems and maximising the impact of existing integrated care initiatives
- Optimising existing models – Home First, Reablement, Discharge to Assess (D2A), Rapid response, Virtual ward
- Developing and embedding escalation processes and procedures to address delayed transfers of care (active DToCs and medically optimised patients without a clear discharge plan)
- Embedding senior MDT reviews of complex patients to reduce the number of stranded and super stranded patients
- Embedding the Choice Policy across all wards to enable patients and families understand their rights and options as part of the discharge planning and reduce avoidable delays by managing expectations

The key measures of success and expected benefits from the Outflow programme are: reduction in mental health breaches, reduction in long length of stay patients, reduction in delayed transfer of care into community settings and improved communications between partners in the system contributing to better patient experience.

Reporting arrangements

The Improvement Programme is a live iterative document updated each month after the cycle of A&E Delivery Board Meetings.

The Board receives a monthly update and a highlight report from the Senior Responsible Officers in relation to the performance of their respective programme and any relevant system pressures and issues that need to be addressed jointly at Board level.

The A&E Delivery Board promotes collaborative working and collective responsibility amongst partners in the system in achieving the outcomes set out in the Improvement Programme.

Joint partnership working and positive communication have been key to the success of the improvement programme to date and partners across the system remain equally committed to delivering the expected benefits for our patients and residents.

Improvement Programme	Senior Responsible Officer (SRO)
Inflow	Elizabeth Ogunoye, Director for Acute Commissioning, Islington CCG
Through flow	Carol Gillen, Chief Operating Officer, Whittington Health
Outflow	Katherine Willmette, Director for Social Care, London Borough of Islington

Recommendation
The Trust Board is asked to receive and review the 2019/20 whole system improvement plan and to be assured that the plan will deliver the required improvements in the emergency pathway.

Islington/ Whittington Health Accident and Emergency Delivery Board (AEDB) System Improvement Programme 2019/2020

April 2019 version 1

NHS Islington Clinical Commissioning Group

NHS Whittington Health NHS Trust

NHS Camden and Islington NHS Foundation Trust

Haringey LONDON

London Ambulance Service NHS Trust

ISLINGTON

Moorfields Eye Hospital NHS Foundation Trust

University College London Hospitals NHS Foundation Trust

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System Improvement Programme

About the programme

The Improvement programme is a system wide approach to managing the A&E pressures and improving and standardising processes for patient assessment, admission and discharge across 7 days to achieve the 4 hour operational standard.

We hope to achieve this by:

- better understanding of the inflow of patients to help with early identification of potential pressures
- Improving the internal flow of patients by developing and embedding processes that enable staff to deliver the highest quality of care in a timely way.
- effective transfer and discharge of patients from both Emergency Department and wards by embedding clear transfer processes with partners in the systems and maximising the impact of existing integrated care initiatives.

Our 2019/20 focus and key initiatives

- Improving LAS handover times, embedding Medically enhanced RAT, increasing streaming to AEC, UTC and primary care, optimising CDU and Ambulatory Care, Mental Health pathways, and reducing delayed transfers of care/ Length of Stay.

System Improvement Programme

Our main targets and measures of success:

- < 5% Low acuity caseload
- < 5% GP referrals requiring no treatment or significant investigation
- Admission avoidance – Meet 100% of agreed target for both Haringey and Islington

Inflow metrics

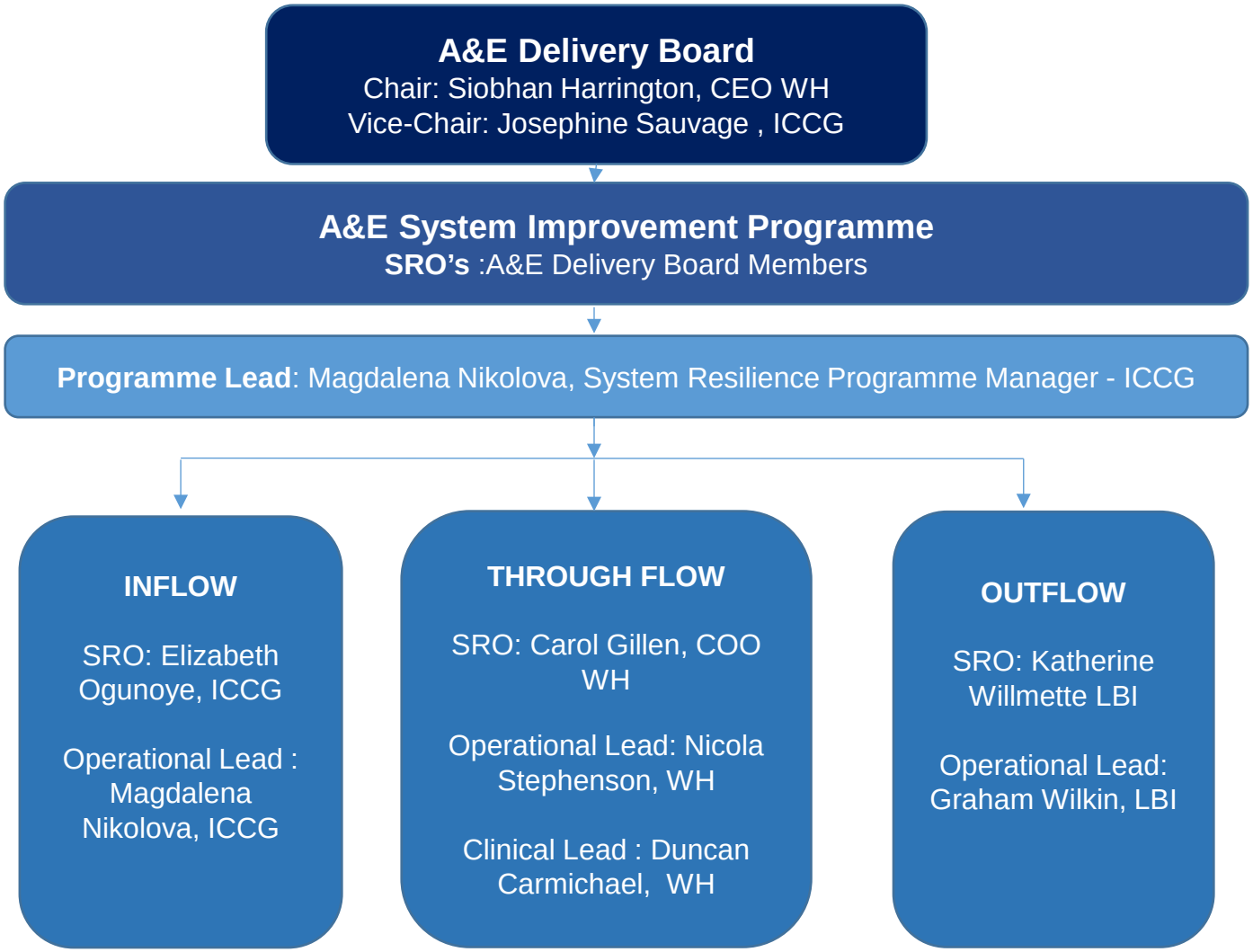
- 95% of patients have an initial assessment within 15 minutes
- 50% of patients are seen by a clinician/decision maker within 60 minutes
- 95% of patients are seen, treated and admitted/discharged within 4 hours

Through flow metrics

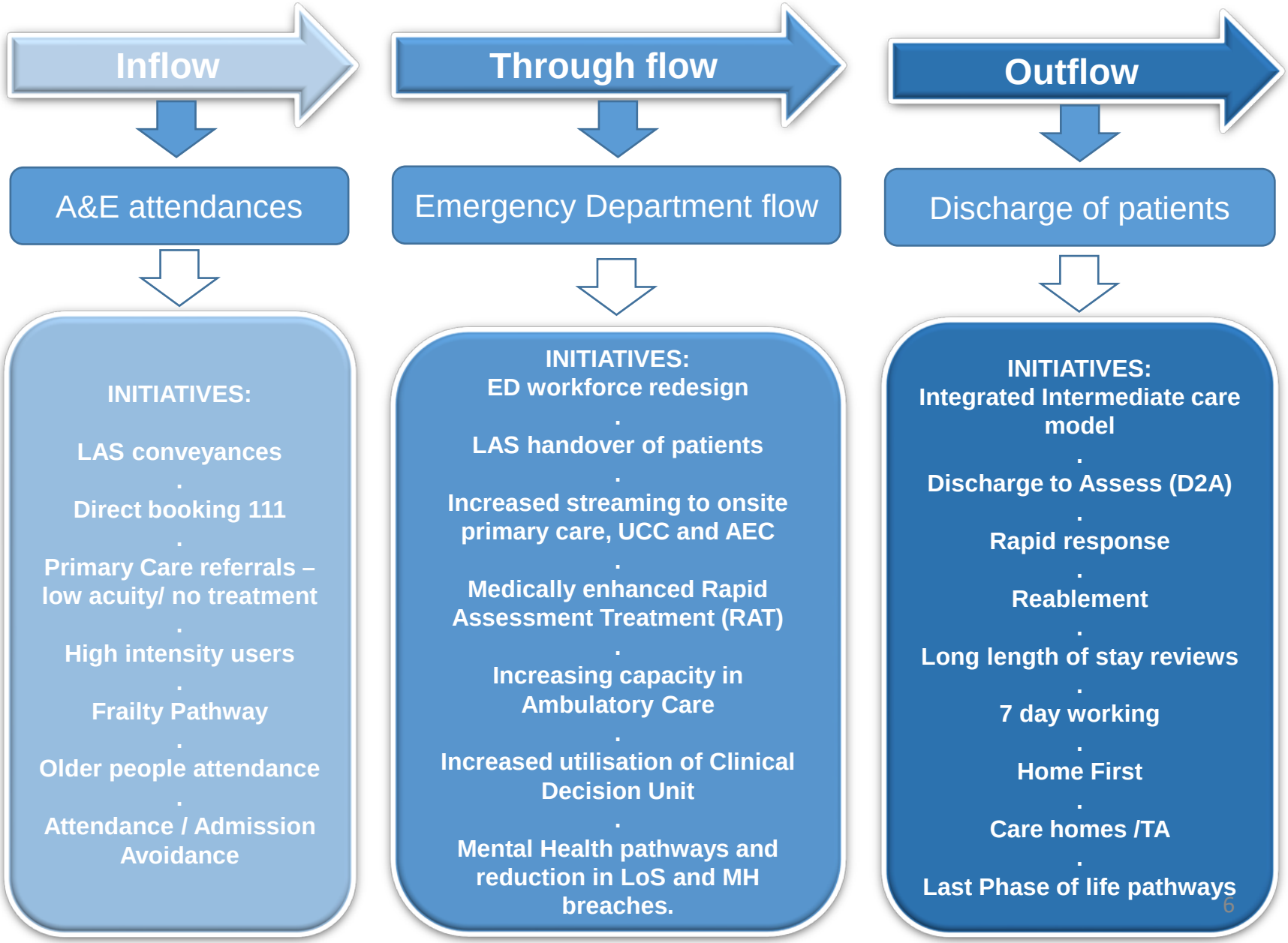
- Meet set targets for D2A pathway 1, 2 and 3
- < 2% of DToC against bedbase
- < 4% of super stranded patients (Length of stay greater than 14 days)

Outflow metrics

Programme Governance



System Improvement flow



Action plan – Inflow of patients

A&E attendances

SRO: Elizabeth Ogunoye, ICCG
Operational Manager: Magdalena Nikolova ICCG
Project Owner: Islington CCG

Aim of this initiative:

To develop a better understanding of the inflow of patients that can help with early identification of potential A&E pressures.

Key actions:

- LAS conveyances and alternative care pathways
- Review of Low acuity attendances
- Reducing GP referrals requiring no treatment or significant investigation
- Reviewing older people attendances – identifying alternative pathways
- Managing high intensity users
- Optimising admission avoidance
- Direct booking from 111

Key performance indicators:

- % Low acuity caseload – 5% or below
- % Older people attendances – 9% or below
- % GP referrals requiring no treatment or significant investigation- 5% or below
- Increasing number of admission avoidance – agree a new target?

Action plan - Emergency Department Flow

Workforce re-design

SRO: Carol Gillen, WH
Operational Manager: Nicola Stephenson, WH
Project owner: Duncan Carmichael, WH

Aim of this initiative:

To develop a staffing structure model with the right skills set that ensures the Emergency Department is more adaptable and resilient to pressures at different times of the day.

Key actions:

- Analysis of WH A&E activity and performance to identify pressure points throughout a 24 hr period
- Conduct a supply and demand assessment work to better inform the staffing structure and skills set
- Agree staffing model following D&C analysis (considering RAT)
- Implement staffing model
- Weekend staffing model to match the weekday model based on demand analysis

Key performance indicators:

- Reduction in breaches overnight
- Weekend shifts with enhanced consultant cover
- Weekend shifts with enhanced doctor cover (exact shifts to be defined)
- % of middle grades posts filled
- 50% of patients are seen by a clinician/decision maker within 60 minutes
- 40% of patients discharged within 2 hours of arrival

Action plan - Emergency Department Flow

LAS Handover of patients

SRO: Carol Gillen, WH
Operational Manager: Nicola Stephenson, WH
Project owner: Elaine McWilliams WH

Aim of this initiative:

To improve Emergency Department flow through effective and timely handover of patients.

Key actions:

- Redesign of FoH pathways to support streaming, redirection, triage and LAS handover
- Development of LAS > AEC pathways
- Embed escalation protocol for early escalation of delays
- Review staffing model in RAT area through D&C work
- Agree and implement staffing model

Key performance indicators:

- Ambulance handover of patients within 15 minutes KPI1 – 100%
- Ambulance handover of patients within 30 minutes KPI2 – 100%
- No ambulance handover breaches 30/60 minutes

Action plan - Emergency Department Flow

Medically Enhanced RAT

SRO: Carol Gillen, WH
Operational Manager: Nicola Stephenson, WH
Project owner: Duncan Carmichael WH

Aim of this initiative:

To improve patient flow through the ED department by providing early senior assessment and treatment patients.

Key actions:

- Develop and implement a RAT model with a senior clinical decision maker
- Develop process and protocols for RAT
- Define and develop handover process between RAT doctor and majors area
- Agree operating hours and staffing structure

Key performance indicators

- 50% of patients are seen by a clinician/decision maker within 60 minutes
- 90% of RAT shifts filled with registrar or equivalent
- 40% of patients seen and discharged within 2 hours of arrival

Action plan - Emergency Department Flow

Streaming and Redirection

SRO: Carol Gillen, WH
Operational Manager: Nicola Stephenson, WH
Project owner: Nathalie Richard WH

Aim of this initiative:

To improve patient flow away from the ED department streaming to onsite services and redirection to offsite services (such as GP or Pharmacy).

Key actions:

- Agree and implement a workforce model which supports effective streaming and redirection
- Increase streaming of patients to Urgent Treatment Centre
- Increase streaming to onsite Primary Care
- Increase Streaming to AEC, GAU and other internal services
- Redirection to primary care/community/pharmacy
- Increase uptake of Frailty Pathway

Key performance indicators:

- 55% patients streamed to Urgent Treatment Centre
- 15% patients streamed to onsite Primary care
- 6% patients streamed to AEC
- 5% of patients identified to have primary care needs to be redirected to offsite primary care, community services, pharmacy
- 25% patients over 75 to be referred to the Frailty pathway

Action plan - Emergency Department Flow

Ambulatory Care

SRO: Carol Gillen, WH
Operational Manager: Nicola Stephenson, WH
Project owner: Paul Attwal

Aim of this initiative:

To increase use of ambulatory care across all specialities as an appropriate alternative to hospital admission for the diagnosis, management & treatment of patients.

Key actions:

- Identify project lead and QI working group
- Conduct a demand and capacity analysis to understand gap between our demand and capacity
- Implement improvements following analysis of service model

Key performance actions:

- 6% of ED attendances streamed to AEC
- AEC open 12 hours per day 7 days per week
- Increase hours of senior medical cover in AEC (0800 – 1800 initially)
- Reduce waiting times in AEC (baseline to be agreed)
- Increase in surgical patients seen in AEC (target to be agreed through initial QI meetings)

Action plan - Emergency Department Flow

Clinical Decision Unit

SRO: Carol Gillen, WH
Operational Manager: Nicola Stephenson, WH
Project owner: Firas Abou-Auda WH

Aim of this initiative:

To improve patient flow by increasing the utilisation of the Clinical Decision Unit.

Key actions:

- Increase throughput through CDU
- Implementation of CDU huddles 9am and 2pm
- Development and implementation of CDU standard operating procedure
- Recruit a CDU ward manager
- Review medical staffing input into CDU to ensure the model is optimised

Key performance indicators:

- 20 patients a day going through CDU
- Reduce CDU LoS (<12 hours)
- 40% of patients seen and discharged from the Emergency Department within 2 hours of arrival

Action plan - Emergency Department Flow

Mental Health Improvements

SRO: Carol Gillen, WH
Operational Manager: Nicola Stephenson, WH
Project owner: Adele McKay, C&I

Aim of this initiative:

To improve the experience of mental health patients by optimising existing Mental Health pathways, increasing the use of Mental Health Recovery Suite, reducing the number of Mental Health breaches and reducing the length of stay in Emergency Department.

Key actions:

- Review existing MH pathways
- Increase referrals to MH Recovery Suite – 50%
- Increase capacity of MHRS by sound-proofing existing area
- Review patient flow and discharge processes to facilitate timely discharge and improve access to acute MH beds for patients in ED/ on acute medical ward

Key performance indicators:

- Reduce time non admitted mental health patients spend in Emergency Department - agree target
- Reduce time admitted MH pts in ED (baseline to be established)
- Mental Health Transfers - 48 hour from Medically Fit For Discharge on ward to Mental Health bed
- Mental Health Recovery Suite - utilisation (50% of people transferred) and capacity (2 people)
- Number of 12 hour mental health breaches - 0
- % of breaches attributed to delays in mental health assessment, treatment or transfer – 5%
- 90% of patients in ED referred to MHLT assessed within 60 minutes of referral
- 90% of patients in acute bed referred to MHLT assessed within 24 hours of referral

Action plan – Outflow of patients

Effective transfer and discharge of patients

SRO: Katherine Willmette
Operational Manager: Graham Wilkin, LBI
Project owner: Theri Thompson and Stephen Day, LBI

Aim of this initiative:

To ensure effective transfer and discharge of patients from both the Emergency Department and wards by embedding clear transfer processes with partners in the systems and maximising the impact of existing integrated care initiatives.

Key actions:

- Agree and embed transfer processes from ED to other organisations to minimise delay
- Optimise existing models - Discharge to Assess (D2A), Rapid response and virtual ward, Reablement
- Weekly reviews of Long length of stay patients
- Weekly reviews of medically optimised patients
- Define virtual ward model and performance measures
- Senior MDT review of complex patients
- Reduction in super stranded patients
- Embed choice policy across all wards

Key performance indicators:

- Meet set targets for D2A pathway 1, 2 and 3
- % of DToC against bedbase < 2%
- Reduction in % of super stranded patients (Length of stay greater than 14 days)
- Number of patients active on the virtual ward per day

Improvement Plan performance dashboard

Key Performance Indicators to monitor inflow of patients

Workstream	Measure	Month	Jan-19	Feb-19	Mar-19	Apr-19
A&E attendances	% Low acuity caseload – 5% or below	Actual	7%	6%	6%	
		Target	5%	5%	5%	5%
	% Older people attendances – 9% or below	Actual	9%	9%	9%	
		Target	9%	9%	9%	9%
	% GP referrals requiring no treatment or significant investigation- 5% or below	Actual	3%	1%	6%	
		Target	5%	5%	5%	5%
	Number of patients accepted onto Community Addmission avoidance Service - Islington	Actual	82	76	95	
		Target	46	46	46	68
	Number of patients accepted onto Community Addmission avoidance Service - Haringey	Actual	94	88	83	
		Target	66	66	66	66

Key performance indicators to monitor workforce

Workstream	Measure	Month	Jan-19	Feb-19	Mar-19	Apr-19
Worforce redesign	Reduction in breaches overnight - no data ATM	Actual				
		Target	TBC	TBC	TBC	TBC
	Weekend shifts with enhanced consultant cover	Actual	100%	100%	100%	50%
		Target	100%	100%	100%	100%
	Weekend shifts with enhanced doctor cover (exact shifts to be defined)	Actual	n/a	n/a	n/a	88%
		Target	100%	100%	100%	100%
	% of middle grades posts filled	Actual	100%	93%	98%	99%
		Target	100%	100%	100%	100%

Key performance indicators to monitor handover of patients

Workstream	Measure	Month	Jan-19	Feb-19	Mar-19	Apr-19
LAS handover of patients	Ambulance handover of patients within 15 minutes KPI1 – 100%	Actual	50%	47%	51%	
		Target	100%	100%	100%	100%
	Ambulance handover of patients within 30 minutes KPI2 – 100%	Actual	98%	98%	98%	
		Target	100%	100%	100%	100%
	Number of Ambulance Handover - 30 minute breaches	Actual	24	52	28	56
		Target	0	0	0	0
	Number of Ambulance Handover - 60 minute breaches	Actual	2	14	7	5
		Target	0	0	0	0

Key Performance Indicators to monitor streaming and redirection improvements

Workstream	Measure	Month	Jan-19	Feb-19	Mar-19	Apr-19
Streaming and Redirection	% patients streamed to Urgent Treatment Centre	Actual	53%	53%	55%	55%
		Target	55%	55%	55%	55%
	% patients streamed to onsite Primary care	Actual	15%	15%	15%	13%
		Target	20%	20%	20%	15%
	% patients streamed to AEC	Actual	4%	3%	3%	3%
		Target	6%	6%	6%	6%
	% of patients identified to have primary care needs to be redirected to offsite primary care, community services, pharmacy	Actual	0%	0%	0%	0%
		Target	5%	5%	5%	5%
	% patients over 75 referred to the Frailty pathway	Actual	58%	39%	39%	
		Target	25%	25%	25%	25%

Key Performance Indicators to monitor mental health improvements

Workstream	Measure	Month	Jan-19	Feb-19	Mar-19	Apr-19
Mental Health Improvements	Average time non admitted mental health patients spend in Emergency Department (mins)	Actual	n/a	n/a	n/a	389
		Target	n/a	n/a	n/a	TBC
	Average time admitted MH pts spend in ED (mins)	Actual	n/a	n/a	n/a	1051
		Target	TBC	TBC	TBC	TBC
	Average time MH patients spend in ED (mins)	Actual	439	497	515	
		Target	TBC	TBC	TBC	TBC
	Mental Health Transfers - 48 hour from Medically Fit For Discharge on ward to Mental Health bed	Actual	n/a	n/a	n/a	
		Target	100%	100%	100%	100%
	Mental Health Recovery Suite - utilisation (50% of people transferred) and capacity (2 people)	Actual				31%
		Target	50%	50%	50%	50%
	Number of 12 hour mental health breaches	Actual	0	1	0	1
		Target	0	0	0	0
	% of breaches attributed to delays in mental health assessment, treatment or transfer – 5%	Actual	9%	9%	11%	10%
		Target	5%	5%	5%	5%
	90% of patients in ED referred to MHLT assessed within 60 minutes of referral	Actual	96%	96%	98%	93%
		Target	95%	95%	95%	95%
	90% of patients in acute bed referred to MHLT assessed within 24 hours of referral	Actual	97%	98%	90%	95%
		Target	95%	95%	95%	95%

Key performance indicators to monitor the effective discharge of patients

Workstream	Measure	Month	Jan-19	Feb-19	Mar-19	Apr-19
Effective discharge of patients	Number of D2A pathway 1 referrals - Islington	Actual	46	64	64	54
		Target	60	60	60	60
	Number of D2A pathway 2 refferals - Islington	Actual	46	47	38	39
		Target	28	28	28	28
	Number of D2A pathway 3 refferals - Islington	Actual	6	9	7	7
		Target	3	3	3	3
	Number of D2A pathway 1 referrals - Haringey	Actual	55	42	20	
		Target	TBC	TBC	TBC	TBC
	Number of D2A pathway 2 referrals - Haringey	Actual	8	2	1	
		Target	TBC	TBC	TBC	TBC
	Number of D2A pathway 3 refferals - Haringey	Actual	4	1	1	
		Target	TBC	TBC	TBC	TBC
	% of DToC against bedbase	Actual	4%	3%	2%	3%
		Target	2%	2%	2%	2%
	% of medically optimised patients	Actual	7%	7%	6%	5%
		Target	4%	4%	4%	4%
	% of stranded patients (Los >7 days)	Actual	44%	43%	40%	40%
		Target				
	% of Super Stranded patients (LoS >14 days)	Actual	16%	14%	15%	14%
		Target				
	Number of patients active on the virtual ward per day	Actual	n/a	n/a	n/a	
		Target	n/a	n/a	n/a	10

Current RAG rating of initiatives (1)

Workstream	Action	Deadline	Owner	RAG rating
A&E attendances	LAS conveyances and alternative care pathways review	01/07/2019	ICCG/WH	
	Review of Low acuity attendances	01/07/2019	ICCG/WH	
	Reducing GP referrals requiring no treatment or significant investigation	ongoing	ICCG/WH	
	Reviewing older people attendances – identifying alternative pathways	ongoing	ICCG/WH	
	Managing high intensity users	ongoing	ICCG/WH	
	Optimising admission avoidance	ongoing	ICCG/WH	
	Direct booking from 111	01/07/2019	ICCG/WH	
				Net projected impact on breaches: ?? per day
Workflow redesign	Analysis of WH A&E activity and performance to identify pressure points	01/04/2019	ICCG	
	Supply and demand assessment work to better inform the staffing structure and skills set	01/05/2019	DC	
	Agree staffing model following D&C analysis (considering RAT)	02/05/2019	DC	
	Implement staffing model	06/05/2019	DC	
	Weekend staffing model to match the weekday model based on demand analysis	06/05/2019	DC	
				Net projected impact on breaches: ?? per day
LAS Handover of patients	Implement (reviewed) medical enhanced RAT	01/06/2019	EM	
	Redesign of FoH pathways to support streaming, redirection, triage and LAS handover	01/07/2019	EM	
	Development of LAS > AEC pathways	TBC	EM	
	Embed escalation protocol for early escalation of delays	01/06/2019	EM	
	Review staffing model in RAT area through D&C work	01/06/2019	EM	
	Agree and implement staffing model	01/06/2019	EM	
				Net projected impact on breaches: ?? per day
Medically Enhanced RAT model	Develop and implement a RAT model with a senior clinical decision maker	31/05/2019	DC	
	Develop process and protocols for RAT	31/05/2019	DC	
	Define and develop handover process between RAT doctor and majors area	31/05/2019	DC	
	Agree operating hours and staffing structure	31/05/2019	DC	

Initiatives of the plan have been RAG rated. The definition of the ratings are the following:

KPI not met. Actions overdue	KPI not met. Actions not overdue	KPI met. All actions completed

Current RAG rating of initiatives (2)

Streaming and Redirection	Agree a workforce model which supports effective streaming and redirection	25/04/2019	NR	
	Implement a workforce model which supports effective streaming and redirection	01/07/2019	NR	
	Increase streaming of patients to Urgent Treatment Centre	01/06/2019	NR	
	Increase streaming to onsite Primary Care	01/06/2019	NR	
	Increase Streaming to AEC, GAU and other internal services	01/06/2019	NR	
	Redirection to primary care/community/pharmacy	01/07/2019	NR	
	Increase uptake of Frailty Pathway	01/07/2019	NR	
			Net projected impact on breaches: ?? per day	
Ambulatory Care	Identify project lead and QI working group	01/05/2019	PA	
	Conduct a demand and capacity analysis to understand gap between our demand and capacity	31/05/2019	PA	
	Implement interim capacity in AEC following D and C analysis	01/07/2019		
	Implement improvements following analysis of service model	01/08/2019	PA	
			Net projected impact on breaches: ?? per day	
Clinical Decision Unit	Increase throughput through CDU (20 per day)	01/06/2019	FA-A	
	Implementation of CDU huddles 9am and 2pm	15/05/2019	FA-A	
	Development and implementation of CDU standard operating procedure	15/05/2019	FA-A	
	Recruit a CDU ward manager	01/06/2019	FA-A	
	Review medical staffing input into CDU to ensure the model is optimised	01/06/2019	FA-A	
			Net projected impact on breaches: ?? per day	
Mental Health Improvements	Review existing MH pathways	31/05/2019	AM/NS	
	Increase referrals to MH Recovery Suite – 50%	01/08/2019	AM/NS	
	Increase capacity of MHRS by sound-proofing existing area	31/05/2019	AM/NS	
	Review patient flow and discharge processes to facilitate timely discharge and improve access to acute MH beds for patients in ED/ on acute medical ward	31/05/2019	AM/NS	

