NHS
Whittington Health
NHS Trust

Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board in Public on **Thursday, 27 January 2022** from **9.30am to 11.05am** via video conference.

Item	Time	Title	Presenter	Action
		Standing agenda items		
1	*9.30*	Welcome, apologies, declarations of interest	Trust Chair	Note
2		Patient experience story	Chief Nurse & Director of Allied Health Professionals	Discuss
3	*9.50*	25 November 2021 public Board meeting minutes, action log, matters arising	Trust Chair	Approve
4		Chair's report	Trust Chair	Note
5		Chief Executive's report	Chief Executive	Note
		Quality and safety		
6	*10.10*	Quality Assurance Committee report	Committee Chair	Note
7		Patient Safety Specialist and National Patient Safety Strategy: Board Briefing	Medical Director	Note
		People		
8	*10.25*	Workforce Assurance Committee report	Committee Chair	Note
		Performance		
9	*10.35*	Financial performance and capital update	Chief Finance Officer	Review
10		Integrated performance report	Chief Operating Officer	Review
11		Delivery of Q3 corporate objectives	Director of Strategy and Corporate Affairs	Note
		Governance		
12	*10.55*	Audit and Risk Committee report	Committee Chair	Approve
13		Charitable Funds Committee report	Committee Chair	Note
14		Questions to the Board on agenda items	Trust Chair	Note
15	*11.05*	Any other urgent business	Trust Chair	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 25 November 2021

Present:	
Baroness Julia Neuberger	Chair
Siobhan Harrington	Chief Executive
Kevin Curnow	Chief Finance Officer
Dr Clare Dollery	Medical Director
Professor Naomi Fulop	Non-Executive Director
Amanda Gibbon	Non-Executive Director
Carol Gillen	Chief Operating Officer
Tony Rice	Non-Executive Director
Anu Singh	Non-Executive Director
Baroness Glenys Thornton	Non-Executive Director
Rob Vincent CBE	Non-Executive Director
In attendance:	
Dr Junaid Bajwa	Associate Non-Executive Director
Chetan Bhan	Clinical Director, Surgery and Cancer Integrated Clinical Service Unit (item 9)
Ruben Ferreira	Freedom to Speak Up Guardian (item 6)
Norma French	Director of Workforce
Jonathan Gardner	Director of Strategy & Corporate Affairs
Dr Sarah Humphery	Medical Director, Integrated Care
Tina Jegede	Joint Director, Race, Equality, Diversity & Inclusion and Nurse Lead, Islington Care Homes
Penny Kenway	Director of Early Intervention and Prevention, the London Borough of Islington (item 3)
Breeda McManus	Deputy Chief Nurse
Marcia Marrast-Lewis	Assistant Trust Secretary
Lesley Platts	Head of Children & Young People Services, Islington and Camden (item 3)
Harriet Rudd-Jones	Service Manager (item 9)
Andrew Sharratt	Acting Director of Communication & Engagement
Swarnjit Singh	Joint Director, Race, Equality, Diversity & Inclusion and Trust Secretary

No.	**Item**
1. 1.1	**Welcome, apologies and declarations of interest** The Chair gave a warm welcome to everyone present at the meeting and noted apologies received from Michelle Johnson MBE, Chief Nurse & Director of Allied Health Professionals.

1.2	Siobhan Harrington declared that her son had secured a new role at the Trust and was employed by the Reablement Service in Islington. There were no other interests declared.
2. 2.1	**Minutes of the meeting held on 30 September 2021** The draft minutes were agreed as a correct record. The action log was noted.
3. 3.1	**Patient experience story** Lesley Platts, Head of Children & Young People Services, and Penny Kenway, Director of Early Intervention and Prevention, delivered a presentation on the outcome of a self- assessment of the Bright Start Partnership, which covered four years since the launch of the partnership in 2017. The self-assessment sought to understand the Partnership's early childhood intervention and to identify strengths and areas for development in order to deliver positive changes for the children and young people services in the Borough. The self-assessment determined that substantial improvement had been made across the majority of elements in any of the local areas that had taken the work forward, and that the Borough of Islington was the most mature of all those that had submitted a self-assessment. 3.2 In terms of continued improvements, Penny Kenway advised that the Early Invention Foundation recommended that population data should be refreshed to support the development of the maternity and early years' strategy, with a stronger focus on the perinatal experience. She explained there would be further development of the strategic partnership and leadership arrangements to take account of maternity services and to oversee the delivery and monitoring of the maternity and early years strategy. An engagement plan across the maternity and early years system was being developed. 3.3 During discussion, the following points arose: • Siobhan Harrington commended the team for their hard work to deliver excellent services during the challenging circumstances of the pandemic • Swarnjit Singh welcomed the fact that the refresh of the service did have a focus on equalities, and asked what additional work might be undertaken to tackle waiting times for speech and language therapy services for children with disabilities, as this would provide excellent evidence for the annual assessment for the NHS Equality Delivery System • Members were advised that an inspection carried out by the Care Quality Commission had identified the successful demonstration of a good level of support given to all children who had accessed the services, regardless of additional needs or disability • Rob Vincent commended the detailed and well-structured presentation which clearly demonstrated the strengths of Bright Start Islington. It was excellent that Bright Start had managed to navigate its way through the pandemic when services were stretched and