Initiatives of the plan have been RAG rated. The definition of the ratings are the following:

KPI not met. Actions overdue	KPI not met. Actions not overdue	KPI met. All actions completed

Current RAG rating of initiatives (2)

Effective discharge of patients	Agree and embed transfer processes from ED to other organisations to minimise delay	31/06/2019	SC	
	Optimise existing models - Discharge to Assess (D2A), Rapid response and virtual ward, Reablement	ongoing	SC	
	Weekly reviews of Long length of stay patients	ongoing	SC	
	Weekly reviews of medically optimised patients	ongoing	SC	
	Define virtual ward model and performance measures	31/05/2019	SC	
	Agree a model for Senior MDT review of complex patients and escalation policy	31/05/2019	SC	
	Reduction in Delayed Transfers of Care <2%	30/06/2019	SC	
	Reduction in super stranded patients	30/06/2019	SC	
	Embed choice policy across all wards	31/06/2019	SC	
				Net projected impact on breaches: ?? per day

Initiatives of the plan have been RAG rated. The definition of the ratings are the following:

KPI not met. Actions overdue	KPI not met. Actions not overdue	KPI met. All actions completed

Risk Register

	Principal risk What could prevent this objective being achieved? Describe in terms of cause, event, effect.	Rating	Mitigation Existing mitigating controls Planned mitigating controls Gaps in mitigation, and action plan	Assurance Existing assurance Planned assurance Gaps in assurance, and action plan	Date last reviewed	Risk lead
1	• Staffing levels (and appropriate skill mix) are insufficient at times to manage daily (and hourly) demand (Increased volumes of attendances and increase acuity impacting on the departments capacity to manage the volume of patients with the 4 hour standard)		Workforce redesign initiative	System Improvement plan monitored by system partners at AEDB and its operational sub group	**April 19**	CG
2	• Patient flow into, through and out of the Whittington is not as efficient as it could be. Delays in patients being identified and prepared for discharge and delays in discharges (DTOCs and MOs) resulting in beds not being available for admission from A&E.		Streaming Initiatives Admission avoidance initiative Integrated Intermediate care model CDU optimisation Ambulatory care Discharge to Assess Programme	System Improvement plan monitored by system partners at AEDB and its operational sub group	**April 19**	EO/CG/ KW
3	• Increasing volumes of MH patients are failing to be seen, admitted or discharged within 4 hours		MH pathways review Mental Health Recovery Suite Initiative	System Improvement plan monitored by system partners at AEDB and its operational sub group	**April 19**	AR/ DS & CG

Meeting title	**Trust Board – public meeting**	**Date: 26 June 2019**
Report title	May (Month 2) 2019/20 – Financial Performance	**Agenda item: 13**
Executive director lead	Stephen Bloomer, Chief Financial Officer	
Report author	Kevin Curnow, Operational Director of Finance	
Executive summary	The Trust is reporting a year to date deficit of £1.5m which is £1.8m behind plan. The Trust is not expecting to achieve the Q1 financial target and therefore has not assumed any Provider & Sustainability Funding relating to its financial performance resulting in a negative variance of £0.3m. The primary driver for the adverse variance is failure to achieve the Cost Improvement Programme (CIP) with delivery of £0.3m in month being £0.4m year to date against a £2m target. The CIP variance is within both pay and non-pay. The year to date pay costs are in excess of budget by £0.9m. Bank spend remained consistent with month 1 at £1.8m, agency spend is almost £1m an increase of £50k on month 1. Agency staffing costs at the end of Month 2 amount to £1.9m and at current run-rate would exceed £11m for the year so needs to be tightly managed to ensure the Trust remains within the NHS Improvement annual agency ceiling of £8.8m. Non pay expenditure is £0.4m overspent in month and £1.1m year to date. The Trust has spent £0.8m on capital expenditure as at month 2. The planned spend is £2.2m. The Trust is currently liaising with NHS Improvement to confirm its capital allocation for the financial year.	
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 May 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	Sustainable 1	
Report history	Trust Management Group, 25 June 2019	
Appendices	1 – month 2 finance report	

May (Month 2) 2019/20 – Financial Performance

Financial Overview

The Trust is reporting a year to date deficit of £1.5m deficit in May, which is a negative variance to plan of £1.8m. As the Trust is failing to achieve the key financial indicator measures it is unlikely to meet its financial target at the end of quarter 1. The table below shows the summary position for the May.

Statement of comprehensive income

2019/20, Month 2 (May 2019)

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	YTD Actuals (£000s)	YTD Variance (£000s)	TFMS FULL YEAR BUDGET (£000s)
Clinical Income	24,805	25,168	363	48,895	49,541	645	290,479
Other Non-Patient Income	2,076	1,959	(117)	4,152	3,813	(339)	24,921
High Cost Drugs	665	613	(52)	1,331	1,406	75	7,984
Pay Award Funding	0	0	0	0	0	0	0
Total Income	**27,546**	**27,740**	**194**	**54,378**	**54,759**	**381**	**323,384**
Pay	(18,974)	(19,559)	(585)	(38,626)	(39,500)	(874)	(232,207)
Non-Pay (excl HCD)	(6,020)	(6,527)	(506)	(12,055)	(13,143)	(1,089)	(72,407)
High Cost Drugs	(668)	(555)	112	(1,335)	(1,362)	(27)	(8,011)
Total Operating Expenditure	**(25,662)**	**(26,641)**	**(979)**	**(52,016)**	**(54,006)**	**(1,990)**	**(312,625)**
	1,884	**1,099**	**(785)**	**2,362**	**753**	**(1,609)**	**10,759**
Depreciation	(621)	(577)	44	(1,241)	(1,169)	72	(7,481)
Dividends Payable	(432)	(432)	0	(864)	(864)	0	(5,187)
Interest Payable	(270)	(279)	(9)	(541)	(547)	(6)	(3,238)
Interest Receivable	9	18	9	18	39	21	156
P/L on Disposal of Assets	0	0	0	0	0	0	0
Total	**(1,314)**	**(1,270)**	**44**	**(2,628)**	**(2,541)**	**87**	**(15,750)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**570**	**(171)**	**(741)**	**(266)**	**(1,788)**	**(1,522)**	**(4,991)**
Provider Sustainability Fund (PSF)	259	164	(95)	518	242	*(276)*	*4,946*
Net Surplus / (Deficit) - before IFRIC 12	**829**	**(6)**	**(835)**	**252**	**(1,546)**	**(1,798)**	**(45)**
Add back							
Impairments	0	0	0	0	0	*0*	0
IFRS & Donate	3	6	3	5	13	*8*	45
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**832**	**0**	**(832)**	**257**	**(1,533)**	**(1,790)**	**0**

Key Indicators of Financial Delivery

MEASURE	TARGET	ACTUAL	Prev month	RAG	RESPONSIBLE OFFICERS
Beds at funded establishment	197	226	221		DOO - Surgery & Cancer & EIM
CIP schemes identified	100%	76%	83%		Head of PMO
CIP schemes delivery April 2019	100%	19%	10%		Head of PMO
Emergency Length of stay	TBC	7.2	6.2		DOO - EIM
Elective Activity planned delivered (DC & Elective)	100%	102%	105%		DOO - Surgery & Cancer
Trust wide agency spend (per month)	£0.7m	£1.0m	£0.9m		DOOs

Despite being off target at month 2 the Trust is forecasting to meet its control total for the full year and is developing a recovery plan. Recovery actions include:

- Third party assurance on Cost Improvement Programme including reviews of specific schemes identifying to give assurance that the details within key schemes are adequate to deliver the target value and where this is not the case advise on the steps required.
- Ensure all escalation beds are closed and the Trust delivers planned activity with the funded bed capacity reducing Average Length of Stay, Delayed Transfers of Care and the number of Medically Optimised patients in beds.
- Ensure all Average Length of Stay targets and metrics signed off by specialty with a clinical lead working with the Performance Director on delivery
- Ensure all ICSUs deliver to funded establishments with Executive sign off for over establishments
- Whilst income is broadly to plan there are areas with shortfalls. Each of these areas to complete an actions plan to address shortfalls and ensure waiting lists do not grow
- Review of Trust capacity to identify opportunities to repatriate work from private providers or assist with other capacity concerns at other NCL organisations
- Increased support for EIM ICSU looking at enhancing controls, managing within the establishment, service capacity modelling and training for managers

The financial position is largely driven by failed CIP of £1.6m year to date. This has translated in to both pay and non-pay overspends which are described below.

Income and activity

The comments and table below refer to the Trust's performance against its overall operating plan. The Trust is performing (before the application of PSF) £0.4m (0.7%) ahead of plan but this is offset by a reduction to PSF (£0.2m) as the Trust's control total has not been met. Revised income after this reduction is £0.1m (0.2%) favourable to plan.

The main areas of material variance are within controllable planned care. Elective admissions and day cases are £0.4m (10%) favourable to YTD plan. Outpatients are £0.3m (7%) YTD adverse to plan caused by adverse performance in M2, £0.3m (13%).

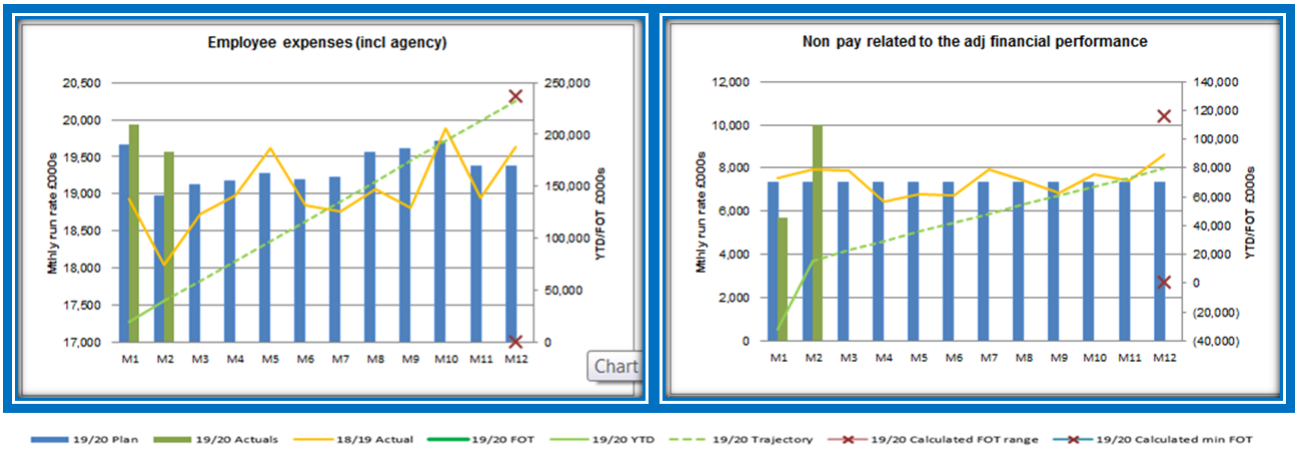
Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance
Elective and Day Case	1,906	2,011	105	3,725	4,100	375
Non Elective 0 LOS	1,057	1,103	46	2,080	2,144	64
Non Elective LOS I Day or Greater	3,723	3,884	161	7,324	7,549	225
OP Attendances - 1st	1,044	894	(150)	2,041	1,925	(116)
OP Attendances - follow up	941	833	(108)	1,839	1,690	(149)
A&E Attendances	1,433	1,420	(13)	2,820	2,805	(15)
High Cost Drugs	650	590	(60)	1,300	1,382	82
Community	6,160	6,160	0	12,320	12,320	0
Other Clinical income NHS	5,427	5,516	89	10,607	10,722	115
Other Clinical Income Non NHS	3,129	3,367	238	6,170	6,310	140
Total Income From Patient Care Activities	**25,470**	**25,778**	**308**	**50,226**	**50,947**	**721**
Other Operating Income Excluding PSF	**2,076**	**1,962**	**(114)**	**4,152**	**3,812**	**(340)**
Total	**27,546**	**27,740**	**194**	**54,378**	**54,759**	**381**
PSF	259	164	(95)	518	242	(276)
Revised Total	**27,805**	**27,904**	**99**	**54,896**	**55,001**	**105**

Monthly run rates – expenditure

The in month combined expenditure position is £1m adverse to plan (£2m adverse YTD). Key points to note are:

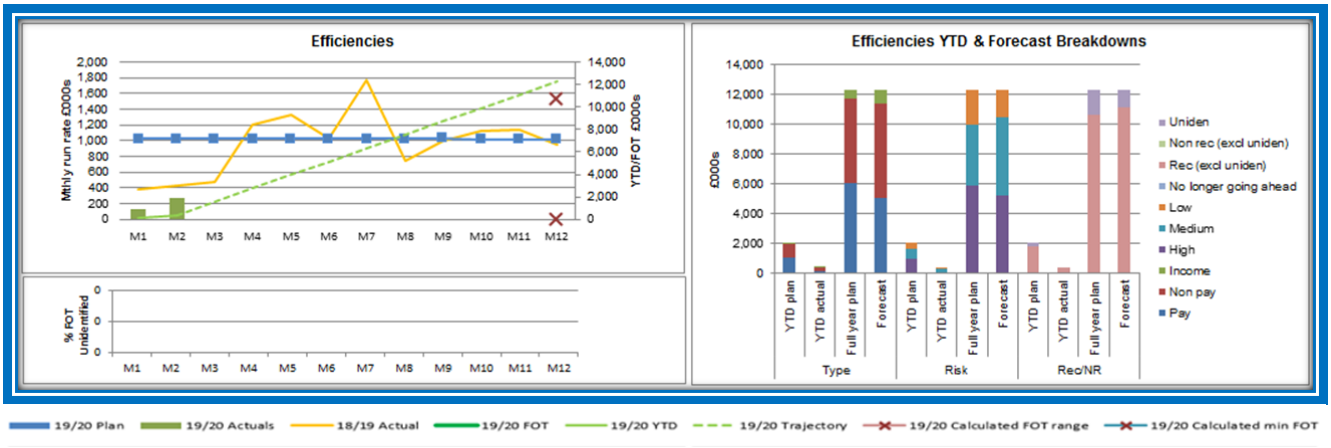
- **Pay and Activity Correlation**
  - Total pay expenditure for May was £19.6m, £0.6m adverse to budget, (£0.9m adverse) YTD.
  - The majority of the pressures are within Emergency Integrated Medicine where there continues to be a high level of over establishment. This sits within the ward areas (£0.4m) as there are a higher than planned number of beds open and a pressure on one to one care and within the Emergency areas (£0.3m) where there is a mix of over establishment in nursing (£0.2m) and premium rate staffing pressures due to vacancies particularly within middle grade doctors (£0.1m).
  - Other ICSUs are experiencing pay pressure including Surgery where excess beds is also an issue.
  - Within total pay expenditure, agency costs were £1m, £1.9m year to date with Bank spend at £1.8m for the second month in a row. Total temporary spend for the year is £5.6m.

- **Non Pay**
  - Non pay expenditure for May was £7.1m, including High Cost Drugs.
  - The non-pay variance in month 2 is an adverse variance of £0.4m. This is an overspend of £0.5m with pressures on pressures within clinical supplies for theatres, endoscopy insourcing and utilities and unachieved CIP.
  - Of-setting the overspend is High Cost Drugs with £0.1m positive variance



Cost Improvement Programme (CIP)

The Trust has planned CIP delivery of £1m each month, with the year to date target being £2m. The Trust has delivered is £0.4m. This is an adverse variance of £1.6m



Next Steps

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

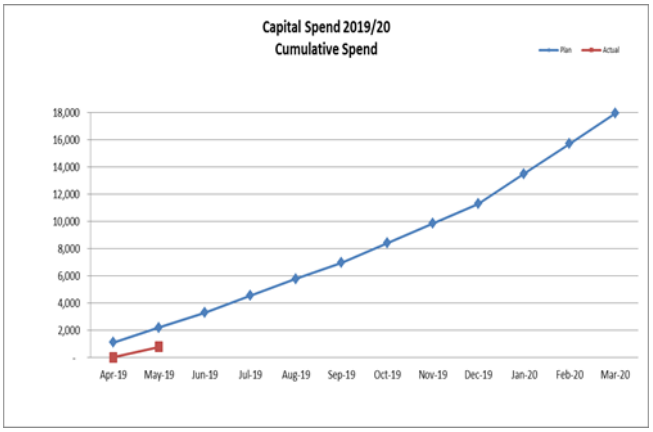
- Third party assurance on Cost Improvement Programme including reviews of specific schemes identifying to give assurance that the details within key schemes are adequate to deliver the target value and where this is not the case advise on the steps required.
- Changes to the PMO structure to provide greater support to ICSUs to assist with the development and delivery of CIP
- 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

	As at 31 May 2019 £000	Plan 31 May 2019 £000	Year to Date Plan variance 31 May 2019 £000
Property, plant and equipment and intangibles	217,822	224,391	(6,569)
Trade and other receivables	737	1,400	(663)
Total Non Current Assets	**218,559**	**225,791**	**(7,232)**
Inventories	1,571	1,355	216
Trade and other receivables	42,862	35,114	7,748
Cash and cash equivalents	24,467	18,044	6,423
Total Current Assets	**68,900**	**54,513**	**14,387**
Total Assets	**287,459**	**280,304**	**7,155**
Trade and other payables	44,163	45,337	(1,174)
Borrowings	28,093	29,147	(1,054)
Provisions	1,031	1,391	(360)
Total Current Liabilities	**73,287**	**75,875**	**(2,588)**
Net Current Assets (Liabilities)	**(4,387)**	**(21,362)**	**16,975**
Total Assets less Current Liabilities	**214,172**	**204,429**	**9,743**
Borrowings	28,830	31,966	(3,136)
Provisions	839	842	(3)
Total Non Current Liabilities	**29,669**	**32,808**	**(3,139)**
Total Assets Employed	**184,503**	**171,621**	**12,882**
Public dividend capital	66,691	66,691	0
Retained earnings	22,844	4,359	18,485
Revaluation reserve	94,968	100,571	(5,603)
Total Taxpayers' Equity	**184,503**	**171,621**	**12,882**



There are some significant variances in the balance sheet against plan. Overall, the value of the balance sheet is £12.9m higher from plan. The taxpayers' equity section is signifcantly more than plan, the main reason behind this is the increased surplus made by the Trust as a result of additional Provider Sustainability Funding (PSF). This has been partially offset by 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 £6.6m lower than plan. This variance against plan largely arises from the revaluation decreases mentioned above.

Cash and cash flow: the Trust has £24.5m in cash at the end of May 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. £17m 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.

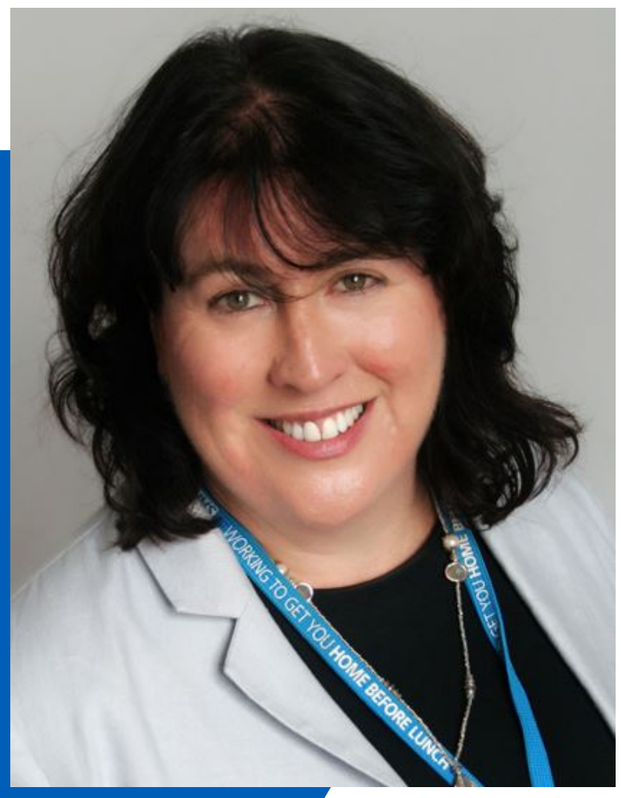
Receivables (Debtors) are £7.7m higher than plan. This increase is primarily driven by the additional £6.3m PSF awarded to the Trust by NHSI as a reward for meeting its financial targets in 2018-19. As stated above, the Trust expects this to be settled in July 2019.

Meeting title	**Trust Board - public meeting**	**Date: 26 June 2019**
Report title	**2018/19 Whittington Health Annual Report & Accounts**	**Agenda Item: 15**
Executive director lead	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	
Report author	Jonathan Gardner	
Executive summary	This paper provides Board Directors with the final version of the 2018/19 annual report and accounts for approval following review by the executive team, Trust Management Group, the Audit & Risk Committee and consideration at the Board seminars.	
Purpose:	Approval	
Recommendation(s)	Board members are invited to approve the final 2018/19 annual report and accounts.	
Risk Register or Board Assurance Framework	All BAF entries	
Report history	Board seminar, 10 April; Executive Team, 23 April Trust Management Group; Trust Board seminar, 8 May; Audit and Risk Committee, 16 May	
Appendices	None	

Whittington Health

NHS Trust

Our Annual Report 2018 - 2019



Welcome

Welcome to our 2018/19 Annual Report. It has been another year of achievement. We are proud of the work our staff and volunteers do to support over 500,000 people living across North Central London and beyond to live longer healthier lives.

Again this year we thank all our colleagues for the continued progress the Trust has made in many areas. We continue to be rated "Good" overall and "Outstanding" for caring by the CQC and we have achieved a planned financial surplus while delivering a cost improvement of £13.3m.

The quality and safety and reported experience of our care continues to be very good, with low mortality rates, infection rates and great outcomes reported from our services; a highlight being that 100% of women in our maternity services saying they were treated with respect and dignity.

We have made huge improvements particularly in the waiting times for our community services, with some services now seeing 100% of patients within 6 weeks, and we have successfully met many of the constitutional standards. Unfortunately as with many Trusts we are still struggling to discharge or admit 95% of Emergency Department attendances within 4 hours despite considerable efforts to improve flow through the hospital. In part this is caused by the continuing rise in the number of people who attend the Emergency Department.

One area of focus this year has been our continued poor staff survey results which indicate that we have much to do around bullying and harassment. As a result we have conducted an external review. Out of this has come a fresh approach to engaging with our staff, which is already beginning to deliver results. These are outlined in the report and demonstrate our commitment to developing and rolling out a compassionate leadership culture to improve our staff experience.

Another theme in the report is that of systems working and partnership with our council, local GPs and NHS colleagues across North Central London as we start to design a new integrated care system to improve the coordination of services. We continue to work closely with UCLH NHS Foundation Trust on clinical pathways and have begun similar conversations with North Middlesex. We have also been liaising

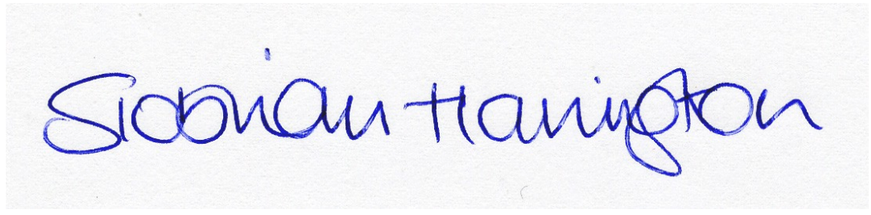
closely with council, mental health and primary care colleagues to see how we can work better together on a locality basis using the assets of the community and voluntary sector better.

Recruitment and retention has been a focus this year with improvements made particularly in the vacancy rates in the District Nursing which have come down from 37% to 18%. We have also made progress in the development of our estate, both through specific maintenance programmes and by starting a review of the longer term estates strategy. We are particularly proud of the comprehensive roll-out of various information technology improvements allowing for example the electronic recording of observations.

Over the last year we have also made the first steps in improving our engagement with the community at large as well as continuing our great work in co-design with our patients and service users. Examples of this have been improving connections with key stakeholders and the voluntary sector, through briefings and meetings; by inviting service users and the public to locality design events, and by Health Watch Islington and Bridge Renewal Trust running some engagement with the public on our estates plans.

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

We trust that this Annual Report reaffirms our ambition to lead the way in the provision of excellent integrated community and hospital services. All at Whittington Health are striving to help local people lead longer healthier lives.



Siobhan Harrington
CEO

Steve Hitchins
Chair


HELPING local people LIVE longer healthier lives!
NHS
Whittington Health
NHS Trust
I RECEIVE GREAT CARE!
I AM TREATED AS A PERSON!
IMPROVED PATIENT EXPERIENCE
COMPASSION
self management
I AM FULLY INVOLVED IN DECISION MAKING ABOUT MY CARE!
RESPECT
SAFETY
IT'S OUR PRIORITY IN EVERY ENCOUNTER!
WE WORK AS A TEAM TO HELP YOU NAVIGATE YOUR JOURNEY!
We are building LONG TERM RELATIONSHIPS
We have a VIBRANT & COMPLEX community
CO-ORDINATED CARE
SOCIAL CARE
LOCAL COUNCILS
INNOVATIVE EDUCATION & RESEARCH

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Tell us what you think about this report:

@WhitHealth

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whh-tr.whitthealthPALS@nhs.net

020 7288 5551

Overview

About us

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

We provide hospital and community care services to over half a million people living in Islington and Haringey as well as those living in Barnet, Enfield, Camden and Hackney. Whittington Health provided over 100 different types of health service (over 40 acute and 60 community services) in 2018/19. Every day, we aim to provide high quality and safe healthcare to people either in our hospital, in their homes or in nearby clinics. We are here to support our patients throughout their healthcare journey – this is what makes us an integrated care organisation.

Our Services and our Approach are Driven by our Mission and Vision:

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

Our mission:
Helping local people live longer, healthier lives

Our vision:
Provide safe, personal, coordinated care for the community we serve

Our Clinical Strategy

continued to help us deliver service improvements, focussing on the challenges faced by our local health and social care economy. This year we added three enabling objectives to create nine corporate objectives for the year:

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

Enabled by:

- To recruit and retain high quality engaged staff
- To deliver efficient and financially sustainable services
- To deliver innovative estate, IT and other support services that enable the clinical objectives.

During the latter half of the year, we began work to review and revise our strategy and engaged with staff and stakeholders, with a revised strategy for 2019/24 being agreed in April 2019.

Our Values

The ICARE values developed through staff engagement and consultation continued to be fundamental to everything we do at Whittington Health and form the basis of expected staff behaviours. They are:

Our Services

Our priority is to deliver the right care, at the right time, and at the right place for our patients. We provide an extensive range of services from our main hospital site and run services from over 30 community locations in Islington and Haringey, and our dental services are run from sites across 10 boroughs.

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

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

Key Themes and Risks:

Quality and safety: quality and safety has remained our top priority and we have made huge progress in many areas such as community waiting times. We have continued to struggle to maintain the 4 hour emergency department target, but have consistently met most other targets.

Culture and recruitment: on the back of concerning staff survey data in the previous couple of years this year we conducted a thorough cultural survey and have put in place a number of interventions to reduce bullying and harassment and improve staff engagement. This also contributes to reducing the risk of high vacancy rates. Notable progress in this area has been made by the community teams who have reduced their vacancy rate considerably.

Systems working and integrated care: this year we have made huge progress with our collaborations with GP federations, councils and mental health trusts to start changing how we work as a system. We have been working hard with North London partners to help design what a North Central London integrated care system will look like, as well as practically working with the councils on how we integrate council services and the voluntary sector around smaller localities.

Improvement and productivity: the quality improvement programme has grown this year and we are seeing projects spring up all over the organisation.Productivity has been a challenge as we continue to live within our means, and we kept the winter escalation beds closed for longer this year than last.

Whittington Health: what we have achieved...

1,328,632 face to face patient contacts

535,209 At our hospital

In the Community **793,423**

97.5% of patients said they would recommend our community services to friends or their family

18,256 Emergency admissions

4.6% up on last year

2,224 Elective inpatient admissions

98.3% of our inpatients said they would recommend us to family or their friends

21,292 Day Case Admissions

8% up on last year

325,129 Community Nursing Visits

7.6%

91,434 Health and School Nurse Visits

8.8%

81,633 Physio Appointments

2.6%

49,792 Dental Appointments

25%

A day in our life...

250 Health Visitor or School Nurse Contacts

Community Nurse Visits **890**

1094 Outpatient Appointments

Babies Delivered **10**

50 Emergency Admissions

298 Accident & Emergency Visits

58 by ambulance

252 X-rays Performed

64 Planned Admissions or Day Case Treatments Provided.

Our Achievements:

We are proud of our staff and their commitment to delivering safe and high-quality care – over the past year our community and hospital teams have helped to pioneer new projects and secure numerous national professional awards and accolades. A few of the many highlights of the year and achievements of our staff are outlined below:

- **A revised strategy and road map** for becoming a successful and sustainable provider of integrated healthcare services for local people and helping them to live longer, healthier lives

- **NHS 70 and Windrush:** Comfort Offorjindu, a Midwife at Whittington Health, was honoured with a Lifetime Achievement award at the NHS Windrush 70 awards, five Whittington Health nurses were awarded nursing leadership scholarships as part of the Leadership for Windrush; and the whole Trust celebrated with an open day

- The Haringey Improving Access to Psychological Therapies (IAPT) service, along with the Shaw Trust, was officially designated as a **Centre of Excellence**. This is the first and only IAPT in the country to have received centre of excellence status

- **Care Quality Commission's (CQC) unannounced visit** to Simmons House resulted in positive feedback

- **Maternity Picker Survey results** - 100% of women responding said they were treated with respect and dignity, 98% had confidence and trust in staff

- The 2018 Nursing Times **Nurse Leader of the Year Award** was awarded to Colette Datt, a Nurse Consultant in Children and Young People's services

- **The haematology team** was awarded 'Highly Commended' for its work to prevent patients from developing dangerous blood clots at the recent prestigious Anticoagulation Achievement Awards

- **UK National Cancer Patient Experience Survey** placed us 2nd in London and 35th overall in the

- **Highest quartile for reporting incidents** on the National Reporting Learning Services which demonstrates a strong culture of openness and reporting to continuously improve patient safety

- **Shortlisted for the 2018 HSJ Value awards for Clinical support services**, for improving the pharmacy outpatient service through design

- **Shortlisted for the 2018 HSJ Value awards for Community health service redesign**

- **The third highest uptake of flu vaccine** by our staff across London at 83.4%

- Three of our consultants received a '**Top Teaching Award'** from UCL Medical School

- An **annual cancer conference** in partnership with Macmillan Cancer Support which 150 people affected by cancer attended

- The Whittington Health HR team, together with UCLH, won the '**Innovation in HR'** award at the Healthcare People Management Association annual awards for developing a new arrangement to simplify processes for staff to work at either Trust

- The signature of a memorandum of understanding with the **Greater London Authority** to help achieve the Mayor of London's aim to increase the supply of affordable housing

- In line with the NHS Long Term Plan, our teams worked very closely with the councils, mental health trusts and GPs to see how we can work in a more coordinated way at a **locality** level

- A successful application to join the first cohort of NHS Improvement's **Children and Young People Transition Collaborative** which aims to support and improve clinical practice

- Signing the **Armed Forces Covenant**

- Our **partnership with The Autism Project** (TAP) resulted in several TAP students starting work placements within the hospital as part of the TAP programme which supports young autistic adults (aged between 18-25 years) to develop employability skills

- The Care of Older People Team held a **Delirium Tea Party**, with volunteers doing art therapy and promoting activities and representatives from The Kissing It Better charity singing for patients on wards

- After an independent report by Professor Duncan Lewis, around 600 staff took part in listening events and fed back on priorities to include in plans to **enhance the workplace culture**

- **Caroline Fertleman, Consultant Paediatrician at Whittington Health, was promoted to Professor** at University College London

- Following a review of operational management arrangements five **Integrated Clinical Service Units** came into operation on 1 July 2018, covering: Surgery and Cancer; Emergency and Integrated Medicine; Community Health for Adults; Children and Young People Services; and, Women's Health, Outpatients and Diagnostics

- Successfully providing 100% of the mandatory items for the Trust's annual **Data Security and Protection toolkit** (DSP) submission

- An excellent outcome from our assessment against NHS England's **Emergency Preparedness**, Resilience and Response Framework.

Performance Report

How we Measure Performance:

Our board and its key committees use a performance scorecard which has been developed to include a suite of quality and other indicators at Trust and service level – enabling centralised reporting of performance and quality data and improved triangulation of information. The scorecard is based on the Care Quality Commission's five domains of quality: safe, effective, caring, responsive and well led. The selection of indicators is based on NHS Improvement guidance for national outcome areas and also the Trust's local priorities.

2018/19 Performance Outcomes and Analysis

The year-end position against a suite of indicators used to measure performance is outlined in the following tables.

Tables 1-5: Performance against national targets 2018/19, at a glance

Safe – people are protected from abuse and avoidable harm		
KPI description	**Target**	**Outcome**
Admission to adult facilities of patients aged under 16	0	0
Incidence of Clostridium Difficile	<16	13
Outstanding CAS alerts	0	0
Actual falls	400	432
Avoidable category 3 or 4 pressure ulcers	0	24
Harm Free Care (%)	>95%	92.6%
Non- Elective C-section rate (%)	<19%	21%
Medication errors causing serious harm	0	0
Incidence of MRSA	0	1
Never Events	0	0
Safety Incidents	0	32
VTE risk assessment (%)	>95%	95.4%
Mixed sex accommodation breaches	0	17

Effective – people's care, treatment and support achieve good outcomes, promote a good quality of life and are based on the best available evidence		
KPI description	**Target**	**Outcome**
Breastfeeding initiated	>90%	92.6%
Smoking at delivery	<6%	5.8%
Non-elective re-admissions within 30 days	<5.5%	5.95%
Hospital standardised mortality ratio rolling within 12 months	100	81.9
Hospital standardised mortality ratio rolling within 12 months (weekend)	100	76.8
Mortality rate per 1000 admissions in-months	14.4	6.6
IAPT Moving to Recovery	>50%	58.0%
% seen within 2 hours of referral to district nursing night	>80%	90.5%
% seen within 48 hours of referral to district nursing night	>95%	92.1%
% of MSK patients with a significant improvement in function	>75%	80.5%
% of podiatry patients with significant improvement in pain	>75%	85.1%
% of patients with self-directed goals set at discharge	>70%	76.6%
% weight loss achieved at discharge	>65%	72%

Caring - Involving people in their care and treating them with compassion, kindness, dignity and respect		
KPI description	**Target**	**Outcome**
Emergency department – FFT % positive	>90%	81%
Emergency department – FFT response rate	>15%	13%
Inpatients – FFT % positive	>90%	92.7%
Inpatients – FFT response rate	>25%	17.8%
Maternity - FFT % positive	>90%	94.7%
Maternity - FFT response rate	>15%	51%
Outpatients - FFT % positive	>90%	91.9%
Outpatients - FFT responses	4800	4069
Community - FFT % positive	>90%	96.6%
Community - FFT responses	18,000	12190
Trust Composite FFT - % recommend	>90%	89.8%
Staff FFT - % recommend	>70%	70.5%
Complaints responded to within 25 working days	>80%	88.6%

Responsive - organising services so that they are tailored to people's needs		
KPI description	**Target**	**Outcome**
Emergency department waits – 4 hours	>95%	87.9%
Median wait for treatment (minutes)	<60 mins	83
Ambulance handovers waiting more than 30 minutes	0	245
Ambulance handovers waiting more than 60 minutes	0	39
12 trolley waits in A&E	0	4
Cancer – 14 days to first seen	>93%	94.2%
Cancer – 31 days to first treatment	>96%	100%
Cancer – 62 days from referral to treatment	>85%	91.1%
Diagnostic waits (<6 weeks)	>99%	98.9%
Referral to treatment times waiting <18 weeks (%)	>92%	92.2%
Referral to treatment time over 52 weeks	0	2

Well led - leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, support learning and innovation, and promote an open and fair culture		
KPI description	**Target**	**Outcome**
Staff appraisal rate (%)	>90%	73.1%
Mandatory training rate (%)	>90%	82.0%
Permanent staffing WTEs utilised	>90%	87.2%
Staff sickness rate (%)	<3.5%	3.52%
Staff FTT – recommending the trust as a place to work	>50%	59.4%
Staff turnover rate (%)	<10%	12.6%
Vacancy rate against establishment (%)	<10%	12.8%

Monitoring Performance

The Trust's performance management framework acknowledges the national context as well as addressing local quality and service priorities. Whittington Health has a culture of continuous improvement using the cycle of performance management and uses a system of performance reporting against agreed measures and quality priorities. The monthly performance scorecard allows continuous monitoring of specific datasets such as quality and finance, service specific information and deviation from commissioned targets. This information is used to monitor compliance with service standards and contract review and is used to populate national external data sets.

Outcomes against scorecard indicators are reported to the weekly executive team meeting, bi-weekly to the Trust Management Group, monthly to respective Integrated Clinical Service Unit (ICSU) Boards, regularly to board sub-committees, and monthly to the Trust Board itself. All reports are monitored and discussed at these meetings to identify reasons for any underperformance, as well as reviewing progress of action plans to remedy underperformance. The Trust has developed a new performance scorecard for 2019/20 to ensure we continue to monitor the things that matter to the delivery of high quality care.

STATEMENT OF FINANCIAL POSITION

Spending on Agency and Temporary Staff

The Trust was set a very challenging agency cap target by NHS Improvement of £8.8m for 2018-19. The Trust realised early in the year that it would not remain within the cap and therefore, for internal operational management purposes, set itself a target of £12.8m. Trust spend on agency in the financial year is £12.0m. The Trust is aware that maintaining and improving our performance in relation to the use of agency and temporary staff is key to delivering quality and financial sustainability. As such, the Trust is putting a number of measures into place to control agency spend going forward, not least transferring its temporary staff management to Bank Partners from May 2019.

Financial Position

At the start of the 2018-19 financial year, the Trust agreed a control total target of a £4.7m surplus in year with NHSI. Following an agreement with NHSI around the disposal of a non-clinical part of the main hospital site to Camden and Islington NHS FT, this target was revised to a surplus of £22.7m, after NHSI offered the Trust £12m in additional incentive Provider Sustainability Funding (PSF) in the event of exceeding the original control total. Following a decision by NHSI to exclude the impact of the Agenda for Change pay uplift from the assessment against financial targets, the Trust bettered this revised target by £0.1m and was eligible for an additional £6.2m in further incentive and bonus PSF. The final financial outturn was a £28.2m surplus against a control total of £21.9m.

This means that the Trust has achieved its control total for four years in a row, and has cleared its historic deficit from previous years (see also the value for money section below). While the Trust has been able to meet its financial targets for the year, some of this has been achieved through the use of non-recurrent measures and the application of PSF. Ignoring the impact of these measures, the Trust continues to run an underlying deficit each year, reported by NHSI of £6.6m at the end of March 2019.

Going Concern and Value for Money

As with previous years, we have prepared our annual accounts for 2018-19 on the going concern basis. This is in line with DH accounting guidance, which states that the Trust is a going concern if continuation of services exists. We have detailed above the positive trend in the Trust's finances. This improvement means that the Trust is now complying with the Department of Health duty to breakeven over a three-year period. This is significant for the Trust, as it means that external audit's conclusion on the Trust's arrangements for ensuring value for money in the use of its resources should be unqualified for the first time since 2014.

Financial Performance and Statement of Financial Position

Above, we have detailed the Trust's financial position for the year ending 31 March 2019, which indicates effective arrangements in the use of resources and a strongly positive trend in financial results. However, as a Trust we continue to face a challenging financial future.

Over the year we generated £348.6m in income, which was £25.3m higher than 2017-18 and £11.5m ahead of revised plans. This resulted primarily from the PSF award which was £27.6m as opposed to £10.6m in 2017-18;

Pay expenditure exceeded our budgeted level by £5.8m. The principal causes of this overspend were:

- Continued high level of vacancies across the Trust, leading to increased use of bank and agency staff;
- As with other Trusts, a national Agenda for Change pay award was applied in August 2018. The Trust was awarded £3.3m in additional income from DH, but it did not fully mitigate the £4.1m cost pressure resulting from the award.

Non-pay expenditure exceeded budgeted levels by £0.9m. The principal movements behind this were:

- Recognition of the costs associated with a new contract with a community education provider (£0.3m)
- Four of the Trust's main hospital blocks experienced an I&E impairment in year of £0.2m
- Depreciation in month relating to new additions added an extra £0.2m into non-pay costs
- Increased corporate costs relating predominately to legal fees £0.4m

Cash

The Trust has been in a strong cash position throughout the 2018-19 financial year, and ended the year with £25.2m in cash. This was £21.1m higher than at the end of 2017-18. The positive movement in cash resulted from:

- Receipt of PSF funding through the year;
- Receipt of proceeds from the sale of land to Camden and Islington NHS FT; and
- Strong collection rates on debt from both NHS and non-NHS organisations.

During the year, the Trust did not receive any additional cash support from the Department of Health, and has continued to pay down historic cash support loans. The Trust is not anticipating any significant cash issues in 2019-20, and has forecast to recycle cash holdings into capital programmes for future years, most notably into the Trust's estates strategy.

Property, Plant and Equipment

The Trust's outturn capital expenditure for the year is £14.7m. This is £0.1m lower than its revised forecast outturn, having reduced this outturn by £1m in month 5. The Trust has spent within its Capital Resource Limit of £8.8m by completing a disposal with a net book value of £6.3m. Notable within these levels of spend were investments in maternity and imaging, and updates to IT systems and hardware.

Receivables (debtors)

The Trust's receivables at the end of the financial year are £41.0m. This is £7.9m higher than plan and £10.6m higher than in 2017-18. These increases have been driven by the higher levels of core and incentive PSF. At the end of 2018-19, the Trust is owed £21.5m for PSF alone. The Trust expects this to be settled in July 2019. Collection of other old and current year debts in year has performed strongly.

Payables (creditors)

The Trust's payables at the end of the financial year are £40.6m. This is £0.9m higher than plan and £3.8m higher than in 2017-18. Overall, creditor performance has improved slightly on 2017-18. The Trust paid 88% of the value of invoices within 30 days, compared with 83% in 2017-18. Increases in creditor balances at year end have been partly driven by an ongoing supplier dispute (value £1.5m) and a change in Trust policy to invest spare cash rather than settle creditors in advance.

Risks

The Trust has a robust risk management policy and process as outlined in the annual governance statement below. However, For the purposes of this performance report, however, the key risks on our Board Assurance Framework are as follows:

- 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.
- Failure to support fragile services adequately, internally or via partnership with other providers leads to further instability where quality is reduced, or vital service decommissioned, or Trust reputation is damaged (e.g. Lower Urinary Tract service, Breast, Bariatrics).
- Failure to hit national and local performance targets results in low quality care, financial penalties and decommissioning of services – (e.g. Emergency Department, community etc.)
- 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)
- Failure to deliver savings plan for 2018/19 leads to adverse financial position, not hitting control total, loss of STF and reputational risk
- That the long term financial viability of the Trust is threatened by changes to the environment, long term plan, social care risks, political changes, organisational form changes
- Failure to provide robust urgent and emergency pathway for people with mental health care needs results in poor quality care for them and other patients, as well as a performance risk.
- Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience
- Breach of established cyber security arrangements results in IT services failing, data being lost and care being compromised
- 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

Each of these risks had a clear mitigation plan and assurance process. The board considered other risks throughout the year as they arose, including for example the risk of losing staff or being unable to recruit as a result of the pending EU Exit. Many of these are highlighted throughout this report.

DELIVER CONSISTENT, HIGH QUALITY, SAFE SERVICES

We are on a journey to outstanding (#BetterNeverStops) to continually improve the quality of our services and the experience of the people who use our services. In preparation for a Care Quality Commission inspection we are starting with an evidence-based assessment of our current position. The Accountable Officer for quality and the Care Quality Commission is the chief nurse and director for patient experience.

Registration with the Care Quality Commission (CQC)

We are registered with the CQC without any conditions. During 2018/19, we participated in the following special reviews or investigations:

Over the last year the Trust has been focusing on sustainable improvements to the care provided to vulnerable children and young people in Haringey. This was in response to a Joint Targeted Area Inspection in November 2017 focusing on Neglect across Haringey Local Safeguarding Children's Board (LSCB) area. There has been effective collaboration across all agencies working in Haringey and the recommendations specifically identified for Whittington Health have been completed. 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 of the implementation 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 the improvements which had been made since they last inspected the service

in November 2017. The inspectors spoke very highly of the staff and patient care 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 Trust's response and supporting actions addressing the CQC recommendations was submitted to the CQC on 2nd April 2019.

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

The new CQC methodology also includes Well Led and the Use of Resources which will be undertaken by NHS Improvement alongside CQC.

The Trust is focused on improving its safety rating and there is improved governance in place. For example;

- The Trust Board receives monthly reports on all serious incidents that have occurred that the previous month and importantly on how the Trust is learning from care and service delivery problems identified
- The Medical Director provides a quarterly Safety and Quality report to the Trust Board which is informed by reporting directly from the Patient Safety Committee and the Quality Committee
- Internal Audits of risk management and serious incident processes were completed with good learning and development which are being addressed through clear actions for the quality governance team

- The Trust's Safeguarding Adults & Safeguarding Children Committees have been brought together as one Committee under the responsibility of the Chief Nurse
- The Trust works closely with external regulators and patient safety reporting bodies such as the CQC, CCGs, NHS Improvement (NHSI) and the National Reporting and Learning System (NRLS)
- The Trust has processes in place to respond to patient safety alerts via the Central Alerts System (CAS).

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

- Providing safe services
- Providing clinically effective services
- Providing caring and compassionate services
- Providing the best experience of our services

The Trust was shortlisted for the CHKS 2018 Top Hospital Award for best performing Trust for 'Quality of Care' across the UK.

Quality Priorities

Each year the Trust agrees a number of priorities to improve the quality of our care for the people we serve. The priorities for 2018/19 were published in the 2017/18 Quality Account published in June 2018. The publication included progress on the previous year's priorities. Following consultation with staff, managers and stakeholders the Trust set 26 Quality priorities covering 3 domains

- Patient Safety
- Patient Experience
- Clinical Effectiveness

The Trust successfully met over 60% of its quality priorities and moved forward significantly with the remainder (some require another year as priorities for 2019-20).

Freedom to Speak Up Guardian

A new and full-time Freedom to Speak Up Guardian (FTSUG) for Whittington Health NHS Trust has been in post since late November 2018. As a priority, there has been good engagement with teams and services across Community and Hospital departments. Several services have been proactive in inviting the Guardian to attend local team meetings. This has been extended across the hospital and Trust corporate areas. Communication and visibility are two key points for the success of engaging with staff who may wish to raise concerns. The FTSUG has developed leaflets and posters explaining how to raise concerns in a safe and confidential way.

This year a clear and direct communication strategy has been developed in partnership with the Organisational Development Team and improvements are being made to the FTSUG intranet page regarding information on how to raise concerns. The Whistleblowing/ Raising Concerns policy has been updated March 2018. The role of the Trust Speak Up Inclusion Champions has been revised and is now aligned to the National Guardian's Office guidelines on helping staff to safely raise concerns. In order to avoid misunderstandings, the role was renamed Speak Up Advocate. The intention moving forward is to develop a network of Advocates throughout all different services across the Trust, with the vison being to have at least one Advocate in each Health Centre, Service and Ward area.

PATIENT SAFETY

Serious Incidents

The Serious Incident Executive Approval Group (SIEAG) comprising the Executive Medical Director/Associate Medical Directors, Chief Nurse, Chief Operating Officer, the Head of Quality Governance and Serious Incident (SI) Coordinator meets weekly to monitor and review Serious Incident investigation reports as defined within the NHSE Serious Incident Framework (March 2015). In addition, internal root cause analysis (RCA) investigations and resulting recommendations and actions are also monitored and reviewed by the panel.

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

For 2018/19 the Trust reported 32 serious incidents compared to 38 reported in 2017/18. These included the themes of:

- safeguarding; adult & children
- patient absconding
- attempted self-harm
- confidential information leak, loss, information governance breach
- diagnostic incident including delay
- maternity obstetric incident
- slip, trips and falls
- sub-optimal care
- treatment delay
- unexpected death of a patient in hospital or the community

From January 2019, certain maternity incidents affecting the baby are being investigated by the Health Safety Investigation Bureau (HSIB); to date, three maternity incidents have been referred to HSIB and investigations are currently in progress.

Final investigation reports are reviewed at the SIEAG panel and ICSU directors or their representatives are required to attend to present their reports. The panel offers scrutiny and

challenge on the investigation and findings to ensure that contributory factors in relation to care and service delivery problems have been fully explored, root causes identified and actions required are aligned with the recommendations. The panel discusses lessons learnt and appropriate action, both immediate if applicable, and planned to prevent future harm occurrences.

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

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

Never Events

A never event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented. The Trust reported one never event in 2018/19 and this related to:

A peripheral nerve block administered to the wrong shoulder. Actions taken to ensure this does not occur again included:

- Incident report shared to ensure all staff are aware of the 'Stop Before You Block' process; highlighted in Patient Safety Newsletter.
- Labels provided for staff to document performance of 'stop before you block'.
- Process to be re-audited to ensure compliance.

Learning from Deaths

During the period 1 April 2018 to 31 March 2019, 433 Whittington Health patients died in our inpatient wards 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 score 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

Infection Control and Prevention

The Infection Prevention and Control Team (IPCT) provide a full service to hospital and community sites across Whittington Health. An executive director is responsible as the Director of Infection Prevention and Control (DIPC). The Chief Nurse and Director of Patient Experience took on this responsivity in June 2018.

Whittington Health takes the prevention and control of all infection seriously and supports the delivery of the Trust objective to deliver consistent, high quality, safe services by ensuring safe

care to patients and ensuring a clean and safe working environment for staff employed by the organisation. Infection prevention and control continues to be everyone's business.

There are reporting requirements on reporting of Healthcare associated infections (HCAI) in particular MRSA bacteraemia, Clostridium difficile diarrhoea, diarrhoea and/or vomiting outbreaks, E.coli bacteraemia, respiratory tract viral infection including influenza and surgical site infections.

MRSA	•There is a zero tolerance on MRSA blood stream infections (BSI). In 2018/19 WhittHealth reported one MRSA BSI that was line related and deemed avoidable.
Clostridium Difficile Infections (CDI)	•The Public Health England (PHE) recommendation for 2018/19 for CDI was 16, WhittHealth reported 13 cases of CDI.
E.Coli Bacteraemia	•There were 9 Trust-attributed EColi BSI this year, WhittHealth are in line with the national objective - halving healthcare-associated Gram-negative BSIs by 2021.
Infuenza	•This winter there have not been any serious incidents declared and investigations undertaken into the care of any patients who died of influenza whilst an inpatient in the hospital. However, the Trust did palliate 3 people who came into hospital with influenza
Surgical Site Infections	•SSISS mandatory reporting to PHE is for 'at least 1 orthopaedic category for 1 period in the financial year'. WhittHealth participated in Q1 and Q2 in four categories (Hips, Knees, Neck of Femur and large bowel) reporting no infections.

Winter Flu Vaccination

Whittington Health has run a successful internal campaign in 2018/19 to encourage staff to have the annual flu vaccine. The campaigns are driven by staff safety and importantly, patient safety.

The uptake of the vaccine by front line staff was 83.4% which is the third highest rate in London and shows a consistent improvement year on year in the Trust. The campaign is a collaborative effort with the Occupational Health team, Infection Prevention and Control team, HR team and nursing teams working together to promote the staff vaccine.

PATIENT EXPERIENCE

Throughout 2018/19 the patient experience team has worked to develop a three year patient experience strategy. It was written to complement the Trust's clinical strategy, and to promote the Trust's ICARE principles and mission statement of helping local people live longer healthier lives.

It has been co-produced with professionals, facilitated patient focus groups, engaged patients, service users, and HealthWatch Haringey and Islington.

The Strategy was approved at the Trust Board in March 2019. It includes three ambitions, and the first year implementation plan has been drafted:

- We will improve the information we provide to patients and carers to enhance two-way communication.
- We will work in partnership with patients, families and carers to build a foundation for co-design and service improvement.
- We will improve our patients' journey ensuring we provide integrated holistic care, from the first contact and throughout their care.

In line with national reporting requirements in relation to **mixed sex/gender accommodation** we revised our reporting of mixed gender accommodation breaches to include intensive care patients. 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 with between 5-7 breaches reported each month. This reduced over quarters two and three then as winter progressed there was 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.

It is important to our staff that we get feedback from the people who use our services regarding their experience and the Trust uses an online system (Meridian) to collect feedback. The information is collected via iPads, comment cards, electronic links and on the website. Paper surveys are also available when electronic means are not appropriate.

In 2018/19, 42,080 people told us about their care and treatment as compared to 44,061 in 2017/18. One of the key questions we ask all patients is whether they would recommend the Trust to **Friends and Family** if they needed treatment.

In 2018/19 the average FFT recommend rate across all services was 91.76%; a slight increase from the 2017/18 average recommend rate of 91.65%.

Significant focus has been made within the largest clinical areas of the Trust to ensure improvements are seen in the response rate and recommendation rate. These departments and actions taken are described below:

Emergency department	• Emergency 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
Hospital Inpatient Wards	• Consistent improvement recommending rate with Trust typically performing above national average • Introducing RITA (Reminiscence Interactive Therapy and Activities) in response to patient feedback on one of our busier inpatient wards • Launching Sleep Well initiative to improve night time experience for patients on adult inpatient wards developed in response to patient feedback collected locally through FFT as well as national surveys • An increase over 30% for total number of volunteers supporting staff and inpatients on wards compared to previous year
Community Health Services	• Consistently exceeded the national average in response and recommending rate) • 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. 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.

Learning from National Patient Surveys

The Trust received results for three national patient experience surveys during 2018/19. These were maternity survey (2018), inpatient survey (2018) and national cancer patient experience survey (2017).

The 2017 national cancer patient experience survey reported that Whittington Health remains a high performer across London, with over 50% of our feedback being above the national average. The overall care rating by respondents was 8.8, which sits alongside the national average and has remained consistent in recent years. Areas of particular improvement included:

- Inpatient experience
- Appointment delays
- Waiting times/communication about appointments and experiences within primary care

Narrative feedback from the survey details high volumes of very positive feedback for the oncology services, the chemotherapy nursing team, clinical nurse specialists (CNS), medical and Macmillan support teams. A full action plan has been developed, with a focus on inpatient and outpatient experience.

The 2018 maternity patient experience survey was very positive with 100% of women reporting that they were treated with dignity and respect and 98% reporting confidence and trust in staff. There are some areas of development including midwives giving consistent advice and bring aware of medical history. An action plan has been developed with the maternity teams in response to the report's findings.

The 2018 inpatient survey has been sent to the Trust. The results are currently under embargo and will be made public in June 2019.

Listening to what patients tell us is important in order to learn when care goes well, but more importantly, so that we learn when it does not meet the standard of care we should deliver through the concerns and complaints patients and their families or carers raise with us.

We know the vast majority of patients appreciate the kindness, care and expertise of our staff because they tell us. We record and report all compliments and received 327 formal compliments compared to 353 in 2017/18; however, these numbers do not capture the many lovely expressions of thanks that our staff regularly receive from patients. We are always grateful when patients and families take the time to tell us how much they appreciate our care.