	challenged. He asked whether further funding for early years development had been allocated from central Government and whether there were sufficient resources to take forward the strategy • Clare Dollery questioned whether plans were in place to share the learning with other boroughs in North Central London • Amanda Gibbon asked from a Quality perspective, whether a baseline had been established to measure progress in this area and whether there were any plans to extend the service to Haringey. Penny Kenway explained that the success of the initiative was due to the firm backing by Islington Council and Whittington Health and there was a general recognition that resources for early childhood services had been prioritised in Islington. That was evidenced by the retention of children centres in the face of ever-increasing cuts • Penny Kenway outlined plans to incorporate wider family services within family hubs funding in order to facilitate the expansion of the work in children centres through the age ranges. This would provide additional support and outreach for families under an initiative called Bright Futures • In terms of spread across North Central London, Lesley Platts advised that regular discussions on how health services were delivered generally, and not necessarily specific to Bright Start, were held with local authority partners in Haringey and other Boroughs. However, there was an appetite to share learning. Lesley Platts confirmed that the London Borough of Camden had a similar model of care in place for children and young people
3.4	**The Chair thanked Penny and Lesley for their presentation and congratulated them on their efforts for the success of the assessment.**
4	**Chair's report**
4.1	The Chair thanked staff who continued to work hard and were faced with challenging demands while providing high quality services. She highlighted the Holloway District Nursing team which she visited together with Siobhan Harrington.
4.2	In addition, the Chair highlighted her pride at Whittington Health being awarded the freedom of the Borough from the London Borough of Islington. She thanked non-executive director colleagues for their participation in consultant interview panels and acknowledged the contribution of Glenys Thornton who had attended, on behalf of the Trust, NHS England's Workforce Race Equality Programme.
4.3	**The Board noted the Chair's report**.
5.	**Chief Executive's report**
5.1	Siobhan Harrington acknowledged the continued and intense operational pressures that staff at the hospital and in the community had valiantly worked through. She reported that:

	• There were 16 Covid-19 positive inpatients, five of whom were being treated in the Intensive Treatment Unit • Staff remained very busy in the urgent and emergency care pathway and inpatient bed numbers were on the increase • Covid vaccinations for staff would become mandatory from April 2022. Preparations had commenced to support staff and staff would be expected to have received their first vaccinations by the beginning February 2022
5.2	Carol Gillen reported that the Covid-19 booster and winter flu vaccination campaigns had continued with the number of flu vaccinations increasing to 65%.
5.3	Siobhan Harrington highlighted the report on the care of patients with sickle cell disease. She advised that the Trust was currently working through an improvement plan which would be considered at the Trust Management Group and then brought to the Board for final approval. It was noted that meetings with local sickle cell patient groups had made it clear that there was a need to undertake specific work both locally and nationally to improve care. The Trust was moving in the right direction but there was still some way to go. Siobhan Harrington confirmed that an action plan would come back to the Board at the next meeting in January 2022.
5.4	Other areas which Siobhan Harrington went on to draw attention to were: • The Trust had been placed in segment two of the NHS Oversight Framework, which was a good achievement given the current challenges • Following discussion at the 28 October Board seminar, the Digital Strategy was an agenda item at today's meeting for ratification • The October private Board meeting agreed the Trust's Winter Plan • The Board was aware of detailed work under way in relation to fire safety, which was reviewed regularly at Trust Management Group. The Trust would continue to maintain a considered focus on patient and staff safety • There was good progress with the Community Diagnostic Centre due to open in Wood Green in 2022, which would be highly beneficial for the local population
5.5	Siobhan Harrington thanked Tina Jegede for representing the Trust at the recent Islington Remembrance service. She also reported that Robyn Day, a Staff Nurse, was the most recent recipient of a staff excellence award and also drew attention to Disability History Month which would take place between 18 November 2021 and 18 December 2021.
5.6	During discussion, the following issues arose: • Naomi Fulop noted the importance of the sickle cell report and that the Quality Assurance Committee had previously considered a response to a letter received from a Group of Sickle Cell patients,