The Trust has consistently achieved the 25 day response rate for complaints over 2018/19. The common themes of complaints are:

- Medical and nursing care
- Staff attitude
- Communication

Learning from complaints and compliments is reported to the Trust Quality Committee as well as to the Trust Board. Opportunities for staff to learn and act are undertaken in a number of ways and include:

Trustwide learning workshops using case studies	Spotlight on Safety (and service specific newsletters Cats Eyes and Medicines Matters)	Staff awareness campaigns via Communications using screensavers, posters and events	Trustwide communication via weekly noticeboard and targeted emails
ICSU and Trustwide Patient Safety Committees	Patient Safety Learning section on intranet	Patient Safety Forum monthly	Local arrangements such as '10@10' in ED
Patient Safety Learning secion on intranet	Grand Rounds Monthly	Reflective sessions with individual staff and teams and Schwartz rounds	Feedback from Datix to Reporters

Clinical Audit and Quality Improvement

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

Whittington's quality governance and clinical audit and effectiveness teams were re-configured in 2018 to bring all related services within one department, the Quality Governance Department led by the Head of Quality Governance. Previously, the medical director had delegated responsibility from the Chief Executive for implementing effective governance arrangements for clinical audit activity; this now sits with the Chief Nurse. The Medical Director is responsible for leading quality improvement across the Trust.

- Reactive audits, vital to patient safety, will be the local priority on the Trust Integrated Clinical Service Units (ICSU) Quality Improvement programmes.
- Project proposals will be subject to a regular quality review, prior to formal registration, to prevent duplication and to ensure alignment to local speciality priorities.
- Re-launch of the Trust Clinical Audit Registration form to align with registration for Quality Improvement projects. A new, succinct version will facilitate the registration of QI projects to clinical audit.
- Demonstrable improvements to patient care and/or service provision will be identified , to support Trust Learning across clinical effectiveness, patient safety and patient experience
- Multidisciplinary Quality Improvement training and forums will include reflective learning on local clinical audit findings.
- Clinical speciality performance in relation to local QI and clinical audit will continue to be monitored on an ongoing basis, with regular reporting via the ICSU Board meetings.

Research

Research at Whittington Health has had another successful year. The target set by North Thames Local Clinical Research Network (LCRN) was for 709 patients to be recruited in to National Institute of Health Research (NIHR) portfolio studies. This was met within the first nine months of the year and overall we recruited in excess of 1000 patients into these trials. We continued to deliver a cost-effective service, with a low cost per patient recruited compared with other trusts in the North Thames LCRN and have consistently met the NIHR benchmark for RTT (recruitment to time and target) for commercial trials.

The team has again been successful with trials, ASTEROID 5 (Uterine Fibroids study) continued to be delivered efficiently within the Trust to the extent that the research midwives also provided support to other sites at the sponsor's request and it is expected that ASTEROID 9 will open at Whittington Health next year. There has been a substantial increase in the number of patients recruited to commercial trials in year as a result of an observational study to evaluate routine care in Thalassemia patients. Non-commercial studies have also been successful, the qFIT study (looking at early detection of bowel cancer) was the highest recruiting study with 230 Whittington Health patients recruited and the 'Whittington model' of recruitment was shared with other sites to boost recruitment. The reproductive health portfolio has seen multiple successful studies with overall recruitment in the year in excess of 260, and there is agreement in principle from LCRN North Thames for a business case to increase staffing capacity in this area during the coming year.

The size of the research team has remained stable thus maintaining capacity for delivering studies and raising the profile of research within the Trust, and it has been evident that as the team matures there is growing productivity. Following on from the introduction of a Trainee Research Practitioner role last year we have introduced an annual secondment opportunity for a Band 5 Junior Research Nurse post that has been successful and, subject to funding will continue in future years with the aim of increasing research capacity and capability within the Trust.

Aside from research delivery successes there have also been notable successes in terms of grant applications. Professor Ibrahim Abubakar (Institute of Global Health, UCL) has been supported via the Trust's research support service (Noclor) and secured an NIHR Programme Grant worth £2.5 million over 5 years; Research to Improve the Detection and Treatment of Latent Tuberculosis Infection (RID-TB) will begin in 2019 and encompasses various programmes of work including trials that will recruit via the North London TB Hub based at Whittington Health. Dr Sharon Millard (SLT at the Michael Palin Centre) has also been supported to secure an NIHR RfPB Grant (Research for Patient Benefit) work £250,000 over 2 years; Evaluating Michael Palin Stammering Therapy for Children: a feasibility study which will explore the effectiveness of a Whittington Health developed clinical intervention in other specialist SLT settings.

Team successes include Fei Long (Research Nurse), Kayleigh Gilbert (Research Team Lead) and Kathryn Simpson (Research Portfolio Manager) and ‘the Research Team’ being shortlisted in the Trust excellence awards with Kayleigh Gilbert winning the Research Award. Osinachi Egole (Research Midwife) and Kathryn Simpson were both named as Whittington Health Heros in the NHS 70@70 celebrations in recognition for their contributions to research in the Trust. We have recently launched our ICARE for Research campaign and hope to expand on it in the coming year.

Also in the coming year we are keen to work with our nursing, allied health professionals and other colleagues to expand nurse-led research and other research into the impacts of integrated care, community services and population health approaches. One example this year, has been the introduction of outcomes measures for community services.

WORKFORCE

Our People

Our people are fundamental to our success in delivering high-quality patient care. We are proud of all our colleagues and recognise the important role they play in maintaining the health and wellbeing of the people we serve. The people we employ reflect the diverse backgrounds of the communities we serve and we have good representation of women and people from diverse ethnic backgrounds.

Our approach to developing our workforce is set out in our workforce strategy which was co-developed with staff. During 2017/18 we continued to deliver on the ambitions set out in the strategy and are pleased that a number of our performance indicators show how successful our plans have been.

NHS Staff Survey 2018

We know that there is a strong link between positive staff engagement and patient experience and safety. We measure our success in terms of staff engagement and creating a good work environment through the annual NHS Staff Survey and the Staff Friends and Family Test, which is undertaken three times a year and in which we consistently scored above the national average. These survey and test results are closely monitored and discussed at the Trust Management Group, Partnership Group and Board meetings. Our staff survey results continue to be very important to us and are integral to forward planning on all staff matters.

This is the eighth year in which Whittington Health as an Integrated Care Organisation (ICO) has conducted the national staff survey and the second year in which the Trust opted to invite all eligible staff to complete it. Our data is presented as part of a cohort of 43 combined acute and community providers in England.

Of our 4097 eligible staff, 1958 staff took part in this survey, a response rate of 48.5% which is significantly above the average for combined acute and community trusts in England (40%), and compares with a response rate of 42% in the 2017 survey.

Whittington Health's theme score of 7.0 for staff engagement matches the national score. Nationally the staff survey results for 2018 have been presented as ten key themes (moving away from the previous 32 key findings). The Trust's results across the ten themes are set out in the graph below:

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.5	6.4	7.3	6.5	6.2	7.9	8.6	9.7	7.1	7.4
Your org	8.3	5.5	6.6	5.7	5.5	7.5	7.4	9.4	6.6	7.0
Average	9.2	5.9	6.8	6.2	5.4	7.4	8.1	9.5	6.7	7.0
Worst	8.3	5.5	6.5	5.7	4.5	7.1	7.4	9.3	6.3	6.6
Responses	1,861	1,894	1,896	1,846	1,576	1,766	1,852	1,851	1,873	1,935

It is disappointing to note that of the 43 combined acute and community trusts, Whittington Health is not placed in the 'best' ranking for any of the ten themes and placed at the 'worst' for four of the themes, as detailed below:

Table 6: National Staff Survey Themes:

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

As a result of this data and previous reviews, and as detailed in the following section, the Trust carried out an in-depth cultural review in 2018 which began to change the dialogue across the organisation and encouraged staff to speak out and speak up with the assurance that action would be taken. As a result the response rate to the national staff survey improved significantly and as anticipated staff felt comfortable in raising concerns. The staff survey action plan this year will be coupled with our culture improvement programme which will be the vehicle for improvement across the Trust. Whilst each ICSU/Directorate will have their own areas of focus across the ten themes, the Trust Board has agreed a major focus for two priority areas: improving responses to all bullying and harassment scores; and improving staff engagement scores.

Workforce Culture

As highlighted above and in previous reports staff have consistently reported they are experiencing bullying and harassment at work for a number of years. To understand staffs' experience more clearly, Professor Duncan Lewis, from Plymouth University Business School, was commissioned to undertake an independent review of the workplace culture at Whittington Health in 2018. The findings of this survey were reported to the Trust Board in July 2018 and disseminated to all staff.

The Trust immediately set about delivering actions in response to the 14 recommendations within the report. Alongside this staff also expressed a strong desire to have further input into the actions the Trust would take and a series of 'Listening Events' were subsequently held across the Trust. 550 staff took the opportunity to contribute their views through this process.

The initial response presented to the Trust Board, following Professor Lewis' report, set out some immediate actions that would be undertaken whilst further engagement was underway. These were:

- Introduction of Behavioural Framework and Standards
- New approaches to resolution
- Trained 29 coaches from across the Trust from both clinical and non-clinical roles, and at a variety of levels of seniority
- Trained 10 mediators to work with colleagues to improve the way staff address issues of concern and communicate with each other
- Joined with several other London Trusts in a reciprocal agreement to provide external independent mediation
- An electronic employee relations case management system was procured in summer 2018. This has allowed greater monitoring and traction on all cases

- Improved Staff Engagement
- Regular Pulse checks undertaken quarterly - “pulse checks” surveys to explore other elements of staff satisfaction at work. Whittington Health has adopted this approach and has added an additional question to the Staff Friends and Family Test.
- *Listening Events* - engaging over 550 staff
- *Staff Focus Corporate Communication*

Leadership Development Improvements

The new ICSU triumvirates have been supported in their development through a dedicated coaching and organisational development (OD) programme delivered by NHS Elect and the Trust’s OD team. This process has ensured greater clarity on role responsibilities, helped the triumvirate to agree their ICSU priorities, improved communication and teamwork by developing shared purpose and openly identified team strengths and weaknesses to develop strategies to support high levels of team functioning and build confidence and resilience.

Additionally, the following leadership and management developments have been delivered since the culture survey report:

- Executive Team Development
- Visible Leadership
- New Consultant Development Programme
- LEAD – medical leadership development sponsored by the Medical Director
- Leader and Influencer pilot – project based paired leadership development
- Band 6 & 7 clinical leaders programme
- iCARE values-based leadership development
- “Whittington Health “Passport to Manage” developed.

Actions Taken to Consult, Involve and Engage Staff

Our workforce is our primary asset in determining the quality of experience and care we provide. Therefore, staff engagement is paramount in supporting the implementation of improvements so that we foster a more positive work environment. A number of committees have been established to monitor the performance and delivery of the workforce priorities and consult with trade union colleagues:

- Workforce Assurance Committee
- Partnership Group
- Local Negotiating Committee (LNC)
- Culture Steering Group

Staff feedback is also obtained from the national staff survey, results of which are used to develop action plans for improvement. In addition, we communicate and engage in a range of ways, including:

- Monthly Staff Briefings with a written briefing emailed to all staff
- Frequent all staff emails
- A monthly CEO newsletter/blog
- A regularly updated intranet and website
- Social media accounts including Twitter and Facebook feeds for our Trust and some of our key specialisms
- GP newsletters and clinical education events
- Annual open days
- Working with journalists to shout about good news at our hospitals and being responsive to any press enquiries they may have

Embracing Equality, Diversity and Inclusion

We serve diverse local communities across the population and this diversity is reflected in the profile of our patients and workforce and brings many benefits. The Trust remains committed to providing services and employment opportunities that are inclusive across all strands of equality: age, disability, gender, ethnicity, race, religion and belief and sexual orientation in accordance with the Equality Act 2010 and our public sector equality duties. Our equality objectives set out our priorities to drive improvements in staff experience which aim to reduce inequalities for our diverse workforce.

The Inclusion Lead is responsible for monitoring progress against these priorities and regularly reports back on our performance. The Trust has in place a comprehensive plan to ensure better and fairer outcomes in recruitment and progression, as well as ambitious targets to improve diversity in senior management, ensuring all staff have the opportunity to achieve their full potential. The Trust continues to develop fair recruitment practices to ensure equal access to employment opportunities for all.

Our ambition remains to improve the health outcomes, access and experience of all of our patients, carers, visitors, volunteers and employees.

During the past year, we have:

- Submitted our annual Workforce Race Equality Standard outcome to NHS England in July 2018 and published our gender pay gap in March 2019. The Trust has a WRES action plan, delivery of which is overseen by the board's Workforce Assurance Committee.
- Engaged with and involved staff in the review of behaviours linked to the values which form part of our annual performance appraisal process for all staff, as well as agreeing personal development plans and career discussions
- Had equality and diversity training as a mandatory requirement for staff and provided unconscious bias training for managers
- Worked in partnership with staff side colleagues and unions
- The estates team has engaged with the Care Trade's Autism Project, and has integrated a new team member from the project into the team.

However, we know we can do more to build diversity into high-quality services and to meet the health needs of our diverse population. We will, therefore, use our move to locality-based working to better understand the needs of population groups and plan how we can work with our partners in primary care and the local authority to have a real impact on the health of BME communities.

Our latest public sector equality duty annual report shows we have a diverse and representative workforce of the London population. Like other NHS bodies, the Trust is striving to ensure that there is diverse representation at all pay grades in order to help meet guidance issued by NHS Improvement and NHS England in December 2018: A model employer.

Staff Health and Wellbeing

Our occupational health service is committed to a strong focus on health, safety and wellbeing for staff, patients and visitors. Our occupational health services include pre-commencement screening, work-related health checks, vaccination and immunisation programmes, and advice on reducing risks in the workplace. We also offer guidance to staff and managers on maintaining wellness in the workplace. We provide advice and information for managers on managing

sickness absence and how to support staff to return to work. We know that our staff value initiatives that support their health and wellbeing. We offer a wide range of opportunities to support staff through health and well-being programmes. Specialist referral services include cognitive behavioural therapy for mental wellbeing, along with advice, information and counselling via the Employee Assistance Programme

Statutory and Mandatory Training

The majority of core and mandatory skills are delivered through the Trust's online training site. The training modules and programmes are all tailored to meet the requirements of the organisation using software, voiceovers and videos to enable the e-learning to be interactive. The target completion rates vary according to the topic.

Regular corporate induction has been held throughout the year to welcome and orientate new colleagues to the trust. Trust induction includes key information such as Trust values and objectives and Trust-specific information to prepare new starters to be an effective member of the WH team. Each induction starts with a personal welcome on the first session on the first day from our Chief Executive who shares the progress that the Trust has made over the years, has a question and answer session and informs of the latest Trust updates.

The target of 90% compliance in statutory/mandatory training not being met and is at 82%. The Trust appraisal compliance rate is sitting at 73.1%. We are making a concerted effort to improve these two figures at the moment.

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.

Commitment to Multi-Professional Education and Training

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

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

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

Excellence in Medical Education

As well as delivering first class care to our patients, we are committed to delivering the very best education and training to support our clinical student colleagues in taking the next steps in their careers. There was a successful Quality assurance visit from UCL Medical School in 2018/19. We were pleased to see the work of three of our consultants celebrated with a Top Teaching Award from UCL Medical School; Dr Bernard Davis, Dr Johnny Swart and Dr Anna Gerratt were presented with the awards in 2018.

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

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

The has moved forwards with the Faculty of Medical Leadership/ NHS Providers/ NHS Improvement ‘Eight high impact actions to improve the working environment for junior doctors’ and set up a task and finish group to ensure all actions are fully implemented.

Introduction of the Nursing Associate Role

The Trust was part of the national pilot to train Nursing Associates alongside other trusts in North Central London in partnership with Middlesex University and London South Bank University. The role was designed to bridge the gap between health care assistants and registered nurses and was a recommendation of the Shape of Caring Review (2015). The standards for Nursing Associates are set by the NMC who are their regulatory body. The register opened on 28 January 2019 nationally and our nursing associates were among the first to be accepted onto the register. We are proud to have seventeen nursing associates working with us and have 26 currently in training.

CLINICAL SERVICE DEVELOPMENTS

Community Services

Our community services have worked extremely hard to significantly improve access times across this year, for example our Podiatry team has improved from seeing 27% within 6 weeks to 94% seen within 6 weeks. Nutrition and Dietetics have improved from 30% to 100% seen within 6 weeks.

We have designed and launched 4 new service websites to support our patients in self-care and referrers access our services eg. www.whittington.nhs.uk/BB for our Bladder and Bowel Service.

Our outstanding District Nursing service was the worthy winner of a HSJ Value Award in June 2018 for E-Community in Community Health Service Redesign. It was also used as a national example of good practice by NHSI for ‘safer caseloads’. They have also reduced their vacancy rate from 39% to 12% improving continuity of patient care.

Our Improving Access to Psychological Therapies (IAPT) service not only has one of the highest recovery rates of any IAPT service nationally and is improving year on year, but is the first and only IAPT service to be designated by the Centre for Mental Health as a Centre of Excellence in Employment Support. They now also offer an innovative online computerised Cognitive Behavioural Therapy (CBT) which is achieving excellent recovery rates. IAPT for people with chronic physical health conditions (LTCs) is in its second year since the initial NHSE-funded pilot was first launched in September 2017. Ongoing funding has now been secured locally. IAPT for LTCs now sees patients with diabetes, chronic obstructive pulmonary disease (COPD), musculoskeletal chronic pain and cardiac illness, and very soon will start working with patients who have a medically unexplained symptom.

Our Self-Management Service has successfully delivered 17 Expert Patient Programmes/Diabetes Self-Management programmes over this year with very positive improvements in patient activation measures, demonstrating that our patients are better able to self-care their long term conditions. The service ran a successful self-management pilot for children and young people with asthma which resulted in a 66% reduction in the need for GP visits as well as a 33% increase in self-management confidence.

Our contract with Hackney Council to become lead provider of the Hackney Smokefree Service started July 1st 2018. The service consists of specialist advisors in behavioural change principles and interventions across over 40 locations in GP surgeries, participating pharmacies, and community clinics including at The Homerton University Hospital. We enjoy a strong partnership with the GP Confederation and The London Pharmacy Committee in Hackney to deliver this service.

Our Musculoskeletal (MSK) service has been leading on integrating the MSK patient pathway and is rolling out a single point of access for all MSK patients. This provides enhanced triage for all MSK patients and ensures patients are seen in the right place first time. It has now been rolled out to 50% of Haringey and Islington GP practices with plans for full roll out this year. The service has also developed an online self-referral form for MSK Physiotherapy improving patient access to prompt MSK care. They have also launched their own twitter account @WhitthealthMSK to increase access to self-care information.

Our community services are now able to evidence that our patients show significant benefit from their community treatment for a wide range of services including Musculoskeletal Physiotherapy, Podiatry, Nutrition and Dietetics and Community Rehabilitation Services. For example 93% of patients completing MSK Physiotherapy report a clinically significant improvement in their functional level and 93% of our patients undergoing community rehabilitation achieve their treatment goals. We are continuing to bring more patient reported outcomes online over the next quarter.

Maternity

The 2018 NHS Maternity Service survey is carried out annually by the Care Quality Commission. This year's survey results show that new families report that they were treated with dignity and respect 100% of the time with more than 95% reporting that they had confidence in staff at Whittington Health NHS Trust and that they were involved enough in decisions about their care.

Intermediate Care Pathways

We held 5 workshops regarding the redesign of the intermediate care pathways across Haringey & Islington. Agreement from the Trust and the two councils for further work is now in place and a clinical lead has been appointed to take this forward in the coming year.

Pathology

We have reached agreement with North West London NHS Partners to move to the next stage in becoming partners in their pathology network.

Children and Young People

Islington MSK has tackled significant DNA rates through the development of a ‘back on track’ exercise group at Lift gym in Islington for teenagers to bridge the gap between 1:1 physiotherapy sessions and returning to sport/goals. This has received good feedback and is well attended. There are plans to review how many CYP join the gym after the sessions on an ongoing basis.
Integrated and co-located Bright start areas are now established in Islington across 3 localities focussing on early identification and support for families right from the start and working with the local authority to develop integrated outcomes.

Islington, Haringey and Camden have now developed designated clinical officers for children and young people with Special Educational Needs and Disability (SEND) to act as a strategic advisor to CCGs and monitor the quality of work and statutory time scales for CYP with accessing support with SEND

The Community Children’s Nursing Team at Whittington Health NHS Trust led the implementation of a new service within the Hospital at Home service, offering home based phototherapy to babies with physiological jaundice. The Hospital at Home service is part of the Community Children’s Nursing Team, delivering nursing care to acutely unwell children at home. The H@H team had their case study on home based phototherapy published on NHSI’s atlas of shared learning and was showcased at the NHSI event in March.

The following awards were also celebrated:

- Hannah Marsden Band 5 Staff nurse shortlisted for Student Nursing Times awards - Mentor of the Year
- Colette Datt, Nurse Consultant CYP - Nurse of the Year 2018 - Nursing Times
- Laura Gratton and Sonal Patel Oncology Nurse CNSs - PENNA - Fiona Littledale - excellence in oncology award 2019
- Colette Datt, Sandra Frimpong, Naheeda Rahman, Madeline Ioannou with external partners - PEnNA - National Patient experience award - Partnership working to improve the experience
- Edith Aimiuwu CNS Haemoglobulinopathy Nurse - CYP Nurse of the Year 2018 - Whittington Health
- Sinead Doherty CNS Allergy Nurse - Patient Safety Award 2018 - Whittington Health

- Marion Coyle HCA Ifor Ward - Whittington Health Hero 2018
- Transforming asthma care in schools in Islington: The Asthma Friendly Schools Project UK
- Karen Rodesano CCNT wrote an article on Transforming asthma care in schools in Islington: The Asthma Friendly Schools Project UK. It was published in the journal of school nursing.

SYSTEM WORKING

GP Federations

We have signed a memorandum of understanding with the two local GP Federations, that we will work together for the benefit of our populations. We have been working closely with GPs and commissioners in Haringey and Islington to develop new ways of working as they begin to work more at scale through primary care networks. Examples of this include our new integrated diabetes team that supports and trains GPs to keep patients' diabetes managed in the community, and our team working with Age UK and the GPs to use an e-frailty index to find and support patients before they deteriorate.

Localities

This year we have begun to work even more closely with our colleagues in the councils, mental health trusts, GPs, and the voluntary sector to create a new vision for our joined up services based around localities (3 in Islington and 4 in Haringey). We have agreed the following vision and we are now designing the operating model to deliver it:

We want to create a step forward in how well we prevent issues arising and nip them in the bud early, through more integrated public services and more resilient local communities. This means:

- A simpler, more joined up local system that offers the right support at the right time that manages the growth in demand and to reduce duplication in the system
- Integrated, multi-disciplinary teams from across the public sector working together on the same geography and tackling issues holistically, focused on relationship-building and getting to the root causes
- A workforce who feel connected to each other and able to work flexibly, better able to meet people's needs
- A new system partnership with the voluntary sector to co-ordinate local activity, networks and opportunities – so that we make the best use of the strengths and assets of our communities

Health and Wellbeing Partnership and North London Partners Strategic Transformation Plan

Our work with the Health and Wellbeing Partnership has accelerated as we have progressed areas of collaboration in frailty, diabetes, respiratory and intermediate care. Much of this work is now continuing as business as usual and we are going further through the work around localities. We have also worked closely with our North London Partners in health and care to start to develop a new Integrated Care System across the five boroughs of North Central London. Through

numerous workshops we have created prototypes with patients and services users and are beginning now to create the governance for borough level partnerships.

University College London NHS Foundation Trust

We have continued to work well with UCLH in various areas of collaboration including breast services, maternity, and general surgery. One particular success has been that patients with abscesses now come to Whittington Health for their day surgery instead of being admitted to a bed at UCLH.

North Middlesex University Hospital NHS Trust

At the latter end of the year we signed a Memorandum of Understanding with NMUH with the view to collaborating on clinical pathways and other areas where we can improve quality and efficiency better together.

INFORMATION GOVERNANCE AND CYBER SECURITY

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 has 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 submission scan 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 manages classroom-based sessions at induction.

INFORMATION MANAGEMENT AND TECHNOLOGY DEVELOPMENTS

This year we continued our work as a NHS England Global Digital Exemplar fast follower with the roll out of NEWS2 scoring system and “CareFlow Vitals”. Patients being treated at Whittington Hospital’s adult wards are now seeing staff recording details of their vital signs like breathing, blood pressure, oxygen saturation levels, pulse and temperature onto iPods and iPads instead of onto paper charts kept at the end of their bed.

The ‘CareFlow Vitals’ electronic observation system is cutting the amount of time it takes to complete a set of patient observations and reduces the likelihood of recording errors. Crucially, combined with the clinical skills and judgement of staff, it helps to identify deteriorating patients more rapidly, allowing specialist care to be provided more quickly.

The IT team has also successfully upgraded nearly 2000 computers to Windows 10.

SUSTAINABILITY

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

Our Plan

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

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

Reducing Carbon Emissions

The Trust has continued to invest in projects to reduce carbon emissions, including the continuation of a programme of improvements to our heating and ventilation control systems. The Trust has also successfully bid for a match funded NHSI LED lighting replacement project, with the intention of this work taking place during 2019, the project will reduce our carbon emissions by a further 204 tonnes per annum.

The Trust has also provided a letter of support to Islington Council to work with them in the development of a local heat network to collaboratively reduce carbon emissions across both the council and Trust estate.

Waste Disposal

2018/19 has seen the in-house recycling centre become fully imbedded within the normal operations of the Facilities waste team. A number of waste streams are sorted and recycled in large quantities, including cardboard, paper, plastic, oil, metal, wood and food.

The team has engaged with the Care Trade's Autism Project, and has integrated a new team member from the project into the team.

2019/20 will see a new waste contract implemented for both the acute and community sites. The main focus will be to improve recycling rates within the community estates.

Procurement

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

Travel and Transport

We continue to work with Islington Council to improve sustainable transport within the borough. As part of our commitment to this we operate a total of 13 electric cars and we have issued approximately 370 Oyster cards to community staff to encourage the use of public transport while undertaking Trust business. Staff can take part in the Whittington Health Cycle2Work salary sacrifice scheme, and we have engaged with Islington Council's Zero Emission Network, and are committed to the borough's cleaner air strategy.

Our work with our local council has seen the introduction of carbon absorbing plants and soil at the hospital. Our patient transport team has undertaken training that ensures they meet the requirements of Islington's anti-idling campaign.

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

EMERGENCY PREPAREDNESS

Each year Whittington Health NHS Trust participates in the annual Emergency Preparedness, Resilience and Response (EPRR) assurance process by NHS England. The Core standards for EPRR are set out for NHS organisations to meet and the Trust's annual assessment was completed on the 11th of November 2018 by the North Central NHS England Assurance Team. The following results were achieved:

55 EPRR standards evidential measures.

- 55= Green (Fully Compliant),
- 0=Amber (Evidence of Progress),
- 0= (No evidence of progress)

Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) standards evidential measures

- 14=Green (Fully Compliant) 0= Amber (Evidence of Progress)
- Governance- Deep Dive Questions 6 = Green (Fully Compliant)

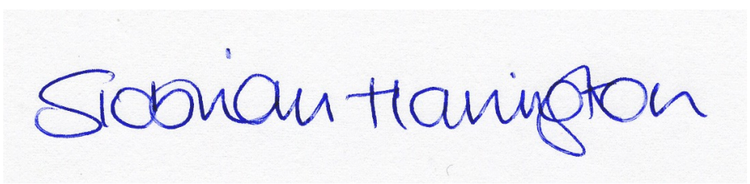
The trust has made progress on last year increasing the level of resilience to "Fully Compliant". The EPRR Action Plan for 2019 addresses areas for improvement throughout Whittington Health NHS Trust. The actions are reported through the Executive Committee and in six-monthly reports to Trust Board.

EU Exit Preparations

The Whittington Health NHS Trust has established an EU Exit Planning Group. The planning group is chaired by an executive member, Carol Gillen Chief Operating Officer. The chair provides regular updates to the Trust Management Group. The group is represented by Directors and service leaders. The group meets bi-weekly to discuss issues, actions and update the Trust's EU Exit Plan. The EU Exit Planning Group is regularly engaged with planning networks within Haringey, Islington, and London. The planning group has conducted table top exercises recommended by the Department of Health in preparation for EU Exit. The Whittington Health EU Exit planning team submits, daily, weekly and specific situation reports as requested by NHS England.

CONCLUSION TO THE PERFORMANCE REPORT AND STATEMENT OF FINANCIAL POSITION

The above document represents the performance report and statement of financial position of Whittington Health for the financial year 2018/19. As the CEO I believe this represents an accurate and full picture of the Trust for the year.



Siobhan Harrington
CEO

Accountability report

Members of Whittington Health's Trust Board

Non-Executive Directors:

Steve Hitchins, Chairman

Graham Hart (to September 2018)

Naomi Fulop (from October 2018)

David Holt

Deborah Harris-Ugbomah

Tony Rice

Anu Singh

Yua Haw Yoe

Executive Directors:

Siobhan Harrington, Chief Executive

Julie Andrews, Acting Medical Director (from mid-November 2018)

Stephen Bloomer, Chief Finance Officer

Norma French, Director of Workforce*

Carol Gillen, Chief Operating Officer

Richard Jennings, Medical Director (to mid-November 2018)

Michelle Johnson, Chief Nurse & Executive Director of Patient Experience

Jonathan Gardner, Director, Strategy, Development & Corporate Affairs (from May 2018)*

Sarah Humphery, Medical Director, Integrated Care*

*denotes non-voting board members

Membership of board committees

The following committees reported to the Board. (* denotes the committee chair)

Audit & Risk Committee

NEDs: Tony Rice, David Holt*, Deborah Harris-Ugbomah

Exec Directors: Stephen Bloomer, Jonathan Gardner, Carol Gillen

Charitable Funds' Committee

NEDs: Steve Hitchins, Tony Rice*, Graham Hart (Resigned September 2018)

Exec Directors: Jonathan Gardner, Michelle Johnson, Steve Bloomer, Siobhan Harrington

Estates Strategy Delivery Committee

NEDs: David Holt*, Anu Singh, Yua Haw Hoe

Exec Directors: Stephen Bloomer, Adrien Cooper, Jonathan Gardner

Finance & Business Development

NEDs: Tony Rice*, Deborah Harris-Ugbomah, Naomi Fulop (joined October 2018), Graham Hart (Resigned September 2018

Exec Directors: Steve Bloomer, Norma French, Carol Gillen, Siobhan Harrington, Jonathan Gardner

Quality Committee

NEDs: Anu Singh*, Deborah Harris-Ugbomah, Yua Haw Yoe (Deputy Chair)

Exec Directors: Michelle Johnson, Adrien Cooper, Carol Gillen, Julie Andrews/Richard Jennings

Remuneration Committee

Neds: Anu Singh, David Holt, Yua Haw Yoe, Graham Hart (Resigned Sept 2018) Naomi Fulop (Joined October 2018) Tony Rice, Steve Hitchins*

Workforce Assurance Committee

NEDs: Steve Hitchins (*Sept), Graham Hart (*May) (Resigned Sept 2018) Naomi Fulop (joined October 2018) (*January).

Exec Directors: Norma French, Siobhan Harrington, Michelle Johnson, Steve Bloomer, Jonathan Gardner, Carol Gillen

Non-executive appraisal process

Each year, the chairman and non-executive directors evaluate their performance through appraisal and identify any areas for development. The appraisal of the non-executive directors is carried out by the chairman.

Trust Board of Directors' declarations of interest

In line with the Nolan principles of public life, Whittington Health NHS Trust is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish a register of interests which draws together declarations of interests made by members of the Board of Directors. In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests in respect of specific items on the agenda. The declarations for 2018/19 are shown below:

Table 7: Non-Executive Directors – voting Board members:

Steve Hitchins, Chair	▸ Member: Liberal Democrats ▸ Trustee, Whittington Health Charity Conflicts of interests that may arise out of any known immediate family involvement ▸ Wife : voting member of House of Lords who sits on Liberal Democrat benches
Anu Singh	▸ Nil ▸ Trustee, Whittington Health Charity Conflicts of interests that may arise out of any known immediate family involvement ▸ Nil
Naomi Fulop	▸ Honorary contract, Professor of Health Care Organisation & Management, Department of Applied Research, University College London ▸ Trustee, Whittington Health Charity Conflicts of interests that may arise out of any known immediate family involvement Nil
David Holt	▸ NED/SID, Chair of Audit Committee at Tavistock and Portman NHSFT ▸ NED, Chair of Audit Committee, Hanover Housing Association ▸ Deputy Chair, Chair of Audit Committee Ebbsfleet Development Corporation (MCLG) ▸ NED and Chair of Audit Committee, Planning Inspectorate (MCLG) ▸ Trustee, Whittington Health Charity Conflicts of interests that may arise out of any known immediate family involvement ▸ Wife Dr Kim Holt employed by Whittington Health – Children's Safeguarding Lead Haringey
Deborah Harris-Ugbomah	▸ Governor / Audit Committee Chair, Trinity Laban Conservatoire ▸ Director/ Audit Committee Chair, The Shared Learning Trust ▸ Independent Member -Audit Committee and Independent Member - Treasury Committee, Notting Hill Housing ▸ Director, Harris Manor Properties Ltd ▸ Director, HJM Property Solutions Ltd ▸ Co-founder & Consultant, Inspiring Insights ▸ Founder and UK Regional Lead, Lean In (UK Chapter) ▸ Trustee, Whittington Health Charity Conflicts of interests that may arise out of any known immediate family involvement ▸ Nil

Prof Graham Hart	• Nil • Trustee, Whittington Health Charity Conflicts of interests that may arise out of any known immediate family involvement • Nil
Tony Rice	• Chair, Dechra Pharmaceuticals PLC • Chair, Xerxes (Investment company) • Trustee, Whittington Health Charity Conflicts of interests that may arise out of any known immediate family involvement • Nil
Yua Haw Yoe	• Nil • Trustee, Whittington Health Charity Conflicts of interests that may arise out of any known immediate family involvement • Nil

Table 8: Executive Directors – voting Board members:

Siobhan Harrington	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Stephen Bloomer	• Chair, Whittington Pharmacy, Community Interest Company Conflicts of interests that may arise out of any known immediate family involvement • Nil
Julie Andrews	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Michelle Johnson	• Trustee on Board of Roald Dahl Marvellous Children's Charity Conflicts of interests that may arise out of any known immediate family involvement • Nil
Carol Gillen	Non-Executive Director, Whittington Pharmacy Community Interest Company Conflicts of interests that may arise out of any known immediate family involvement • Nil

Table 9: Non-voting Board members:

Sarah Humphery	▸ GP Partner Goodinge Group Practice, Goodinge Health Centre, 20 North Road, London N7 9EW: General Medical Services Conflicts of interests that may arise out of any known immediate family involvement ▸ Nil
Jonathan Gardner	▸ Nil Conflicts of interests that may arise out of any known immediate family involvement ▸ Tbc
Norma French	▸ Nil Conflicts of interests that may arise out of any known immediate family involvement ▸ Husband is consultant physician at CNWL (at UCLH)

Remuneration and Staff Report

The salaries and allowances of senior managers who held office during the year ended 31 March 2019 are shown in Table 1 below.

The definition of ‘Senior Managers’ given in paragraph 3.35 of the Department of Health Group Accounting Manual (GAM) 2018-19 is: “…those persons in senior positions having authority or responsibility for directing or controlling the major activities within the group body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments”. For the purposes of this report, senior managers are defined as the chief executive, non-executive directors and executive directors, all Board members with voting rights.

Notes on table 10 (below)

1. The salary figures above represent the 2018-19 financial year and, therefore, reflect that some Directors were only in post for part of the year.
2. Tony Rice donated his salary to Whittington Hospital NHS Trust Charitable Funds.

Table 10: Salaries and allowances 2018-19

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Non-executive						
Steve Hitchins, Chair	20-25	0	0	0	0	20-25
David Holt	5-10	0	0	0	0	5-10
Tony Rice (Note 2)	5-10	0	0	0	0	5-10
Anu Singh	5-10	0	0	0	0	5-10
Yua Haw Yoe	5-10	0	0	0	0	5-10
Deborah Harris-Ugbomah	5-10	0	0	0	0	5-10
Professor Graham Hart	0-5	0	0	0	0	0-5
Professor Naomi Fulop	0-5	0	0	0	0	0-5
Executive						
Siobhan Harrington, Chief Executive	175-180	0	0	0	180-182.5	355-360
Carol Gillen, Chief Operating Officer	130-135	0	0	0	80-82.5	210-215
Dr Richard Jennings, Medical Director (to November 2018)	100-105	0	0	0	0	100-105
Dr Julie Andrews, Acting Medical Director (from November 2018)	75-80	0	0	0	62.5 – 65	135-140
Stephen Bloomer, Chief Finance Officer	155-160	0	0	0	27.5-30	185-190
Norma French, Director of Workforce	125-130	0	0	0	127.5-130	255-260
Michelle Johnson, Chief Nurse and Director of Patient Experience	105-110	0	0	0	107.5-110	210-215
Dr Sarah Humphery, Executive Medical Director: integrated care	35-40	0	0	0	17.5-20	55-60
Jonathan Gardner, Director of Strategy and Corporate Affairs	100-105	0	0	0	50-52.5	150-155

Table 11: Salaries and allowances 2018-19

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Non-executive						
Steve Hitchins, Chair	20-25	0	0	0	0	20-25
David Holt	5-10	0	0	0	0	5-10
Tony Rice (Note 2)	5-10	0	0	0	0	5-10
Anu Singh	5-10	0	0	0	0	5-10
Professor Graham Hart	5-10	0	0	0	0	5-10
Yua Haw Yoe	5-10	0	0	0	0	5-10
Deborah Harris-Ugbomah	5-10	0	0	0	0	5-10
Executive						
Simon Pleydell Chief executive to 15/9/2017	100-105	0	0	0	0	100-105
Siobhan Harrington, Director of Strategy / Deputy CEO to 15/9/2017 Chief Executive from 15/9/2017	140-145	0	0	0	127.5-130	270-275
Carol Gillen, Chief Operating Officer	120-125	0	0	0	0	120-125
Dr Richard Jennings, Medical Director	160-165	0	0	0	5-7.5	165-170
Dr Greg Battle, Executive Medical Director: Integrated Care	35-40	0	0	0	2.5-5	40-45
Stephen Bloomer, Chief Finance Officer	145-150	0	0	0	10-12.5	155-160
Norma French, Director of Workforce	115-120	0	0	0	12.5-15	130-135
Philippa Davies, Director of Nursing / Patient Experience	90-95	0	0	0	0	90-95
Sarah Hayes, Acting Chief Nurse (15/12/2017 to 12/2/2018)	10-15	0	0	0	35-37.5	45-50
Michelle Johnson, Chief Nurse and Director of Patient Experience (from 12/2/2018)	10-15	0	0	0	180-182.5	195-200

Statement of the Policy on Senior Managers' Remuneration

The remuneration committee follows national guidance on the salary of senior managers.

All elements of remuneration, including 'annual cost of living increases' (when applicable) continue to be subject to performance conditions. Executive directors were awarded a 3% pay increase (limited to £2,075) by the remuneration committee in June 2018; other decisions made by the Committee are reflected in the tables above. This is subject to the achievement of goals being objectively assessed. The governance arrangements for the committee form part of the Whittington Health's standing orders, reservations and delegation of powers and standing financial instructions last updated in April 2017.

In line with the requirements of the NHS Codes of Conduct and Accountability, the purpose of the committee is to advise the Trust Board about appropriate remuneration and terms of service for the chief executive and other executive directors including:

- all aspects of salary (including any performance-related elements/bonuses)
- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms

Policy on Duration of Contracts, Notice Periods and Termination Payments

The contracts of employment for all senior managers are substantive (permanent), subject to market conditions when it may be imperative to consider other recruitment options. Senior managers are subject to regular and rigorous review of performance. All such contracts contain notice periods of either three months or six months. There is no provision for compensation for early termination in the contract of employment, but provision is made in the standard contract as follows

Clause 11: 'The Trust may at its discretion terminate a senior manager's contract with less or no notice by paying a sum equal to but no more than basic salary in lieu of notice less any appropriate tax and statutory deductions.'

Clause 12: 'Senior manager contracts may be terminated with immediate effect and without compensation for gross misconduct.'

Table 12: Board members' pension entitlements for those in the pension scheme 2018-19

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Siobhan Harrington	7.5 – 10	20-22.5	45-50	140-145140	795	274	1087	26
Carol Gillen (note 1)	2.5 – 5	12.5 – 15	45-50	145-150	999	N/A	N/A	19
Richard Jennings	0-2.5	0-2.5	40-45	130-135	878	107	1005	15
Julie Andrews	2.5 -5	2.5-5	35-40	80-85	477	116	604	9
Stephen Bloomer	2.5 – 5	0	50-55	115-120	765	135	917	21
Norma French	5-7.5	12.5-15	30-35	70-75	489	95	596	19
Michelle Johnson	5-7.5	15-17.5	35-40	105-110	547	178	736	14
Sarah Humphery	0-2.5	0-2.5	10-15	15-20	161	18	203	5
Jonathan Gardner	2.5-5	0	15-20	0	118	55	175	15

Note 1: Due to individual circumstances NHS Pensions do not calculate a CETV for Carol Gillen.

The Trust's accounting policy in respect of pensions is described in Note 8.3 of the complete annual accounts document that will be uploaded to www.whittington.nhs.uk in September 2018. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a point in time.

The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement, which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing of additional years of service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in CETV reflects the increase in the CETV effectively funded by the employer. It takes account of the increase in the accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The membership of the remuneration committee comprises the chairman and all the non-executive directors of Whittington Health NHS Trust. The committee has agreed several key principles to guide the remuneration of directors of the Trust.

Pay Multiples

Non-Executive Directors

The Trust follows NHS Improvement guidance for appointing non-executive directors.

The terms of the contract apply equally to all non-executive directors with the exception of the Chairman, who has additional responsibilities and accountabilities. The remuneration of a non-executive director is £6,157. The Chairman receives £21,105.

Salary range

The Trust is required to disclose the ratio between the remuneration of the highest-paid director in their organisation and the median remuneration of the workforce.

The mid-point remuneration of the highest paid director at Whittington Health in 2018-19 was £177,500 (2016-17 £162,500). This was 5.94 times the median remuneration of the workforce, which was £29,608 (2016-17 £34,495). The multiple has reduced from 2017-18 due to a change of the most highly paid individual.

In 2018-19, we had no employees (unchanged from 2017-18) who received remuneration in excess of the highest-paid director. Remuneration ranged from £6,157 to £175,945 (2016-17 £6,157 - £159,950).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind and severance payments. It does not include employer contributions and the cash equivalent transfer value of pensions.

Staff numbers and composition

To comply with the requirements of NHSI's Group Accounting Manual, the Trust is also required to provide information on the following:

- staff numbers and costs;
- staff composition by gender;
- sickness absence data;
- expenditure on consultancy;
- off-payroll arrangements; and
- exit packages.

This information has been included below:

Table 13: Breakdown of temporary and permanent staff members:

	Average WTE	
	2018/19	2017/18
Permanent staff		
Administration and Estates	893	993
Medical and Dental	464	458
Nurses & Midwives	1046	1069
Scientific, Therapeutic & Technical	692	680
Healthcare Assistants	532	516
Permanent staff total	**3639**	**3717**
Temporary staff		
Administration and Estates	202	201
Medical and Dental	48	47
Nurses & Midwives	233	222
Scientific, Therapeutic & Technical	82	48
Healthcare Assistants	142	113
Temporary staff total	**707**	**631**
All staff total	**4346**	**4348**

Table 14: Costs of temporary and permanent staff members

	Costs (£k) 2018/19
Permanent staff	
Administration and Estates	38,593
Medical and Dental	41,752
Nurses & Midwives	55,517
Scientific, Therapeutic & Technical	38,533
Healthcare Assistants	17,641
Apprenticeship Levy	873
Permanent staff total	**192,909**
Temporary staff	
Administration and Estates	7,321
Medical and Dental	6,830
Nurses & Midwives	12,840
Scientific, Therapeutic & Technical	3,267
Healthcare Assistants	5,086
Temporary staff total	**35,344**
All staff total	**228,253**

Table 15: Sickness absence data

Staff Sickness Absence	2018/19	2017/18
Total days lost (Calendar Days Lost)	30,374	49,323
Average working days lost	8	8
Number of persons retired early on ill health grounds	1	0

Equality, Diversity and Inclusion

We believe that employing a workforce that reflects the diverse nature of the communities we serve will make us better at meeting the needs of our patients. At 31st March 2019 the Trust had 4,265 staff in post. 3,314 of these are female and 951 male. Of the executive board members at 31 March 2019, 5 are female and 3 are male.

Consultancy Spend

The Trust spent £0.7m on consultancy in 2018-19 (£1.2m in 2017-18). The majority of this expenditure was incurred with a partner organisation to help the Trust develop savings scheme ideas.

Off-Payroll Engagements

The Trust is required to disclose all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months. The Trust does not have any of these engagements.

Table 16: Exit packages for 2018-19

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
		£s		£s		£s		£s
Less than £10,000	1	6,096	0	0	0	6,096	0	0
£10,000 -£25,000	0	0	0	0	0	0	0	0
£25,001 -£50,000	0	0	0	0	0	0	0	0
£50,001 -£100,000	0	0	0	0	0	0	0	0
£100,001 -£150,000	0	0	0	0	0	0	0	0
£150,001 -£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**1**	**6,096**	**0**	**0**	**1**	**6,096**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where Whittington Health has agreed early retirements, the additional costs are met by the Trust.

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Whittington Health NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Whittington Health NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has a robust approach to risk management with:

- The Board annually reviewing its risk management strategy and setting out its risk appetite
- The Audit and Risk Committee taking delegated authority from the Board for oversight and assurance on the control framework in place to manage strategic risks to the delivery of the Trust's financial objectives. It is supported in this by other Board Committees providing assurance to the Board on the effective mitigation of risks, as follows:
- The Quality Committee reviews and provides assurance to the Board on the management of risks relating to quality and safety, including all risk entries scored above 15 on individual Integrated Clinical Service Units (ICSUs) and corporate areas
- The Finance & Business Development Committee provides assurance to the Board on the delivery of the Trust's financial sustainability strategic objective and reviews risks scored higher than 15 which relate to finance, information governance and information technology
- The Workforce Assurance Committee reviews all workforce-related risks and their effective mitigation. It is supported in this by the Quality Committee which also monitors those workforce risks related to patient quality and safety

- A robust organisational governance structure, with clear lines of accountability and roles responsible for risk is in place for all staff
- The Chief Executive has overall accountability for the development of risk management systems and delegates responsibility for the management of specific areas of risk to named Directors
- All relevant staff being provided with risk management training as part of their induction to the Trust and face-to-face training from Risks Managers for those staff regularly involved in risk management
- Risk management training being provided for all executive and non- executive directors as part of Board development
- An open culture to empower staff to report and resolve incidents and risks through the Datix recording system and to share learning with teams

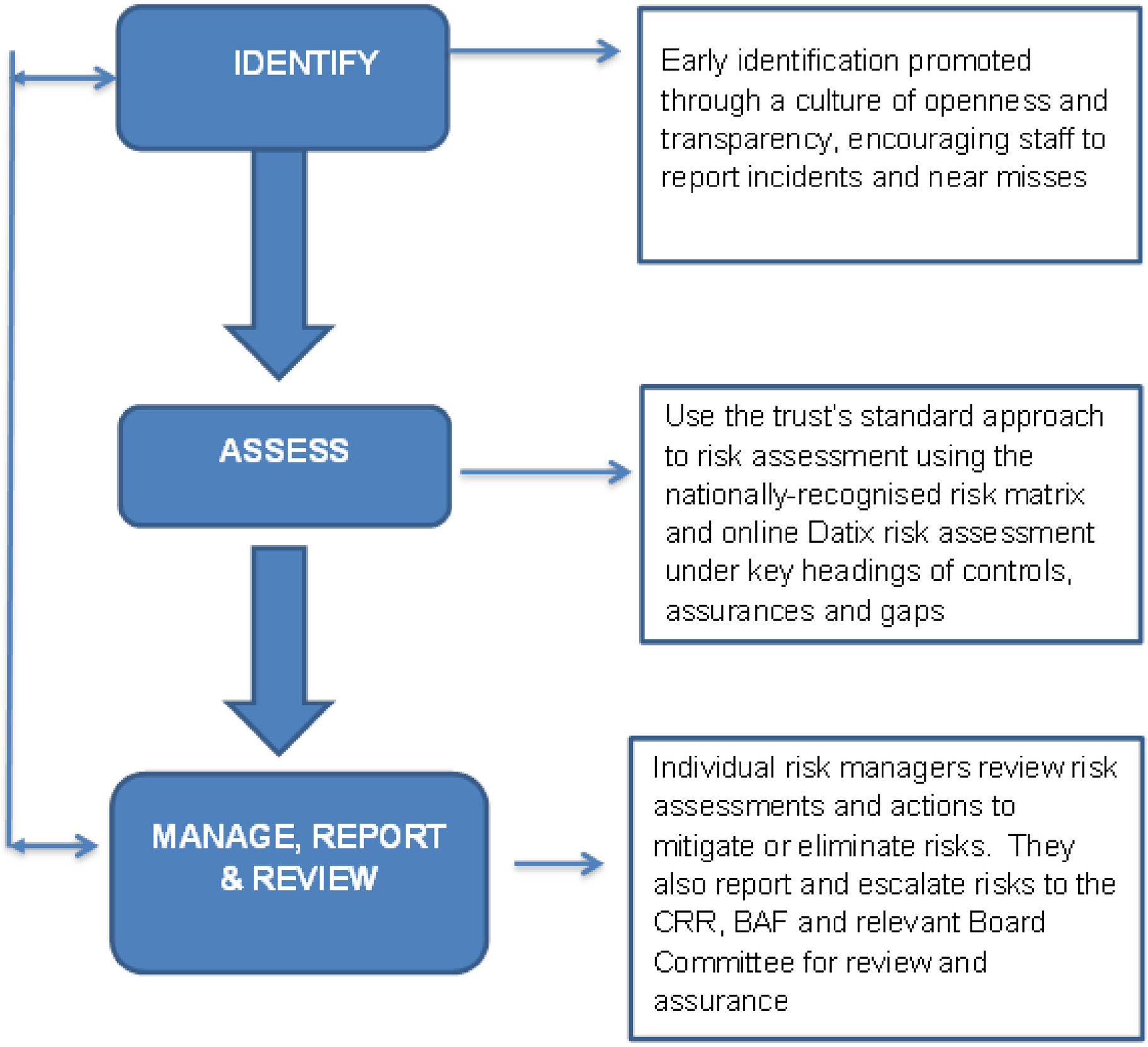
The risk and control framework

The aim of the Trust's risk management strategy is to support the delivery of organisational aims and objectives through the effective management of risks across all of the Trust's functions and activities through effective risk management processes, analysis and organisational learning.

The Trust's approach to risk management aims to:

- embed the effective management of risk as part of everyday practice
- support a culture which encourages continuous improvement and development
- focus on proactive, forward looking, innovative and comprehensive rather than reactive risk management
- support well thought through decision-making

A snapshot of the trust's risk management process is highlighted overleaf



Local risk registers at ICSU and corporate level along with the corporate risk register (CRR) and board assurance framework (BAF), seek to present an overview of the main risks facing the organisation. The local risk registers are reviewed, updated and monitored regularly by the relevant ICSU Board and corporate services' leads and, if necessary, a risk can be escalated onto the corporate risk register, which is monitored by the Trust Management Group and Quality Committee. Respective BAF entries are monitored by executive director risk leads who assess the status of their risk entry and its effective mitigation. The BAF is also monitored by the Audit & Risk Committee and Trust Board.

Board assurance framework

The Board Assurance Framework (BAF) has been reviewed thoroughly this year and provides a framework for reporting of the principal strategic risks to the delivery of the Trust's business. It identifies the risk appetite and the controls and assurances in place to mitigate these risks, the gaps or weaknesses in controls and assurances, and actions required to further strengthen these mechanisms. The Audit & Risk Committee leads on oversight of the mitigation of risks to delivery of the Trust's strategic objectives and is supported by other relevant board committees and the executive committee. We are conducting a further iteration of the BAF in 19/20 to make the risk appetite clearer and link to the new strategic objectives.

One of the key improvements the Board have made to the BAF this year has been to include a more explicit link to the strategic objectives of the Trust and be clear about the first, second, and third lines of assurance for each of these risks. Where there were gaps in assurance these have been discussed and filled.

Structure and presentation:

BAF entries to the delivery of the Trust's 2018/19 strategic objectives were as follows. Each entry has a detailed assurance framework of first, second and third line committees or processes:

- 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.
- Failure to support fragile services adequately, internally or via partnership with other providers leads to further instability where quality is reduced, or vital service decommissioned, or Trust reputation is damaged (e.g. Lower Urinary Tract service, Breast, Bariatrics).
- Failure to hit national and local performance targets results in low quality care, financial penalties and decommissioning of services – (e.g. Emergency Department, community etc.)
- 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)
- Failure to deliver savings plan for 2018/19 leads to adverse financial position, not hitting control total, loss of STF and reputational risk
- That the long term financial viability of the trust is threatened by changes to the environment, long term plan, social care risks, political changes, organisational form changes
- Failure to provide robust urgent and emergency pathway for people with mental health care needs results in poor quality care for them and other patients, as well as a performance risk.
- Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience
- Breach of established cyber security arrangements results in IT services failing, data being lost and care being compromised
- 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

Assurances

The BAF includes assurances and these were rated as relevant to the control/risk reported against. The assurances are timely and are also updated over time. Furthermore, there is allocated responsibility for submission and assessment.

Gaps in the assurance framework

The BAF also highlights gaps within assurances which trigger development of actions to improve assurances.

BAF review and update

The review and updating of BAF entries is led by Executive risk leads

Risk appetite

In line with good practice, the Trust has a documented risk appetite based upon the impact on the Trust of risks materialising. Individual risks on the BAF are allocated a target score against which progress is reported in the BAF.

Embedding risk management

Risk management is embedded throughout the organisation in a variety of ways including:

- Face-to-face training for key risk managers
- Review of the risk register entries by the Quality Committee and Trust Management Executive
- Oversight of key BAF entries by Board Committees
- A review of the BAF every six months by the Trust Board

In addition, the trust can highlight the following in its risk and control framework:

- The clinical governance agenda is led by the Trust's Director of Nursing & Medical Director. Monitoring arrangements are delivered through a structure of committees, supporting clear responsibilities and accountabilities from board to front line delivery.
- The Quality Committee is a committee of the Board, which affords scrutiny and monitoring of our risk management process and has oversight of the quality agenda. Serious incidents and the monitoring of the Corporate Risk Register (TRR) is a standing item
- The Trust's clinical governance structure ensures there are robust systems in place for key governance and performance issues to be escalated from frontline services to Board and gives assurance of clinical quality. It gives a strong focus on service improvement and ensures high standards of delivery are maintained.

- The Board and the relevant committees use a performance scorecard which has been developed to include a suite of quality indicators at Trust and service level aligned to each of the Care Quality Commission's five domains of Quality.
- The Trust's quality improvement strategy is encapsulated in our Better Never Stops (our journey to outstanding) programme. The programme is a structured quality improvement plan and we have quality improvement plans in all services to monitor and demonstrate compliance with the CQC's fundamental standards and against each of the CQC's domains and Key Lines of Enquiry (KLOE).

The Board of Directors

Membership of the Board of Directors is currently made up of the Trust chairman, five independent, non-executive directors, and eight executive directors of which five are voting members of the Board. The key roles and responsibilities of the Board are as follows:

- To set and oversee the strategic direction of the Trust;
- Review and appraisal of financial and operational performance;
- To review areas of assurance and concerns as detailed in the chair's assurance reports from its board committees;
- To discharge their duties of regulation and control and meet our statutory obligations;
- To ensure the Trust continues to deliver high quality patient quality and safety as its primary focus, receiving and reviewing quality and patient safety reports and the minutes and areas of concern highlighted in board committees' minutes, particularly the Quality Committee, which deals with patient quality and safety;
- To receive reports from the audit and risk committee, the annual internal auditor's report and external auditor's report and to take decisions, as appropriate;
- To agree the Trust's annual budget and plan and submissions to NHS Improvement;
- To approve the annual report and annual accounts; and
- To certify against the requirements of NHS provider licence conditions.

The board of directors meets eleven times per year and a breakdown of attendance for the board's meetings held in 2018/19 is shown below:

Table 17: Board Attendance:

Job title and name	Meetings attended (out of 11 unless stated)
Chairman, Stephen Hitchins	11
Non-Executive Director, Graham Hart	2 / 4
Non-Executive Director, Naomi Fulop	5 / 5
Non-Executive Director, David Holt	8
Non-Executive Director, Deborah-Harris-Ugbomah	11
Non-Executive Director, Tony Rice	10
Non-Executive Director, Anu Singh	11
Non-Executive Director, Yua Haw Yoe	11
Chief Executive, Siobhan Harrington	11
Medical Director, Richard Jennings	6 / 7
Acting Medical Director, Julie Andrews	4 / 4
Chief Finance Officer, Stephen Bloomer	11
Chief Operating Officer, Carol Gillen	9
Chief Nurse & Director of Patient Experience, Michelle Johnson	9
Director of Workforce, Norma French	10
Director of Strategy, Development & Corporate Affairs, Jonathan Gardner	9 / 9
Medical Director, Integrated Care, Dr Sarah Humphery	9 / 9

Board and committee oversight and assurance

The board of directors leads on integrated governance and delegates key duties and functions to its sub-committees. In addition the board reserves certain decision making powers including decisions on strategy and budgets.

There are five key committees within the structure that provide assurance to the Board of directors. These are: Audit and Risk; Estates Strategy Delivery, Quality; Finance and Business Development; and Workforce Assurance. There are two additional board committees: Charitable Funds and Remuneration. We also have a wholly owned subsidiary pharmacy.

There are a range of mechanisms available to these committees to gain assurance that our systems are robust and effective. These include utilising internal and external audit, peer review, management reporting and clinical audit.

Audit & Risk Committee

The audit & risk committee is a formal committee of the Board and is accountable to the Board for reviewing the establishment and maintenance of an effective system of internal control. The Committee holds five meetings per annum at appropriate times in the reporting and audit cycle. This committee is supported on its assurance role by the finance & business development, quality and workforce assurance committees in reviewing and updating key risks pertinent to their terms of reference.

This committee also approves the annual audit plans for internal and external audit activities and ensures that recommendations to improve weaknesses in control arising from audits are actioned by executive management. The audit and risk committee ensures the robustness of the underlying process used in developing the Board assurance framework. The board monitors the BAF and progress against the delivery of annual objectives each quarter, ensuring actions to address gaps in control and gaps in assurance are progressed.

Quality Committee

The quality committee is a formal committee of the Board and is accountable to the Board for reviewing the effectiveness of quality systems, including the management of risks to the Trust's quality and patient engagement strategic priorities as well as operational risks to the quality of services. The committee meets at least six times per year. It also monitors performance against quarterly quality indicators, the quality accounts and all aspects of the three domains of quality namely - patient safety, clinical effectiveness and patient experience.

Finance & Business Development Committee

The finance & business development committee reviews financial and non-financial performance across the Trust, reporting to the Board. It also has lead oversight for risks to the delivery of Trust's strategic priorities relating to sustainability, along with delivery of the Trust's strategy for information management and technology. The committee holds six full meetings each year.

Estates Strategy Delivery Committee

Established in November 2018 as a formal committee of the Board, this forum in the Trust's governance structure provides assurance to the Board on the delivery of the organisation's estates strategy and reviews risks to effective delivery.

Workforce and Education Committee

The workforce and education committee meets five times each year and leads on oversight of BAF risks which relate to the Trust's staff engagement and recruitment and retention strategic priorities.

It reviews performance against the delivery of key workforce recruitment and retention plans and the annual outcome for the Workforce Race Equality Standard submission to NHS England. In addition, the committee will also review those staff engagement actions taken following the outcome of the annual NHS staff survey and delivery of the Trust's workforce culture improvement plan.

Workforce planning

The workforce planning process is aligned and integrated with the Trust's business planning process, led by individual ICSUs. Throughout the process ICSUs Clinical and Operational Directors are supported by HR Business Partners who advise and challenge ICSUs on the workforce impact of their plans and ensure alignment with workforce and clinical strategy. This involves:

- Working with ICSUs to discuss workforce issues such as recruitment and retention, activity planning, education requirements and the delivery of key performance indicators;
- Analysing and monitoring workforce changes at a local level (which is aggregated to a Trust wide position);
- Ensuring current and future workforce needs are represented in business plans, consider growth, as well as options to develop new roles, new ways of working, and associated training implications.
- Monthly 'run rate' meetings, to analyse temporary staffing to ensure long term recruitment strategies are in place
- Dedicated nurse recruitment team focusing on international and local recruitment
- Middle grade doctor recruitment working group focussed on ED.

Final ICSU plans are presented individually to the Trust's Board, Executives and all other Clinical, Operational and Corporate Directors in a peer-review and challenge session. Following this, amended plans are used to inform the Trust's Operational Plan.

Whittington Health complies with the "Developing Workforce Safeguards" through the following actions:

- The Medical Director and Chief Nurse have confirmed that there are established processes to ensure that staffing is safe, effective and sustainable.
- The nursing and midwifery staffing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) is reported to the Board by ward or service area twice a year
- All workforce risks are reviewed quarterly at the Performance Review Groups.Action plans for reducing amber and red rated risks are monitored on a quarterly basis by the Trust Management Group.

- High level risks are reported to Workforce Assurance Committee quarterly, which is chaired by a Non-Executive Director and subsequently added to the Board Assurance Framework.
- Safe nurse staffing levels are monitored continuously, supported by ongoing assessment of patient acuity. As part of 'Showing we care about speaking up' we encourage and support all staff to nursing scorecards triangulate workforce information with other quality metrics.
- Workforce intelligence and Key Performance Indicators (KPIs) are reported alongside quality metrics at the Trust Board monthly and are standing items on Performance Review Group meetings (PRGs). The Workforce Assurance Committee receives comprehensive corporate workforce information and analysis. Metrics include vacancy and sickness rates, turnover and appraisal compliance and temporary staffing.
- Any changes and significant (over £50k) cost improvement plans have a quality impact assessment.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Sustainability

The Trust is currently reviewing its sustainability strategy and delivery model as part of its broader Estates strategy review process, this in line with statutory and mandatory requirements.

The organisation is committed to delivering its core services from energy efficient buildings, utilising sustainable transport infrastructure and supply chains for its consumables usage.

Review of economy, efficiency and effectiveness of the use of resources

The trust has in place a range of processes which help to ensure that resources are used economically, efficiently and effectively. These include:

- monthly reporting of financial and non-financial performance to the Trust Board of directors and the finance and business development committee of the Board;
- a monthly review of performance by the Trust Management Group and additional review meetings where ICSUs and corporate directorates are held to account for financial and non-financial performance;
- the production of annual reference costs, including comparisons with national reference costs;
- benchmarking of costs and key performance indicators (KPIs) against other combined acute and community Trusts providers;
- standing financial instructions, standing orders and treasury management policy;
- a budget holder's manual which sets out managers' responsibilities in relation to managing budgets;
- guidance on the declaration of conflicts of interest and standards of business conduct;
- reports by Grant Thornton part of the annual internal audit work plan on control mechanisms which may need reviewing;
- the Head of Internal Audit's draft and final opinions being presented to the audit and risk committee;
- external audit of our accounts by KPMG LLP who also provide an independent view of the Trust's effective and efficient use of resources, particularly against value for money considerations; and
- good performance under NHS Improvement's Single Oversight Framework for NHS providers

Information governance

The following are the incidents and outcomes of investigations in relation to information governance breaches this year:

- IGSI028 (May 2018) – Theft of a backpack of a containing health visitor sheet and diary. ICO decision: no further action.
- IGSI029 (June 2018) - Inappropriate access to staff member's medical record another staff member. ICO decision: to be confirmed.
- IGSI030 (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. ICO decision: To be confirmed.

Annual quality account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. A committee of the Trust's Board, the Quality Committee, provides assurance on the Quality Account and the quality priorities and ensures the maintenance of effective risk management and quality governance systems. This includes reviewing key areas identified in the Trust Patient Safety Committee and Patient Experience Committee, and undertaking two deep-dives per annum into each of the ICSUs. The Trust has sought external assurance on its quality account and has selected indicators for external assurance in line with the national guidance. There are mandatory reporting requirements which include 'Learning from deaths' and a statement regarding progress in implementing the priority clinical standards for seven day hospital services. The report will also include information on ways that Whittington Health ensures 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 report will also include a statement on the annual position on medical and dental staff in training rota gaps and plans for improvement to reduce these gaps. Also as part of our annual internal audit we have asked our RTT waiting lists to be looked at.

Provider licence conditions

In terms of the NHS provider license condition four, the Board confirmed that the trust applies principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services. In particular, the board is satisfied that the trust has established and implements:

- an effective Board and Committee structure;
- clear responsibilities for the Board and Committees reporting to the Board and for staff, reporting to either the Board or its Committees; and
- clear reporting lines and accountabilities throughout the organisation.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit and risk committee and quality committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

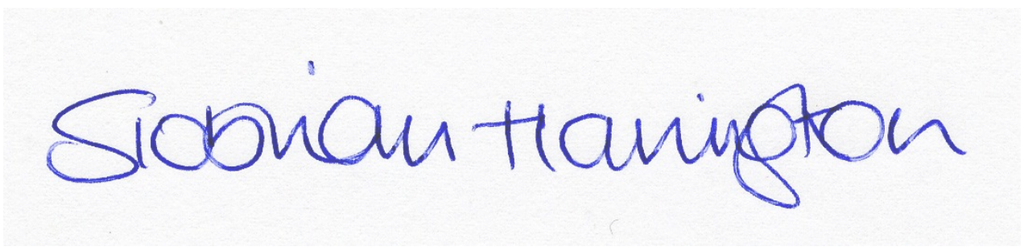
The board ensures the effectiveness of the system of internal control through clear accountability arrangements.

An annual “Head of Internal Audit Opinion” based on the work and audit assessments undertaken during the year for 2018/19 was issued and states:

“Our overall opinion for the period 1 April 2018 to 31 March 2019 is that based on the scope of reviews undertaken and the sample tests completed during the period, that Partial assurance can be given on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control. The level of non-compliance in certain areas puts some system objectives at risk. The weaknesses identified which put system objectives at risk relate to the Trust communicating its risk appetite and controlling the removal of risks from the risk register, and the need to ensure that consultant job plans are recorded and approved on the system”

The Trust’s executive team has reviewed and fully-accepted the internal audit team’s recommendations. An action plan is in place so that a revised risk management strategy, incorporating the recommended changes, is considered and adopted at the in early 2019 to set out the updated expectations in this area for 2019/20.

I confirm that no other significant internal control issues have been identified.



Siobhan Harrington
CEO

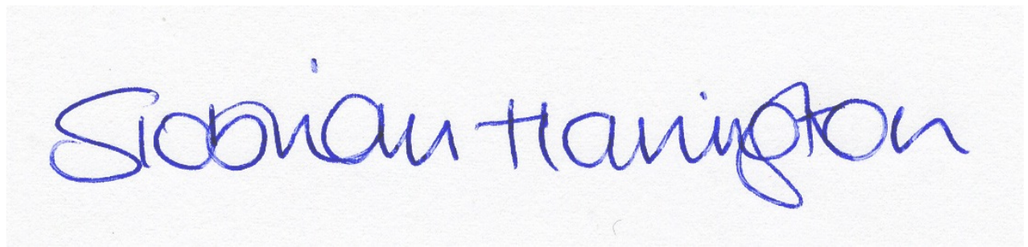
Date: 24 May 2019

Statement of the chief executive’s responsibilities as the accountable officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.



Siobhan Harrington
CEO

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

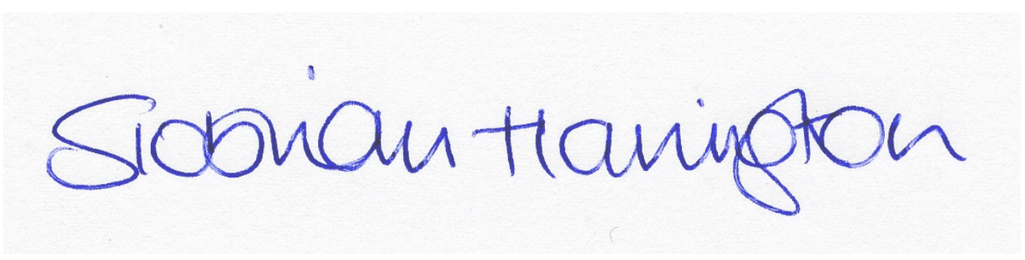
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

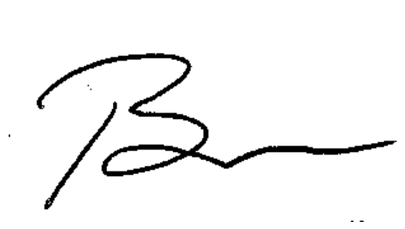
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board



Siobhan Harrington
CEO



Stephen Bloomer
Finance Director

Finance Report and Accounts

The Whittington Health NHS Trust

Annual accounts for the year ended 31 March 2019

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF WHITTINGTON HEALTH NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Whittington Health NHS Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations, including the impact of Brexit, and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we

have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2018/19. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2018/19.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 3, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 2 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 2, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's

arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017 as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of Whittington Health NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Whittington Health NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Neil Hewitson
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
London E14 5GL

28 May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	293,280	285,505
Other operating income	4	55,366	37,889
Operating expenses	6.1	(317,863)	(310,068)
Operating surplus/(deficit) from continuing operations		**30,783**	**13,326**
Finance income	11	96	44
Finance expenses	12.1	(3,192)	(3,163)
PDC dividends payable		(5,008)	(4,667)
Net finance costs		**(8,104)**	**(7,786)**
Other gains / (losses)	13	6,176	(28)
Surplus / (deficit) for the year from continuing operations		**28,855**	**5,512**
Surplus / (deficit) for the year		**28,855**	**5,512**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(4,521)	(119)
Revaluations		2,193	4,981
Other reserve movements		-	470
Total comprehensive income / (expense) for the period		**26,527**	**10,844**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14.1,14.2	6,799	4,144
Property, plant and equipment	15.1, 15.2	212,298	215,731
Receivables	19.1	604	656
Total non-current assets		**219,701**	**220,531**
Current assets			
Inventories	18	1,448	1,354
Receivables	19.1	40,438	30,363
Cash and cash equivalents	20.1	25,165	4,051
Total current assets		**67,051**	**35,767**
Current liabilities			
Trade and other payables	21	(40,614)	(36,977)
Borrowings	23	(29,776)	(20,195)
Other financial liabilities		-	-
Provisions	25.1	(693)	(1,343)
Other liabilities	22	(281)	(320)
Total current liabilities		**(71,364)**	**(58,835)**
Total assets less current liabilities		**215,388**	**197,463**
Non-current liabilities			
Borrowings	23	(27,542)	(38,448)
Provisions	25.1	(1,182)	(890)
Total non-current liabilities		**(28,724)**	**(39,338)**
Total assets employed		**186,664**	**158,125**
Financed by			
Public dividend capital		66,691	64,679
Revaluation reserve		95,735	98,542
Income and expenditure reserve		24,238	(5,096)
Total taxpayers' equity		**186,664**	**158,125**

The notes on pages 13 to 61 form part of these accounts.

Name	**Siobhan Harrington**
Position	**Chief Executive Officer**
Date	**28-May-19**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Financial assets reserve*	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**64,679**	**98,542**	**-**	**-**	**-**	**(5,096)**	**158,126**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-	-	**-**
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	-	-	**-**
Surplus/(deficit) for the year	-	-	-	-	-	28,855	**28,855**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	**-**
Other transfers between reserves	-	-	-	-	-	-	**-**
Impairments	-	(4,521)	-	-	-	-	**(4,521)**
Revaluations	-	2,193	-	-	-	-	**2,193**
Transfer to retained earnings on disposal of assets	-	(479)	-	-	-	479	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	**-**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	-	-	-	**-**
Fair value gains/(losses) on equity instruments designated at fair value through OCI	-	-	-	-	-	-	**-**
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	-	-	-	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	**-**
Public dividend capital received	2,012	-	-	-	-	-	**2,012**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	-	**-**
Other reserve movements	-	-	-	-	-	-	**-**
Taxpayers' equity at 31 March 2019	**66,691**	**95,735**	**-**	**-**	**-**	**24,239**	**186,665**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**62,404**	**94,093**	**-**	**-**	**-**	**(11,491)**	**145,006**
Surplus/(deficit) for the year	-	-	-	-	-	5,513	**5,513**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(413)	-	-	-	413	**-**
Other transfers between reserves	-	-	-	-	-	-	**-**
Impairments	-	(119)	-	-	-	-	**(119)**
Revaluations	-	4,981	-	-	-	-	**4,981**
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	**-**
Public dividend capital received	2,275	-	-	-	-	-	**2,275**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	-	**-**
Other reserve movements	-	-	-	-	-	470	**470**
Taxpayers' equity at 31 March 2018	**64,679**	**98,542**		**-**	**-**	**(5,096)**	**158,126**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve / Available-for-sale investment reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevivable election at recognition.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		30,783	13,327
Non-cash income and expense:			
Depreciation and amortisation	6.1	6,516	8,375
Net impairments	7	258	25
Income recognised in respect of capital donations	4	(1,000)	(187)
(Increase) / decrease in receivables and other assets		(11,088)	(4,696)
(Increase) / decrease in inventories		(93)	347
Increase / (decrease) in payables and other liabilties		3,216	(2,515)
Increase / (decrease) in provisions		(358)	(7)
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		(394)	-
Net cash generated from / (used in) operating activities		**27,840**	**14,669**
Cash flows from investing activities			
Interest received		112	28
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(3,665)	(1,107)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(8,139)	(4,924)
Sales of property, plant, equipment and investment property		12,500	-
Receipt of cash donations to purchase capital assets		1,000	-
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions / disposals of subsidiaries		-	-
Net cash generated from / (used in) investing activities		**1,808**	**(6,003)**
Cash flows from financing activities			
Public dividend capital received		2,012	2,275
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		(164)	(164)
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		(869)	(848)
Capital element of PFI, LIFT and other service concession payments		(1,159)	(1,121)
Interest on loans		(339)	(405)
Other interest		(20)	-
Interest paid on finance lease liabilities		(201)	(197)
Interest paid on PFI, LIFT and other service concession obligations		(2,577)	(2,437)
PDC dividend (paid) / refunded		(5,217)	(4,879)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from / (used in) financing activities		**(8,534)**	**(7,776)**
Increase / (decrease) in cash and cash equivalents		**21,114**	**890**
Cash and cash equivalents at 1 April - brought forward		**4,051**	**3,161**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**4,051**	**3,161**
Cash and cash equivalents transferred under absorption accounting		-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	20.1	**25,165**	**4,051**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

The Trust has continued to deliver against its financial targets. By delivering its control total the Trust benefitted from additional Provider Sustainability Funding of £6.2m, enabling to Trust to report a surplus of £28.9m.

Note 1.3.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).
Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.3.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.3.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

During the year the Trust sold land to another NHS organisation resulting in a surplus of £6.1m.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.6.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Full revaluations are undertaken every 3 years, with indexation adjustments used in the intervening years. The last full valuation was on 31 March 2017. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

An item of property, plant and equipment which is surplus with no plan to bring back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:

  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.6.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income. Lifecycle costs are capitalised in the same way as other capital expenditure.

Note 1.6.6 Useful lives of property, plant and equipment
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Land	-	-
Buildings, excluding dwellings	16	85
Dwellings	66	66
Plant & machinery	5	15
Transport equipment	-	-
Information technology	3	10
Furniture & fittings	5	5

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets

Note 1.7.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.
Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.7.3 Useful economic life of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Software licences	5	5
Licences & trademarks	5	5
Patents	5	5
Other (purchased)	5	5

Note 1.8 Inventories
Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the hig turnover of stocks.

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.11.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value trough income and expenditure
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 The trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.12.2 The trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 25.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in the notes (when they arise) where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in the notes when they arise, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.19 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Property, plant and equipment
The Trust's land and building assets are valued on the basis explained in note 17 to the accounts. Cushman & Wakefield (C&W), our independent valuer, provided the Trust with a valuation of land and building assets (estimated fair value and remaining useful life). The valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, leads to revaluation adjustments. Future revaluations of the Trust's property may result in further changes to the carrying values of non-current assets.

Provisions
Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the accounts are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made. The carrying amounts and basis of the Trust's provisions are detailed in note 25 to the accounts.

Impairment of receivables
The Trust impairs different categories of receivables at rates determined by the age of the debt. Additionally, specific receivables are impaired where the Trust deems it will not be able to collect the amounts due. Amounts impaired are disclosed in note 19.2 to the accounts.

Note 1.20 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. We also refer to the following financial statement disclosure notes where further detail is provided on individual balances containing areas of judgement:

Notes 3 and 4: revenue - work in progress and credit note provisions;
Notes 15 and 17: property, plant and equipment;
Note 19.2: provisions for credit notes and impairment of receivables; and
Note 21: accruals.

Note 1.21 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 2 Operating Segments

The Trust's operational management structure is delivered through five clinical integrated care service units covering both the acute and community services.

The Trust has aggregated its operating segments in line with IFRS 8 on the basis that the nature of the services continue to be the same, the provision of healthcare.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.1

Note 3.1 Income from patient care activities (by nature)	**2018/19**	**2017/18**
	£000	**£000**
Elective income	22,446	21,831
Non elective income	51,866	50,077
First outpatient income	11,514	10,604
Follow up outpatient income	14,741	9,909
A & E income	14,540	10,953
High cost drugs income from commissioners (excluding pass-through costs)	8,479	7,883
Other NHS clinical income	59,726	69,416
Community services		
Community services income from CCGs and NHS England	70,284	-
Income from other sources (e.g. local authorities)	-	68,952
All services		
Private patient income	86	195
Agenda for Change pay award central funding	3,263	-
Other clinical income	36,335	35,685
Total income from activities	**293,280**	**285,505**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19**	**2017/18**
	£000	**£000**
NHS England	29,275	30,953
Clinical commissioning groups	245,267	230,841
Department of Health and Social Care	3,263	-
Other NHS providers	2,606	3,833
NHS other	-	-
Local authorities	10,763	18,210
Non-NHS: private patients	86	62
Non-NHS: overseas patients (chargeable to patient)	134	120
Injury cost recovery scheme	546	319
Non NHS: other	1,340	1,167
Total income from activities	**293,280**	**285,505**
Of which:		
Related to continuing operations	293,280	285,505
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19	2017/18
	£000	£000
Income recognised this year	134	120
Cash payments received in-year	17	98
Amounts added to provision for impairment of receivables	100	169
Amounts written off in-year	7	105

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	422	186
Education and training (excluding notional apprenticeship levy income)	16,228	17,943
Non-patient care services to other bodies	7,142	6,048
Provider sustainability / sustainability and transformation fund income (PSF / STF)	27,626	10,640
Income in respect of employee benefits accounted on a gross basis	294	253
Other contract income	1,768	1,757
Other non-contract operating income		
Research and development (non-contract)	-	-
Education and training - notional income from apprenticeship fund	-	-
Receipt of capital grants and donations	1,000	187
Charitable and other contributions to expenditure	-	-
Support from the Department of Health and Social Care for mergers	-	-
Rental revenue from finance leases	-	-
Rental revenue from operating leases	886	875
Amortisation of PFI deferred income / credits	-	-
Other non-contract income	-	-
Total other operating income	**55,366**	**37,889**
Of which:		
Related to continuing operations	55,366	37,889
Related to discontinued operations	-	-

Note 5 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	320
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.1 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019 £000
within one year	-
after one year, not later than five years	-
after five years	-
Total revenue allocated to remainig performance obligations	**-**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	-	-
Purchase of healthcare from non-NHS and non-DHSC bodies	729	626
Purchase of social care	-	-
Staff and executive directors costs	228,253	219,002
Remuneration of non-executive directors	60	60
Supplies and services - clinical (excluding drugs costs)	24,240	23,390
Supplies and services - general	3,734	4,159
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	13,137	12,601
Inventories written down	-	-
Consultancy costs	705	1,229
Establishment	2,153	2,084
Premises	10,546	12,425
Transport (including patient travel)	278	378
Depreciation on property, plant and equipment	5,691	6,188
Amortisation on intangible assets	825	2,187
Net impairments	258	25
Movement in credit loss allowance: contract receivables / contract assets	18	
Movement in credit loss allowance: all other receivables and investments	397	136
Increase/(decrease) in other provisions	97	413
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services- statutory audit	72	61
other auditor remuneration (external auditor only)	12	12
Internal audit costs	-	-
Clinical negligence	10,113	10,742
Legal fees	792	453
Insurance	193	188
Research and development	17	80
Education and training	1,493	1,982
Rentals under operating leases	6,280	5,169
Early retirements	-	-
Redundancy	-	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,089	1,037
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	-	-
Car parking & security	-	-
Hospitality	15	23
Losses, ex gratia & special payments	-	-
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other	6,666	5,418
Total	**317,863**	**310,068**
Of which:		
Related to continuing operations	317,863	310,068
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration

	2018/19	2017/18
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	12	12
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**12**	**12**

The net figure paid to the auditor for the 2018/19 financial statement audit is £60k.

It is also noted that the auditor is also engaged for the trust's wholly owned subsidiary Whittington Pharmacy CIC (Company No.10593765); their fee for this work is £12k (excl VAT). This fee is not included within table 6.2 above as the subsidiary does not exceed the materiality test and is therefore not consolidated.

Note 6.3 Limitation on auditor's liability

The contract signed on 24 October 2018, states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1m, aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

Note 7 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	258	25
Other	-	-
Total net impairments charged to operating surplus / deficit	**258**	**25**
Impairments charged to the revaluation reserve	4,521	119
Total net impairments	**4,779**	**144**

Note 8.1 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	177,954	171,508
Social security costs	17,858	17,266
Apprenticeship levy	873	844
Employer's contributions to NHS pensions	20,743	20,314
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	6	587
Temporary staff (including agency)	11,961	9,355
Total gross staff costs	**229,395**	**219,874**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**229,395**	**219,874**
Of which		
Costs capitalised as part of assets	1,142	872

In line with the GAM, employee benefits should be shown in the accounts note in a single column for all categories of staff, which matches those shown for employee benefits in the staff costs disclosure in the Staff Report part of the annual report. See paragraphs 5.32 - 5.36 in the GAM for more detail.

See the "Staff report tables" tab for the disclosure that is now required in the Staff Report section of the annual report.

Note 8.2 Retirements due to ill-health

During 2018/19 there was 1 early retirement from the trust agreed on the grounds of ill-health (none in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £52k (0k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Operating leases

Note 10.1 The Trust as a lessor

This note discloses income generated in operating lease agreements where The Whittington Health NHS Trust is the lessor.

	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	886	875
Contingent rent	-	-
Other	-	-
Total	**886**	**875**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	886	875
- later than one year and not later than five years;	3,544	3,500
- later than five years.	-	-
Total	**4,430**	**4,375**

Note 10.2 The Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Whittington Health NHS Trust is the lessee.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	6,280	5,169
Contingent rents	-	-
Less sublease payments received	-	-
Total	**6,280**	**5,169**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	6,280	4,868
- later than one year and not later than five years;	22,671	18,849
- later than five years.	37,418	34,795
Total	**66,369**	**58,512**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19	2017/18
	£000	£000
Interest on bank accounts	96	28
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	16
Total finance income	**96**	**44**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	394	530
Other loans	-	-
Overdrafts	-	-
Finance leases	201	197
Interest on late payment of commercial debt	20	-
Main finance costs on PFI and LIFT schemes obligations	1,600	1,513
Contingent finance costs on PFI and LIFT scheme obligations	977	923
Total interest expense	**3,192**	**3,163**
Unwinding of discount on provisions	-	-
Other finance costs	-	-
Total finance costs	**3,192**	**3,163**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims under this legislation	20	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	6,176	-
Losses on disposal of assets	-	(28)
Total gains / (losses) on disposal of assets	**6,176**	**(28)**
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of financial assets mandated as fair value through OCI	-	-
Total other gains / (losses)	**6,176**	**(28)**

Note 14.1 Intangible assets - 2018/19

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Goodwill	Websites	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**12,448**	**-**	**-**	**-**	**-**	**-**	**-**	**1,292**	**-**	**13,740**
Transfers by absorption	-	-	-	-	-	-	-	-	-	**-**
Additions	2,426	-	-	-	-	-	-	-	-	**2,426**
Impairments	-	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	-	**-**
Reclassifications	2,097	-	-	-	-	-	-	(1,043)	-	**1,054**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 31 March 2019	**16,971**	**-**	**-**	**-**	**-**	**-**	**-**	**249**	**-**	**17,220**
forward	**9,596**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**9,596**
Transfers by absorption	-	-	-	-	-	-	-	-	-	**-**
Provided during the year	825	-	-	-	-	-	-	-	-	**825**
Impairments	-	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	-	**-**
Amortisation at 31 March 2019	**10,421**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**10,421**
Net book value at 31 March 2019	**6,550**	**-**	**-**	**-**	**-**	**-**	**-**	**249**	**-**	**6,799**
Net book value at 1 April 2018	**2,852**	**-**	**-**	**-**	**-**	**-**	**-**	**1,292**	**-**	**4,144**

Note 14.2 Intangible assets - 2017/18

	Software licences £000	Licences & trademarks £000	Patents £000	Internally generated information technology £000	Development expenditure £000	Goodwill £000	Websites £000	Intangible assets under construction £000	Other (purchased) £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	**11,394**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**11,394**
Prior period adjustments	-	-	-	-	-	-	-	-	-	**-**
restated	**11,394**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**11,394**
Transfers by absorption	-	-	-	-	-	-	-	-	-	**-**
Additions	1,054	-	-	-	-	-	-	1,292	-	**2,346**
Impairments	-	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 31 March 2018	**12,448**	**-**	**-**	**-**	**-**	**-**	**-**	**1,292**	**-**	**13,740**
previously stated	**7,409**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**7,409**
Prior period adjustments	-	-	-	-	-	-	-	-	-	**-**
Amortisation at 1 April 2017 - restated	**7,409**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**7,409**
Transfers by absorption	-	-	-	-	-	-	-	-	-	**-**
Provided during the year	2,187	-	-	-	-	-	-	-	-	**2,187**
Impairments	-	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	-	**-**
Revaluations	-		-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	-	**-**
Amortisation at 31 March 2018	**9,596**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**9,596**
Net book value at 31 March 2018	**2,852**	**-**	**-**	**-**	**-**	**-**	**-**	**1,292**	**-**	**4,144**
Net book value at 1 April 2017	**3,985**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**3,985**

Note 15.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**47,896**	**158,473**	**1,116**	**1,279**	**32,546**	**-**	**13,590**	**136**	**255,036**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	1,194	-	7,889	2,092	-	1,045	2	**12,222**
Impairments	(458)	(4,321)	-	-	-	-	-	-	**(4,779)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	1,610	583	-	-	-	-	-	-	**2,193**
Reclassifications	-	451	1	(1,477)	(17)	-	(14)	2	**(1,054)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	(3,409)	(1,848)	(1,067)	-	(152)	-	-	-	**(6,476)**
Valuation/gross cost at 31 March 2019	**45,639**	**154,532**	**50**	**7,691**	**34,469**	**-**	**14,621**	**140**	**257,142**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**4,992**	**32**	**-**	**24,422**	**-**	**9,825**	**34**	**39,305**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	2,800	18	-	1,564	-	1,281	28	**5,691**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(152)	-	-	-	**(152)**
Accumulated depreciation at 31 March 2019	**-**	**7,792**	**50**	**-**	**25,834**	**-**	**11,106**	**62**	**44,844**
Net book value at 31 March 2019	**45,639**	**146,740**	**-**	**7,691**	**8,635**	**-**	**3,515**	**78**	**212,298**
Net book value at 1 April 2018	**47,896**	**153,481**	**1,084**	**1,279**	**8,124**	**-**	**3,765**	**102**	**215,731**

Note 15.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**47,896**	**150,284**	**1,054**	**2,426**	**28,745**	**-**	**12,127**	**93**	**242,625**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2017 - restated	**47,896**	**150,284**	**1,054**	**2,426**	**28,745**	**-**	**12,127**	**93**	**242,625**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	2,267	-	-	3,981	-	1,463	43	**7,754**
Impairments	-	985	-	(1,147)	-	-	-	-	**(162)**
Reversals of impairments	-	18	-	-	-	-	-	-	**18**
Revaluations	-	4,919	62	-	-	-	-	-	**4,981**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(180)	-	-	-	**(180)**
Valuation/gross cost at 31 March 2018	**47,896**	**158,473**	**1,116**	**1,279**	**32,546**	**-**	**13,590**	**136**	**255,036**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**2,394**	**15**	**-**	**22,423**	**-**	**8,423**	**14**	**33,269**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2017 - restated	**-**	**2,394**	**15**	**-**	**22,423**	**-**	**8,423**	**14**	**33,269**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	2,598	17	-	2,151	-	1,402	20	**6,188**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-		-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(152)	-	-	-	**(152)**
Accumulated depreciation at 31 March 2018	**-**	**4,992**	**32**	**-**	**24,422**	**-**	**9,825**	**34**	**39,305**
Net book value at 31 March 2018	**47,896**	**153,481**	**1,084**	**1,279**	**8,124**	**-**	**3,765**	**102**	**215,731**
Net book value at 1 April 2017	**47,896**	**147,890**	**1,039**	**2,426**	**6,322**	**-**	**3,704**	**79**	**209,356**

Note 15.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	45,639	69,686	-	7,691	6,653	-	3,515	78	**133,262**
Finance leased	-	4,381	-	-	1,750	-	-	-	**6,131**
On-SoFP PFI contracts and other service concession arrangements	-	71,777	-	-	-	-	-	-	**71,777**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	896	-	-	232	-	-	-	**1,128**
NBV total at 31 March 2019	**45,639**	**146,740**	**-**	**7,691**	**8,635**	**-**	**3,515**	**78**	**212,298**

Note 15.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	47,896	75,207	1,084	1,279	6,663	-	3,765	89	**135,983**
Finance leased	-	4,465	-	-	1,441	-	-	-	**5,906**
On-SoFP PFI contracts and other service concession arrangements	-	72,894	-	-	-	-	-	-	**72,894**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	915	-	-	20	-	-	13	**948**
NBV total at 31 March 2018	**47,896**	**153,481**	**1,084**	**1,279**	**8,124**	**-**	**3,765**	**102**	**215,731**

Note 16 Donations of property, plant and equipment

The GAM 5.90 and 5.91 require trusts to disclose details of any donations of property, plant and equipment received during the year, including any restriction or conditions imposed by the donor.

The Whittington Charity has donated cash rather than assets in year, £1,000k towards the Trust's maternity redevelopment.

Note 17 Revaluations of property, plant and equipment

Land, buildings and dwellings were valued in March 2019 by qualified independent valuers Cushman and Wakefield. The assets were revalued on a fair value basis.

In line with the current valuation methodology, buildings have been recategorised as 'blocks' and the various components within each block grouped as one. Each block is considered as an individual item and depreciated over its estimated useful economic life.

Note 18 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	1,081	1,171
Work In progress	-	-
Consumables	91	43
Energy	39	26
Other	237	115
Total inventories	**1,448**	**1,355**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £13,137k (2017/18: £12,670k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 19.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	35,842	
Contract assets*	-	
Trade receivables*		18,999
Capital receivables	-	-
Accrued income*		11,020
Allowance for impaired contract receivables / assets*	(1,228)	
Allowance for other impaired receivables	(1,364)	(2,177)
Deposits and advances	-	-
Prepayments (non-PFI)	2,603	758
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	16
Finance lease receivables	-	-
PDC dividend receivable	(71)	-
VAT receivable	2,430	1,746
Corporation and other taxes receivable	-	-
Other receivables	2,226	-
Total current trade and other receivables	**40,438**	**30,363**
Non-current		
Contract receivables*	-	
Contract assets*	-	
Trade receivables*		-
Capital receivables	-	-
Accrued income*		-
Allowance for impaired contract receivables / assets*	-	
Allowance for other impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	604	656
Total non-current trade and other receivables	**604**	**656**
Of which receivables from NHS and DHSC group bodies:		
Current	33,277	22,461
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 19.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**2,177**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,210	(1,210)
Transfers by absorption	-	-
New allowances arising	18	397
Changes in existing allowances	-	-
Reversals of allowances	-	-
Utilisation of allowances (write offs)	-	-
Changes arising following modification of cotractual cash flows	-	-
Foreign exchange and other changes	-	-
Allowances as at 31 Mar 2019	**1,228**	**1,365**

Note 19.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables £000
Allowances as at 1 Apr 2017 - as previously stated	**2,806**
Prior period adjustments	
Allowances as at 1 Apr 2017 - restated	**2,806**
Transfers by absorption	
Increase in provision	136
Amounts utilised	(765)
Unused amounts reversed	
Allowances as at 31 Mar 2018	**2,177**

Note 20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**4,051**	**3,161**
Prior period adjustments	-	-
At 1 April (restated)	**4,051**	**3,161**
Transfers by absorption	-	-
Net change in year	21,114	890
At 31 March	**25,165**	**4,051**
Broken down into:		
Cash at commercial banks and in hand	60	64
Cash with the Government Banking Service	7,105	3,987
Deposits with the National Loan Fund	18,000	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**25,165**	**4,051**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**25,165**	**4,051**

Note 20.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019	31 March 2018
	£000	£000
Bank balances	7	6
Monies on deposit	-	-
Total third party assets	**7**	**6**

Note 21 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	10,857	18,345
Capital payables	5,620	4,903
Accruals	14,965	8,010
Receipts in advance (including payments on account)	-	-
Social security costs	2,811	2,507
VAT payables	-	-
Other taxes payable	2,530	-
PDC dividend payable	(185)	95
Accrued interest on loans*		55
Other payables	4,016	3,062
Total current trade and other payables	**40,614**	**36,977**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	6,469	9,167
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 22 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	281	320
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Other deferred income	-	
Total other current liabilities	**281**	**320**
Non-current		
Deferred income: contract liabilities	-	-
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Other deferred income	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**-**	**-**

Note 23.1 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health and Scoial Care	27,445	18,490
Other loans	-	-
Obligations under finance leases	1,185	655
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,146	1,050
Total current borrowings	**29,776**	**20,195**
Non-current		
Loans from the Department of Health and Scoial Care	2,128	11,192
Other loans	-	-
Obligations under finance leases	186	1,667
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	25,228	25,589
Total non-current borrowings	**27,542**	**38,448**

Note 23.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**29,682**	**-**	**2,322**	**26,639**	**58,643**
Cash movements:					
Financing cash flows - payments and receipts of principal	(164)	-	(869)	(1,159)	**(2,192)**
Financing cash flows - payments of interest	(339)	-	(201)	(2,577)	**(3,117)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	55	-	-	-	**55**
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	-	**-**
Application of effective interest rate	394	-	201	1,600	**2,195**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Other changes	(55)	-	(82)	1,871	**1,734**
Carrying value at 31 March 2019	**29,573**	**-**	**1,371**	**26,374**	**57,318**

Note 24 Finance leases

Note 24.1 The Trust as a lessee

Obligations under finance leases where The Whittington Health NHS Trust is the lessee.

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**3,439**	**4,390**
of which liabilities are due:		
- not later than one year;	981	981
- later than one year and not later than five years;	1,831	2,782
- later than five years.	627	627
Finance charges allocated to future periods	(2,068)	(2,068)
Net lease liabilities	**1,371**	**2,322**
of which payable:		
- not later than one year;	1,185	655
- later than one year and not later than five years;	1	1,482
- later than five years.	185	185
Total of future minimum sublease payments to be received at the reporting date	-	-
Contingent rent recognised as an expense in the period	-	-

The Trust leases the Stroud Green Health Centre. The lease started in 1993 and is scheduled to last for 125 years. The Trust's main finance lease is for imaging equipment through the Managed Equipment Service contractor, Althea. This arrangement started in 2007 and is currently scheduled to run until 2027.

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2018	**1,018**	**-**	**48**	**-**	**-**	**-**	**1,167**	**2,233**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	-	-	-	**-**
Arising during the year	-	-	25	-	-	-	100	**125**
Utilised during the year	(179)	-	-	-	-	-	(276)	**(455)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	(28)	-	-	-	-	**(28)**
Unwinding of discount	-	-	-	-	-	-	-	**-**
At 31 March 2019	**839**	**-**	**45**	**-**	**-**	**-**	**991**	**1,875**
Expected timing of cash flows:								
- not later than one year;	150	-	45	-	-	-	498	**693**
- later than one year and not later than five years;	150	-	-	-	-	-	50	**200**
- later than five years.	539	-	-	-	-	-	443	**982**
Total	**839**	**-**	**45**	**-**	**-**	**-**	**991**	**1,875**

Other provisions include:
1. estimated employer's liability in relation to pending negligence claims with NHS Resolution
2. ongoing and potential employment tribunal cases. The employment tribunal provision represents management's estimate (and that of our legal advisers) of liability based on experience.
3. potential dilapidations from the transfer of leased estates back to the lessor.
4. potential liability in the event that the Trust is unable to achieve a range of greenhouse gas reduction targets.

Note 25.2 Clinical negligence liabilities

At 31 March 2019, £121,917k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Whittington Health NHS Trust (31 March 2018: £99,506k).

Note 26 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	(18)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**-**	**(18)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**-**	**(18)**
Net value of contingent assets	**-**	**-**

Note 27 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	10,624	365
Intangible assets	4,754	3,530
Total	**15,378**	**3,895**

The Trust's principal capital commitments relate to significant capital schemes ongoing in future years, most notably GDE Fast Follower in IM&T and the ongoing estates strategy work.

Note 28 On-SOFP PFI, LIFT or other service concession arrangements

Blocks A and L of the Trust's sites are provided under a PFI arrangement and were brought onto the balance sheet in 2007.

Note 28.1 Imputed finance lease obligations

The Whittington Health NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**38,618**	**40,299**
Of which liabilities are due		
- not later than one year;	2,504	2,465
- later than one year and not later than five years;	10,185	10,040
- later than five years.	25,929	27,794
Finance charges allocated to future periods	(12,244)	(13,660)
Net PFI, LIFT or other service concession arrangement obligation	**26,374**	**26,639**
- not later than one year;	1,146	1,050
- later than one year and not later than five years;	5,374	4,966
- later than five years.	19,854	20,623

Note 28.2 Total on-SOFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**104,653**	**94,173**
Of which liabilities are due:		
- not later than one year;	5,637	5,285
- later than one year and not later than five years;	23,992	21,815
- later than five years.	75,024	67,073

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19	2017/18
	£000	£000
Unitary payment payable to service concession operator	**5,560**	**5,261**
Consisting of:		
- Interest charge	1,600	1,513
- Repayment of finance lease liability	1,153	1,089
- Service element and other charges to operating expenditure	1,089	1,037
- Capital lifecycle maintenance	741	699
- Revenue lifecycle maintenance	-	-
- Contingent rent	977	923
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	**5,560**	**5,261**

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	34,257	-	-	**34,257**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents at bank and in hand	25,165	-	-	**25,165**
Total at 31 March 2019	**59,422**	**-**	**-**	**59,422**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	27,881	-	-	-	**27,881**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	4,051	-	-	-	**4,051**
Total at 31 March 2018	**31,932**	**-**	**-**	**-**	**31,932**

Note 29.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	29,573	-	**29,573**
Obligations under finance leases	1,371	-	**1,371**
Obligations under PFI, LIFT and other service concession contracts	26,374	-	**26,374**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	34,331	-	**34,331**
Other financial liabilities	-	-	**-**
Provisions under contract	1,032	-	**1,032**
Total at 31 March 2019	**92,681**	**-**	**92,681**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	29,682	-	**29,682**
Obligations under finance leases	2,322	-	**2,322**
Obligations under PFI, LIFT and other service concession contracts	26,639	-	**26,639**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	34,470	-	**34,470**
Other financial liabilities	-	-	**-**
Provisions under contract	1,215	-	**1,215**
Total at 31 March 2018	**94,328**	**-**	**94,328**

Note 29.4 Fair value of financial assets and liabilities

The Trust considers that book value is a reasonable approximation of the fair value of financial assets and liabilities.

Note 29.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	63,210	55,879
In more than one year but not more than two years	2,029	2,791
In more than two years but not more than five years	6,080	4,499
In more than five years	21,362	31,159
Total	**92,681**	**94,328**

Note 30 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	18	18	12	11
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	33	29	104	123
Stores losses and damage to property	-	-	-	-
Total losses	**51**	**47**	**116**	**134**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	-	-	-	-
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**-**	**-**	**-**	**-**
Total losses and special payments	**51**	**47**	**116**	**134**
Compensation payments received		-		-

Note 31.1 Impact of the implementation of IFRS 9 Financial Instruments

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £55k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £1k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £1,084k.

Note 31.2 Impact of the implementation of IFRS 15 Revenue from Contracts with Customers

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 32 Related parties

During the year no Trust Board members or members of key management staff, or parties related to them, has undertaken any material transactions with the Trust.

Dr Sarah Humphery is both Executive Medical Director for Integrated Care for the Trust and a GP with Goodinge Group Practice. In 2018-19, the Trust paid £10k to Goodinge. There were no balances outstanding.

David Holt is a non-executive director at the Trust and also at Tavistock and Portman NHS FT. The Trust's balances and transactions with Tavistock and Portman were as follows: income £80k, expenditure £41k, debtors £11k, creditors £99k.

The Department of Health is considered a related party. During the year the Trust has had a significant number of material transactions with the Department and with other entities for which the Department is the parent Department. For example material income was received from the following such entities:

	Income (£000s)	Expenditure (£000s)	Debtors (£000s)	Creditors (£000s)
Islington CCG	108,332	0	945	321
Haringey CCG	95,371	0	2,846	59
NHS England	58,098	0	21,529	0
Health Education England	15,553	13	246	18
Barnet CCG	11,812	0	34	166
Camden CCG	10,890	0	17	0

Material expenditure was incurred with the following other entity within the NHS:

	Income (£000s)	Expenditure (£000s)	Debtors (£000s)	Creditors (£000s)
NHS Resolution (formerly NHS Litigation Authority)		10,287		

The Trust completed a land sale transaction with Camden and Islington Foundation Trust in the financial year. The proceeds from this transaction were £12,500k.

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of the material transactions have been with:

	Income (£000s)	Expenditure (£000s)	Debtors (£000s)	Creditors (£000s)
London Borough of Islington	7,552	1,869	502	21

Note 33 Prior period adjustments

No adjustments have been made to prior period audited figures.

Note 34 Events after the reporting date

The Trust has considered whether there are any material post balance sheet events to disclose. We have concluded that there is nothing to disclose here.

Note 35 Better Payment Practice Code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	65,436	138,751	88,858	130,706
Total non-NHS trade invoices paid within target	56,233	129,821	80,109	119,606
Percentage of non-NHS trade invoices paid within target	85.9%	93.6%	90.2%	91.5%
NHS Payables				
Total NHS trade invoices paid in the year	5821	17965	7019	19622
Total NHS trade invoices paid within target	4160	8671	2541	5660
Percentage of NHS trade invoices paid within target	71.5%	48.3%	36.2%	28.8%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 36 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Cash flow financing	**(21,294)**	**(748)**
Finance leases taken out in year		
Other capital receipts		
External financing requirement	**(21,294)**	**(748)**
External financing limit (EFL)	(10,021)	(716)
Under / (over) spend against EFL	**11,273**	**32**

Note 37 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	14,648	10,100
Less: Disposals	(6,324)	(28)
Less: Donated and granted capital additions	(1,000)	(166)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**7,324**	**9,906**
Capital Resource Limit	10,700	11,314
Under / (over) spend against CRL	**3,376**	**1,408**

Note 38 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	28,190
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	1,172
Breakeven duty financial performance surplus / (deficit)	**29,362**

Note 39 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		139	508	1,120	3,614	1,165	(7,342)	(14,788)	(3,670)	6,158	29,362
Breakeven duty cumulative position	3,971	4,110	4,618	5,738	9,352	10,517	3,175	(11,613)	(15,283)	(9,126)	20,237
Operating income		176,853	186,300	278,212	281,343	297,397	295,007	294,211	309,255	323,394	348,646
Cumulative breakeven position as a percentage of operating income		2.3%	2.5%	2.1%	3.3%	3.5%	1.1%	(3.9%)	(4.9%)	(2.8%)	5.8%

Whittington Health
NHS Trust

@WhitHealth

/WhittingtonHealth

whh-tr.whitthealthPALS@nhs.net

020 7288 5551

PALS, Whittington Health NHS Trust, Magdala Avenue, London N19 5NF

Meeting title	**Trust Board – public meeting**	**Date: 26 June 2019**
Report title	Risk Management Strategy Review 2019-2020	**Agenda item: 16.1**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Patient Experience	
Report author	Lynda Rowlinson, Interim Head of Quality Governance	
Executive summary	The purpose of this report is to provide the Board with a summary of the current status of risk management within the Trust and to highlight recommended amendments to the Risk Management Strategy for 2019-20. 1. The review of the Risk Management Strategy for 2019-20 provides a framework for the identification, management and escalation of risk within the organisation. 2. The Trust recognises that quality and risk management must be embedded in order for the organisation to function safely and effectively. 3. This paper details the current strategy and the framework set to control the risks to its key functions. The overall objectives outlined within the Strategy are to provide: • A robust organisational governance structure, with clear of a accountability and roles responsible for risk in place • A framework and clear processes for robust risk management at all levels across the Trust • A risk register driven from Ward/Service level to divisional level (Integrated Clinical Service Unit - ICSU) to Trust Corporate Department level to Trust Board • A relationship with the Board Assurance Framework that clearly articulates risks to the achievement of the Trust's objectives • Support and on-going development as a learning organisation 4. A risk management Internal Audit was completed in March 2019. It reviewed nine areas of risk management processes as set out in Risk Management Strategy. Eight recommendations were made (see Appendix 1) including 2 high, 5 medium and 1 low priority actions to improve the design and operational effectiveness of controls in place to ensure the strategy and objectives in relation to risk management are achieved.	

Purpose:	Approval
Recommendation(s)	The Board is requested to: i. review the strategy to ensure the recommendations from the Internal Audit (Appendix 1) are embedded into the revisions to the Strategy; and ii. approve the risk management strategy for 2019-20.
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	Quality Committee, May 2019; Trust Management Group, June 2019
Appendices	1: Risk Management Internal Audit Action Plan May 2019 2: Link to Trust Policies

RISK MANAGEMENT STRATEGY 2019 – 2020

1. INTRODUCTION

1.1. Risk is inherent within the delivery of healthcare. The Risk Management Strategy provides a framework for the identification, management and escalation of risk within the organisation.

1.2. The Trust vision is to 'help local people live longer healthier lives' and ensuring quality governance and risk management is fundamental to this ambition. The Trust recognises that quality and risk management must be embedded in order for the organisation to function safely and effectively. The Trust Board is committed to ensuring that risk management forms an integral part of the organisation's philosophy, practices, activity and planning and not viewed as a separate programme of work.

1.3. The Trust Board seeks assurance that systems, policies and people are operating in a way that is effective, focused on key risks, and is driving the delivery of the Trust's goals and objectives. It is aware of the risks within the organisation, and that it has made effective decisions on the management of risk based on the available evidence. The risk management strategy functions within a governance framework described in a number of Trust policies (Appendix 2).

1.4. The Trust Board seeks assurance from the Board Assurance Framework and Trust Risk Register.

1.5. This Strategy will be reviewed by the Trust Board annually and updated in line with current best practice and/or any change in legislation.

2. DEFINITIONS

Risk management - is a systematic process of risk identification, analysis and evaluation and correction of potential and actual risks to a patient, visitor or member of staff.

Clinical Risks - which relate to the provision of high quality patient centred care e.g. medication errors, patient falls, and patient safety risks.

Non-clinical Risks – relate to the environment in which patient care takes place including the use of facilities by staff, patients, contractors and other visitors e.g. health and safety risks, financial risks, reputational risks, information governance risks etc.

Risk Register - database used to collate and monitor all risks in an organisation

3. PURPOSE

3.1 Strategic aims for the Risk Management Strategy are:

- Compliance with relevant statutory mandatory and professional requirements and maintenance of the Trust's registration with the Care Quality Commission (CQC)
- Consistent and effective risk management processes at all levels of the organisation
- Open culture where people feel encouraged to take responsibility for reporting and managing risks
- Integration of risk management into business processes, such as ensuring service developments do not adversely impact on safety
- Ensure awareness of and alliance with the Board Assurance Framework (BAF)
- Describe the Trust's Risk Appetite

4. ORGANISATIONAL STRUCTURE FOR RISK MANAGEMENT

4.1 A robust organisational governance structure, with clear lines of accountability and roles responsible for risk is key to the delivery of the Trust's risk management strategy.

4.2 To strengthen the Trust's ability to deliver effective risk management, the organisational structure includes a number of Board Committees with responsibility for risk. The Audit & Risk Committee, Quality Committee, Finance & Business Committee and Workforce Assurance Committee all have a responsibility in monitoring risk and providing assurance to the Trust Board that there are systems in place to effectively identify, manage and escalate risks across the trust.

4.3 Each Committee has responsibility for specific risks to ensure there is clear accountability and oversight, and that information flows quickly to the Board and its committees. Each committee has a responsibility to commission 'deep dives' into areas that warrant closer scrutiny in order to manage risk.

5. KEY PRINCIPLES OF RISK MANAGEMENT

5.1 Through a process of risk identification, risk assessment, mitigation and control, the organisation will maintain a Trust wide Risk Register, using DATIX, the Trust's risk management software programme.

- **Identification**: Early identification promoted through a culture of openness and transparency, encouraging staff to report incidents and near misses
- **Assessment**: The trust has a standard approach to risk assessment, using the nationally recognised risk matrix (http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/) and online risk assessment form on DATIX to assess all risks under the key headings of controls, assurance, and gaps
- **Management**: Individual risk managers are responsible for reviewing the risk assessment and identifying the appropriate action to take to reduce or eliminate the risk. Some risks that cannot be reduced or represent a risk to the strategic objectives of the trust must be escalated appropriately to the relevant Trust Board sub-committee.

5.2 To promote a consistent approach the Trust will ensure that risk management is supported by the development of formal mechanisms to assess risk and to measure the effectiveness of risk management, plans and processes. In particular:

- Providing training and support to managers and identified risk leads to enable them to manage risk as part of role and/or line management responsibilities
- Providing a Risk Register guide for staff outlining the approval, monitoring and reporting process for all risks on DATIX
- All risks are collated by ICSU or Corporate Department (IM&T; Facilities and Estates; Finance, Human Resources and Workforce) or as organisation wide
- All risks are categorised under eight key headings:
    - Patient Safety and Quality
    - Financial
    - HR and Workforce
    - Health and Safety
    - Estates or Infrastructure
    - Information Technology
    - Information Governance
    - Security
- There will be a process of challenge at Performance Review meetings by the Executive in relation to assumptions underpinning risk ratings and mitigation plans
- Risk management will be supported by accurate, timely and effective incident reporting, including categorising the consequences of risk and investigating system failures
- Evidence will be maintained to demonstrate that recommendations and action plans have been developed and changes implemented accordingly to mitigate risk
- Risk assessments will be undertaken for strategic policy decisions and documents relating to new projects
- Risk assessments will be undertaken for all cost improvement programmes which includes a quality impact assessment

5.3 Reporting and monitoring risk The Chief Nurse is responsible for ensuring the risk register is maintained according to the risk management strategy.

5.4 Local management of risk ICSU directors and corporate department directors are responsible for developing and maintaining their respective risk registers

5.5 While individual risk handlers are responsible for reviewing and monitoring the risks only ICSU directors and corporate directors can approve new risks or agree significant changes to the risk register.

5.6 Risk registers are reviewed at the relevant ICSU Boards and/or department meetings using the reporting or dashboard function from DATIX to ensure a dynamic, live database.

5.7 Each ICSU's risk register will be formally reviewed as part of the ICSU quarterly performance review process. At these meetings the ICSUs will be expected to report on their top risks rated ≥12, and present action plans for minimising and managing these risks.

5.8 All risks ≥15 will be escalated to the relevant Board Sub-Committee and Trust Management Group for review and agreement.

6. RISK REGISTER

6.1 The Trust has set a threshold of ≥15 risk grading for review at Board sub-committees. This is to ensure that there is Non-Executive Director and Executive Director Lead oversight of these risks and a clear escalation process to Board.

6.2 All ICSUs/Directorates are responsible for ensuring there are clear risk management structures and processes in their areas, including the regular review of all their ≥12 risks from a specialty to ICSU/Directorate level.

6.3 All risks ≥15 and are automatically escalated to the relevant sub-committees and collated from the central database on DATIX

6.4 The Head of Quality Governance is responsible for managing and reporting on the ≥15 Risk Register.

6.5 Monthly review of the ≥15 Risk Register by Trust Management Group and Executive Team monthly.

6.6 Trust Board Sub-Committees have delegated responsibility for risk from the Trust Board and provide assurance to the Trust Board that the ≥15 Risk Register is being actively reviewed. Any concerns are escalated for Board consideration as required. This process ensures that the ≥15 Risk Register has regular Non-Executive and Executive oversight.

7. REPORTING PROCESS FOR ≥15 RISK REGISTER

7.1 The Trust Board delegates responsibility for the ≥15 risk register to the relevant board sub-committees via the executive directors lead for the committee.

7.2 Sub-committee chairs and Executive director lead to escalate any concerns with the risk register to Board as required.

7.3 Each committee produces a bi-monthly report on the ≥15 risk register.

7.4 The Quality Committee reviews all risks from across the ICSUs and Estates and Facilities risks ≥15, as well as any organisation wide risks. In addition, the Quality Committee considers finance, information governance and IT risks for information and escalates any concerns around quality and safety to the responsible Board subcommittee.

7.5 The Finance and Business Development Committee reviews all Finance, IM&T and Information Governance risks ≥15, and also reviews all risks categorised as financial, information governance or information technology from the ICSU risk registers.

7.6 The Workforce Assurance Committee reviews all workforce risks ≥15 and also reviews all risks categorised as ‘HR and workforce’ from the ICSU risk registers.

7.7 The Audit and Risk Committee will review the full ≥15 Risk Register and provide assurance to Trust Board that there is an effective governance structure in place to manage risks.

7.8 In addition, all risks ≥16 to be presented to public Board in a six monthly report and will include the connection to the Board Assurance Framework (BAF).

7.9 The Trust Board will review the BAF six monthly.

8. BOARD ASSURANCE FRAMEWORK

8.1 The Board Assurance Framework (BAF) provides a structure and process that enables the Trust to focus on the risks to achieving its annual objectives and be assured that adequate controls are operating to reduce these risks to tolerable levels (Good Governance Institute 2009).

8.2 The Board and its Committees review the progress in controlling risks to these important objectives, the levels of assurance, and plans to mitigate the impact of the actual or potential risk on the Trust. It importantly determines the accountability structure for the risk.

8.3 All risks to achieving the Trust's objectives will be recorded on the BAF and reported to the Board.

8.4 The relationship between the risk register and BAF is set out in the table below (**note this is an example, not based on actual DATIX references).** The fundamental difference between the Risk Register and the BAF is that the Risk Register is a framework focused on the day to day management of risk for the organisation. The BAF focuses on risk assurance of the corporate objectives and that there are clear mitigation and accountability of any risks that threaten the success of the Trust objectives. At times the risks affecting the day to day management of the Trust will have implications for the delivery of the Trust's strategic objectives; these risks are escalated for inclusion on the BAF via the Board sub-committees and the Executive Team and Trust Management Group.

Example

Strategic objective	***Risks against achieving this objective (BAF)***	***Links with >15 Risk Register***
SO1.To deliver a consistent high quality safe service	*BAF1: Failure to recruit and retain staff*	*DATIX ref 63: Inadequate consultant cover in Emergency Department (scored 16)* *DATIX ref 73: High nursing vacancy rate in District Nursing Service (scored 15)* *DATIX ref 102: High nursing vacancy rate on care of older people's wards (scored 15)*

8.5 Reporting on the BAF the Director of Strategy, Development and Corporate Affairs, with the Head of Quality Governance, will ensure the link between the ≥15 risk register and BAF is maintained.

8.6 The Head of Quality Governance will present the key changes to the >15 Risk Register to the Trust Management Group (TMG), highlighting any correlating implications for the BAF. The TMG is responsible for recommending changes to the BAF that must be approved by the Trust Board.

8.7 The Director of Strategy Development and Corporate Affairs is responsible for maintaining and reporting on the BAF, including updating the framework with assurance and mitigating actions as required, ensuring the BAF is kept up to date with changes to the ≥15 risk register and providing reports to Trust Board as required highlight significant changes to the BAF.

8.8 Director of Strategy Development and Corporate Affairs presents BAF to Trust Board six monthly

9. RISK APPETITE

9.1 Risk appetite is the level of risk, the Trust Board deems acceptable or unacceptable based on the specific risk category and circumstances/situation facing the Trust. This allows the Trust to measure, monitor and adjust via mitigations and investments, as necessary, the actual risk positions against the agreed risk appetite.

9.2 The Trust Board has adopted a risk appetite statement which is the amount of risk it is willing to accept in seeking to achieve its agreed strategic objectives. As well as the overall risk appetite statement, separate statements are provided for each, in the table overleaf.

9.3 The following risk appetite levels, adapted from the Good Governance Institute, along with this statement, will be used to assess the effective mitigation of risks in the Board Assurance Framework and the in-year, operational risk register (Corporate Risk Register).

Appetite level	Description	Comments
None	Avoid	A requirement to avoid risk and uncertainty to deliver and agreed organisational objective
Low	Minimal	A preference for very safe delivery options that have a low degree of inherent risk
Moderate	Cautious	A preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for improvement or value for money gains
High	Open	A willingness to consider all potential delivery options and select those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement or value for money gains
Significant	Seek	There is a preference to be innovative and to choose options potentially seeking higher rewards despite greater inherent risk. This would partly be because there was confidence of assurance that controls, forward scanning and responsive systems are robust,

9.4 Risk Appetite Statement - the Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its service users, carers, staff, public and partners and will not tolerate risks that materially provide a negative impact on quality or patient care. It does, however, have a greater appetite to take considered risks in terms of their impact on organisational issues. It also has the greatest appetite to pursue commercial gain, partnerships, clinical innovation, financial/value for money and reputational risk in

terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

9.5 Risk Tolerance and Risk Management Options - the aim of the Risk Management Strategy is not to remove all risk but to recognise that some level of risk will always exist. It is recognised that taking risks in a controlled manner is fundamental to innovation and developing a positive culture.

9.6 Risk tolerance is the amount of risk that an organisation is prepared to accept, or be exposed to at any point in time and every risk needs to be assessed for the tolerable level of risk. This strategy outlines the approach the Trust will take in assessing its risk tolerance.

9.7 Risk Management Options to provide safe and effective care to patients the organisation identifying risks and takes appropriate action to address them. This will typically be to either eliminate the risk entirely, or to reduce it to an acceptable level. Risk management options are categorised as follows:

Risk Avoidance Risk avoidance is action that avoids any exposure to the risk. Where the level of risk is unacceptably high and the Trust cannot, for whatever reason, put adequate control measures in place the Trust will consider whether to stop the relevant services at the Trust. The decision on Risk Avoidance may only be made by the Executive Team, Trust Management Group and agreed by the Chief Executive, in consultation with the Trust Board and relevant stakeholders as appropriate.
Risk Transfer Risk transfer is the action of handing over a risk to a willing third party. An example of such a risk transfer measure would be the decision that patients requiring certain high-risk surgical procedures for which the required level of surgical expertise or equipment is not available in the Trust will be referred to a tertiary centre for their treatment. In this case a balance of risk must be considered – the risk from transferring the patient must be less than the risk of operating in the Trust environment.
Risk Mitigation Risk mitigation is defined as taking steps to reduce or eliminate risks. This is the most commonly used approach in risk management. Some risks, when identified can be readily reduced or removed through the introduction of suitable control measures, (e.g. new policies, electronic safeguards, and environmental changes).
Risk Acceptance Risk acceptance does not reduce any effects of the risk; it is the process of actively deciding that the trust will accept the consequences (impact) of a risk if it occurs. When all reasonable control mechanisms have been put in place, some residual risk will inevitably remain in many Trust processes and can be accepted. Risk acceptance by the Trust will be systematic, explicit and transparent.

9.8 **Assessing Trust Risk Tolerance Level -** Risk tolerance is the amount of risk that any organisation is prepared to accept, or tolerate, or be exposed to at any point in time. The Trust follows the Good Governance Institute Guidance on setting risk tolerance levels (**https://www.good-governance.org.uk/services/risk-appetite-for-nhs-organisations-a-matrix-to-support-better-risk-sensitivity-in-decision-taking/**). The risk tolerance of the trust may vary across different elements (e.g. financial, regulatory, quality and safety or reputation).

9.9 This will be monitored through the Audit and Risk Committee who review the >15 Risk Register and BAF to provide assurance to Trust Board that the trust is operating within its agreed risk tolerance.

10. TRAINING

10.1 At the heart of this Strategy is the desire to learn from events and situations in order to continuously improve management processes. All members of staff have an important role to play in identifying, assessing, reviewing and managing risk. The Trust will develop all staff to ensure they have the knowledge and skills in risk management appropriate to their role and provide information, training and support to achieve this.

10.2 The Trust will:

- Ensure all staff have access to a copy of this Risk Management Strategy via the Trust's Intranet
- Communicate with staff actions to be taken with respect to assurance, quality and risk issues e.g. via the Trust weekly e-noticeboard
- Develop policies, procedures and guidelines based on the results of assessments, investigations and all identified risks
- Ensure that training programmes raise and sustain awareness of the importance of identifying and managing risk
- Ensure that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies, procedures and guidelines associated with this Strategy
- Facilitate specific risk management training for Board Members, Executives and Senior Managers, as specified

11. MONITORING THE EFFECTIVENESS OF THE STRATEGY

11.1 The Trust Board will review this strategy annually.

11.2 The Trust will seek assurance that risk management activities and systems are being appropriately identified and managed through the following:

- The Annual Governance Statement and the Board Assurance Framework
- Achievement of the Trust's strategic goals and annual corporate objectives
- Achievement of the ICSU business plans
- Compliance with National Standards, e.g. Care Quality Commission
- Monitoring of key performance indicators via the Trust and ICSU performance dashboards
- Receiving assurance from internal and external audit reports that the Trusts risk management and governance processes are being implemented
- External reporting is undertaken in accordance with reporting requirements and timescales
- Risk register reports to TMG and Board sub-committees and minutes from meetings
- Audit and Risk Committee review of trust compliance with agreed risk tolerance

11.3 The Head of Quality Governance will be responsible for ensuring systems and processes are in place to monitor the effectiveness of the Risk Management Strategy.

12. RECOMMENDATIONS FOR THE BOARD

12.1 The Board is requested to

i. Review the strategy to ensure the recommendations from the Internal Audit (Appendix 1) are embedded into the revisions to the Strategy

ii. Approve the risk management strategy for 2019-20.

Internal Audit Recommendations
The audit included: • A review of the Trust's Risk Strategy and its availability • A review of the processes around risk identification, recording, documentation and approval • An evaluation of staff training around risk identification and management • A review of the risk register for completeness – whether risks were identified and appropriately graded, escalated and reported. And removal / de-escalation processes and monitoring processes • A review of the timeliness and completeness of reporting risk through the ICSUs to Board and Executive committees • Culture of risk appetite, management and awareness throughout the Trust • A review of risk alignment to the Trust's strategic objectives and BAF.
Areas of good practice: • There is a Risk Management Strategy which provides detailed guidance on how risk should be managed within the Trust. • There is a clear governance structure with clearly defined roles and responsibilities for managing and reporting of risks. • The Trust's Strategic Objectives are embedded within the Risk Register to ensure that all risks are appropriately aligned to the Board Assurance Framework. • Risks rated ≥16 had been appropriately reported to the Board in accordance with the Risk Management Strategy. • Emerging risks are identified and added to the risk register appropriately. • Datix is appropriately designed to capture risks and to ensure consistency of risks identified, with clear guidelines in place.
Areas recommended for improvement: • Risk ranking is not consistently carried out in accordance to guidance provided by the risk matrix – training was suggested for the risk managers to improve this. • Further guidance was suggested for describing risks, effective controls, gaps in controls, gaining assurance and further actions • The access rights of users of the Risk Register needs to be configured to ensure roles and responsibilities are being carried out in line with the Risk Management Strategy. In particular only ICSU and Corporate directors should be allowed to approve new risk, downgrade existing risk and approve the removal of risks. • Risk management training needs to be more robust and comprehensive in order to equip risk managers for the demands of their risk management roles. • There is a need for more timely responses and feedback to potential risks raised by employees in accordance with procedures documented on the 'Guide to Risk Management' module on Datix. It was noted that some risks appeared to have been sitting in the holding area or classed as

being reviewed for several years without being approved or rejected • Consistency is reporting risks to the Board and committees to be reviewed / improved • Downgrading and removal of risks processes to be improved – so appropriate evidence and controls are in place to ensure this is handled effectively. • All risks should reach their target rating before being removed • Each ICSU should conduct a thorough review of their respective Risk Registers to ensure completeness • The Board was recommended to clearly communicate its risk appetite for each strategic objective annually to its committee to enable staff responsible to manage risk in accordance to this.	
Recommendations and actions taken (incorporated into the revised Risk Management Strategy):	
• The Risk Management Strategy is updated to provide appropriate guidance of the framework for ranking/assessing risks, including a hyperlink to the risk ranking framework.	Completed (Risk Management Strategy Trust Board 26th June 2019)
• A Risk Management Policy is developed and implemented to provide rigor to the Strategy and clear guidance to staff of operational requirements.	Under development and will be completed by end of June 2019
• Levels of access given to users of the Risk Register should be configured with roles and responsibilities outlined in the Risk Management Policy i.e. access rights revised so that only ICSU & Corporate Directors are allowed to approve risks & all new risks should be approved by ICSU & Corporate Directors in accordance with the Strategy	System wide review is underway across the whole Datix incident reporting system this will be completed within quarter 2 of 2019-20
• Training materials for risk managers should be updated alongside the Policy to provide detailed guidance on how risks should be managed within the Trust.	Training materials complete FAQ's complete and training notes for Risk Managers complete. First training date delivered 5th June 2019. Further dates planned.
• Controls to be put in place to ensure risks are consistently reported in Board/Committee/monthly ICSU reports in accordance with the Risk	Completed (Risk Management Strategy Trust Board 26th June 2019)

Management Strategy. • Risk managers to review the risk register monthly to ensure all outstanding risks are approved or rejected in a timely manner, including risks in 'holding area' and 'risks being reviewed'. • All risks being downgraded or removed are approved by ICSU or Corporate Directors. • The Board clearly communicates its risk appetite for each strategic objective annually to committees and risk management staff	This recommendation is currently in progress. Completion of action expected 30 June 2019. This recommendation is currently in progress. Completion of action expected 30 June 2019. Reported to Trust Board April 2019 in the Board Assurance Framework and Risk Appetite Agenda Item.

Appendix 2 – Key Trust Policies

Strategy / Policy	
Risk Register Guidance (including risk scoring matrix)	Located on DATIX
Health & Safety Policies	http://whittnet.whittington.nhs.uk/default.asp?c=7078&
Serious Incident Investigation Policy	http://whittnet whittingtonnhsuk/documentashx?id=8436
Adverse Incident Reporting and Investigation Policy	http://whittnet.whittington.nhs.uk/document.ashx?id=2518
Major Incident Plan	http://whittnet.whittington.nhs.uk/document.ashx?id=8
Business Continuity Plan	http://whittnet.whittington.nhs.uk/document.ashx?id=6
Safeguarding Children Policy	http://whittnet.whittington.nhs.uk/document.ashx?id=7
Safeguarding Adult Policy	http://whittnet.whittington.nhs.uk/document.ashx?id=5
Being Open Policy	http://whittnet.whittington.nhs.uk/document.ashx?id=7
Raising Concerns (Whistleblowing) Policy	http://whittnet.whittington.nhs.uk/document.ashx?id=5

Meeting title	**Trust Board - public meeting**	**Date: 26 June 2019**
Report title	**Board risk appetite statement**	**Agenda item: 16.2**
Executive director lead	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	
Report author	Swarnjit Singh, Trust Corporate Secretary	
Executive summary	**Background** At the April 2019 Board meeting, it was agreed that the proposed risk appetite statement be discussed further. There was a fruitful discussion on 8 May at the Board seminar and key points are captured in the paper overleaf. In the light of feedback at the Board seminar, the executive team has reviewed a revised risk appetite statement which is presented for approval.	
Purpose:	Approval	
Recommendation(s)	The Trust Board is asked to approve the revised 2019/20 risk appetite statement.	
Risk Register or Board Assurance Framework	All BAF entries and linked entries on the corporate risk register	
Report history	Executive Team, 8 April; Trust Management Group, 23 April; Trust Board, 24 April; Board seminar, 8 May	
Appendices	1: 2019/20 Risk Appetite Statement	

Whittington Health NHS Trust

2019/20 Risk Appetite Statement

1. Introduction

1.1 Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to take on in pursuit of a value i.e. the total impact of risk an organisation is prepared to accept in the pursuit of its strategic objectives.

1.2 Risk appetite therefore goes to the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

1.3 The amount of risk an organisation is willing to accept can vary from one organisation to another depending upon circumstances unique to each. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

2. Background - good practice

2.1 External guidance from KPMG and the Good Governance Institute suggests that a well-defined risk appetite should have the following characteristics:

- Reflective of strategy, including organisational objectives, business plans and stakeholder expectations
- Reflective of all key aspects of the business
- Acknowledges a willingness and capacity to take on risk
- Is documented as a formal risk appetite statement
- Considers the skills, resources and technology required to manage and monitor risk exposures in the context of risk appetite
- Is inclusive of a tolerance for loss or negative events that can be reasonably quantified
- Is periodically reviewed and reconsidered with reference to evolving industry and market conditions
- Is approved by the Board and has been articulated throughout the organisation, especially to staff involved in risk management

2.2 The Good Governance Institute (GGI) has produced a briefing paper on risk appetite for NHS organisations, along with a matrix to support better risk sensitivity in taking decisions[1].

2.3 The Financial Reporting Council has recognised that the Board has particular responsibility for identifying risks linked to the strategy, or resulting from external developments such as political and regulatory change. However, some operational risks are just as capable of damaging the long-term viability or reputation of the Trust as strategic risks, and in its oversight and monitoring capacity the Board need to focus on those risks capable of causing most damage to the Trust if they materialise, regardless of how they are classified. It helps to identify different types of risk appetite (money, quality, regulation and reputation) but always to assess these in the round.

[1] https://www.good-governance.org.uk/wp-content/uploads/2017/04/Risk-Appetite-for-NHS-Organisations.pdf

2.4 The GGI advise that risk appetite involves taking considered risks where the long-term benefits outweigh any short-term losses. It may be appropriate to incur a loss if this paves the way to eventual success. The Public Accounts Committee (PAC) has supported well-managed risk taking, recognising that innovation and opportunities to improve public services requires risk taking, providing that we have the ability, skills, knowledge and training to manage those risks well. A practical example given by the GGI for monitoring the Trust's risk profile are the CQC Quality Risk Profiles (QRPs) as they are an important tool in that they bring together a wide range of information on the risk of potential noncompliance with the CQC essential standards of quality and safety (Placeholder2)[2].

2.5 Well led guidance, published by NHS Improvement, references regular review of the Board's risk appetite and tolerance as part of evidence that there are clear and effective processes for managing risks, issues and performance (key line of enquiry 5).

2.6 The Trust has set its strategic objectives for 2019/20 and these are reflected within the current Board Assurance Framework (BAF). The monthly monitoring of the BAF by designated committees and the Board is the key process for managing and assessing strategic and operational risks during the year.

2.7 Finally the internal audit report from 2018/19 specifically recommends that we need to do better at disseminating our risk appetite to ICSUs.

3. May 2019 Board seminar

3.1 Board members considered a draft 2019/20 risk appetite statement based on the Good Governance Institute's risk appetite matrix and provided the following feedback:

- The risk appetite scores for different risk categories were slighty confusing in nomenclature and did not feel right.
- The Trust had tolerated risks in the past but there was little clarity over how the changing environment and context might change our appetite (e.g. we are in a different financial position this year to last)
- It was not clear whether if we scored an appetite in the 0-5 range we would ever achieve that low a level of risk even with all the mitigations in place. Therefore were we setting an unrealistically low risk appetite e.g. quality risk appetite was low but risks in A&E were often high.
- There was a discussion whether this meant that scores in and of themselves were unhelpful, but others argued that they were useful to measure performance and have a concrete target compared what could be considered vague statements.
- The board concluded that while some of the statement might appear formulaic, it was a good starting point and would help the organisation and, in particular, Integrated Clinical Service Units, to understand the range of toleration for types of risk.
- Should an individual risk's score fall outside its expected risk appetite range, there needed to be clear escalation arrangements in place, with referral to the Trust Management Group for review
- The Board should encourage risk-taking in certain areas e.g. innovation
- The Board considered that some of the risks overlapped each other. i.e in partnerships or innovation we might have a higher appetite for financial risk but that that should not compromise our quality and safety. To indicate this, it was suggested that partnership

[2] https://services.cqc.org.uk/sites/default/files/gac_-_dec_2011_update.pdf

category risks should include the wording: “providing alternative models of care without compromising patient health and wellbeing”

- The Board were keen that we provide more details of the impact of workforce risks

3.2 A revised 2019/20 risk appetite statement is attached overleaf for approval.

Appendix 1: 2019/20 Whittington Health Risk Appetite Statement

Overview

This statement sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds. It also supports delivery of the Trust's revised 2019/21 risk management strategy and will be cascaded and communicated to ICSU boards and particularly to staff involved in risk management, in order to embed sound risk management.

The Trust Board is responsible for setting, communicating and monitoring the risk appetite of the organisation in the delivery of its long term strategic objectives.

The Trust recognises that risk is inherent in the provision of healthcare services and therefore a defined approach is necessary to identify risk content and to ensure that there is an understanding and awareness of the risks it is prepared to accept in its pursuit of the delivery of the Trust's aims.

Definition

Risk appetite is the level of risk, the Trust Board deems acceptable or unacceptable based on the specific risk category and circumstances/situation facing the Trust. This allows the Trust to measure, monitor and adjust via mitigations and investments, as necessary, the actual risk positions against the agreed risk appetite.

The Trust Board has adopted a risk appetite statement which is the amount of risk it is willing to accept in seeking to achieve its agreed strategic objectives. As well as the overall risk appetite statement, separate statements are provided for each, in the table overleaf.

Risk appetite

The following risk appetite levels, adapted from the Good Governance Institute, along with this statement, will be used to assess the effective mitigation of risks in the Board Assurance Framework and the in-year, operational risk register (Corporate Risk Register).

Appetite level	Description	Comments
None	Avoid	A requirement to avoid risk and uncertainty to deliver and agreed organisational objective
Low	Minimal	A preference for very safe delivery options that have a low degree of inherent risk
Moderate	Cautious	A preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for improvement or value for money gains
High	Open	A willingness to consider all potential delivery options and select those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement or value for money gains
Significant	Seek	There is a preference to be innovative and to choose options potentially seeking higher rewards despite greater inherent risk. This would partly be because there was confidence of assurance that controls, forward scanning and responsive systems are robust,

2019/20 Risk Appetite Statement
Whittington Health NHS Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its service users, carers, staff, public and partners.

The Trust will not tolerate risks that materially provide a negative impact on quality or patient care. It does, however, have a greater appetite to take considered risks in terms of their impact on organisational issues. It also has the greatest appetite to pursue commercial gain, partnerships, clinical innovation, financial/value for money and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

The Trust's four objectives can be categorised as follows to help us with risk determination:

- Deliver outstanding compassionate care: Quality
- Empower, support and develop staff: People
- Integrate care with partners: Integration
- Transform and develop innovative financially sustainable services: Sustainability

Risk tolerance
Risk tolerance is the minimum and maximum risk score the Trust willing to accept for each risk appetite.

Below, the table shows risk appetite tolerance scores for level of each risk appetite. When a risk exceeds a risk appetite tolerance score this will be used as a framework for a risk to be communicated and reported upwards. Specifically if an ICSU comes across a risk that falls outside of the target range they will escalate to TMG and put in place mitigations that aim to reduce that risk to the target score. If the risk cannot be mitigated to the tolerance range this will be highlighted via the risk register to the board.

A suggested target risk is also added to help inform target risk scoring discussions. The target risk is provided as a guide and not an absolute expectation.

Appetite	None	Low	Moderate	High	Significant
Risk tolerance score	n/a	1-10	12-16	16-20	20-25
Target risk score	n/a	5	9	12	15

Strategic objective	Risk appetite level	Description	Risk tolerance score	Target risk score
Quality (patient safety)	**Low / Minimal**	The Trust recognises that delivering safe, high quality clinical services always comes with some inherent risk and therefore 'no' appetite would not be correct. So specifically: • There is a low appetite for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice • There is a low appetite for risks that may jeopardise patient safety	10	5

Strategic objective	Risk appetite level	Description	Risk tolerance score	Target risk score
		• Strict safety protocols will apply for all of clinical and non-clinical activity, when and wherever possible. We will report, record and investigate our incidents and ensure that we continue to learn lessons to improve the safety and quality of our services.		
Quality (patient care)	**Low / Minimal**	Delivering an excellent care experience for our patients is our highest priority.	10	5
Quality (clinical innovation)	**Moderate / Cautious**	The Trust recognises that it can be in the best interests of patients to have a moderate appetite for some individual patient care and treatment risks in order to achieve the best outcomes. Therefore we support our staff to work in collaboration with the people who use our services to develop appropriate and safe treatment plans based on assessment of need and clinical risk as long as they do not: • compromise the quality of care • result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice	16	9
Quality (regulatory compliance)	**Low / Minimal**	There is a low risk appetite for risks which may compromise the Trust's compliance with its specific statutory duties and regulatory requirements.	10	5
People (culture)	**None / Avoid**	The Trust values and respects all our staff equitably, involving them in decisions about the services they provide and offer the training and development they need to fulfil their roles. The Trust has **no** appetite for risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values.	0	0
People (recruitment and retention)	**Low / Minimal**	A low appetite for risks related to the recruitment, retention and training of staff to deliver safe, high quality services and good patient experience.	10	5

Strategic objective	Risk appetite level	Description	Risk tolerance score	Target risk score
People	**Moderate / Cautious**	There is a moderate risk appetite for risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models where these enhance or improve patient safety, care quality, service delivery or financial sustainability.	16	9
People	**None / Avoid**	The Trust has **no** appetite for any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.	0	0
People	**None /Avoid**	There is **no** appetite for any risk that could result in the Trust being in breach of our contractual or statutory responsibilities in relation to our staff or in a breach of our staff's employment or equality rights.	0	0
Integration (systems and partnerships)	**Significant / Seek**	The Trust will collaborate with commissioners, local authorities, other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards. Overall we have a significant appetite for risks to the achievement of this objective. Specifically: • There is a significant appetite for risk where this results in improvements in the design or delivery of healthcare services for our patients or the population we serve. Our appetite for risk in this area recognises that the Trust operates in a complex environment and is subject to very challenging economic conditions and changing demographics with intense scrutiny. • We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards	25	15
Sustainability	**Low / Minimal**	The Trust strives to use our resources efficiently and effectively for the benefit of our	10	5

Strategic objective	Risk appetite level	Description	Risk tolerance score	Target risk score
		patients and their care and ensure our services are clinically, operationally, and financially sustainable. We will always aim to achieve this objective; however, overall we have a **low** appetite for risk in this area. Specifically: • Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require sign off by the Board • The Trust is committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. It has a low risk appetite for some risks related to our estate and infrastructure where these adversely impact on patient safety, care quality and regulatory compliance • The Trust is prepared to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. Value and benefits will be considered and resources allocated in order to capitalise on opportunities		
Sustainability (Reputation)	**Low / Minimal**	The Trust has a low risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation with internal and external stakeholders.	10	5
Sustainability (Commercial development)	**High / Open**	The Trust has a high risk appetite for commercial gain we are open to new ideas of increasing return if they ensure quality and sustainability for our service users.	20	12