	which would support the Trust in addressing the work needed at national level • Rob Vincent suggested that Frances O'Callaghan, Chief Executive of the North Central London Integrated Care Board (ICB), be invited to address the Board in quarter four on the priorities of the local ICB/ICS • In reply to a question from Junaid Bajwa, Siobhan explained that, historically, Whittington Health's relationship with primary care colleagues was strong and that the Trust was quick to respond to changing demands on hospital and community services. Recent action included a joint letter from her, Clare Dollery and Sarah Humphery to all Consultants, highlighting the importance of the Trust's relationship with GPs in the community and the need to develop innovative ways to support primary care colleagues. The Trust would also ensure continuous engagement with all GP Federations, particularly around the redesign of emergency and urgent care pathways • Sarah Humphrey confirmed that, following the joint letter, letters of appreciation had been received from GPs and that new ways of supporting the streaming of patients at the front door and the community would be progressed through the Clinical Interface Group
5.7	**The Board noted the Chief Executive's report.**
6.	**Quality Assurance Committee**
6.1	Naomi Fulop presented the report and drew attention to the following: • The Committee was able to take significant assurance from the majority of items discussed at the meeting • Significant challenges were being experienced around staffing, recruitment and retention which saw an increase on the Board Assurance Framework risk score for entry Quality 1 from 12 to 16 • Reasonable assurance was received on the provision of patient transport services in Ealing and Hounslow and also for Hillingdon dental services. It was agreed that a further review of the mitigations in place would be considered at the next meeting in January 2022 • The Committee received an update from the Surgery and Cancer Integrated Clinical Service Unit in relation to safety, quality and clinical effectiveness for the period 1 January 2021 to 30 September 2021 • The Committee received good assurance in relation to levels of elective activity, (particularly around high-volume, low complexity work) which was restarted during the reporting period. The Committee noted specific work around prostate cancer and the implementation of support groups for men • The Research and Development 2020/21 Annual Report provided a detailed account of the research and development activities carried out at the Trust
6.2	Breeda McManus briefed Board members on other initiatives in place to increase the uptake in temporary staffing shifts as well as additional work

	in place to support areas of open escalation beds and gaps. She also thanked the Infection Prevention and Control team for all their efforts made during the period which Naomi Fulop had highlighted.
6.3	**The Board noted the Chair's assurance report for the Committee meeting held on 10 November 2021.**
7. 7.1	**Staff wellbeing and support** Norma French presented the report and provided assurance on the measures in place to support staff health and wellbeing. The Board discussed additional measures that could be developed to improve staff resilience, specifically during the Winter period. The following were raised: • Siobhan Harrington noted the number of potential support options available to staff and the ongoing work to channel staff to the most suitable options available, as well as continuing to promote discussions around the development of tangible initiatives which could be undertaken in the short and longer term and from an individual Trust and North Central London system perspective • Clare Dollery apprised the Board of wellbeing discussions at the Medical Committee meeting which took place the previous evening. Access to drinking water and improved on-call parking facilities to improve personal wellbeing were topics that received significant attention • Rob Vincent appreciated that a longer-term view of the development and impact of the help provided to support staff wellbeing was needed. He noted discussions at the Workforce Assurance Committee which highlighted that the leadership development programme at the Trust should ensure that staff moving into leadership roles should be adequately supported in this area • Tony Rice agreed with the concepts and support measures put forward. He advised that discussions in recent months highlighted the need for a more empathetic approach, which would strengthen the initiatives put forward on a domestic and professional level. He highlighted basic improvements that could be made to rest rooms and breakout spaces that would make a positive impact on the psychological wellbeing of staff across the Trust • Glenys Thornton supported the notion to improve physical facilities and reflected that the problems experienced in the maternity unit could have been exacerbated by low staff morale caused by stress • Norma French advised that initiatives were already in place to support psychological wellbeing, specifically employee assistance programmes which could be accessed by self-referrals or through the Occupational Health Service. In addition, the North Central London's Keeping Well Hub was in place and provided a team of psychologists funded for at least a further year. She also gave assurance that work would continue to develop and improve wellbeing provisions for staff going forward

7.2	**The Board noted the report and agreed that an update on staff wellbeing and resilience would be provided to the Trust Board in February 2022.**
8. 8.1	**Financial performance & capital update** Kevin Curnow presented the report and highlighted the following key points: • At the end of month seven, there was an actual deficit of £1.4m which was a favourable variance of £0.2m against a planned deficit of £1.6m • The deficit was driven by overspends resulting from additional capacity to sustain 20% more of the funded bed-base and the delayed delivery of some cost improvement scheme • The cost improvement programme had achieved approximately £2m of savings so far and it was expected that total savings would be around £4m by the end of the financial year • The Trust had spent £6.1m of its capital allocation and it envisaged spending all of its allocation by the end of the year. The Trust maintained a strong cash position of £70.3m • H2 financial arrangements had been agreed with a block contract to the end of the year, and a forecast deficit of £2.5m by the end of the year • The arrangements for H2 included a funding uplift for growth and pay inflation. However, the pay settlement was applied to employees in post rather that the establishment, which meant that the underlying position would include the established workforce. That would drive a further technical deficit
8.2	**The Board noted the financial performance and capital expenditure report for the end of October 2021.**
9. 9.1	**Integrated performance report** Carol Gillen presented the report and highlighted the following key headlines: • There were continued pressures in the Emergency Department with particularly high activity in paediatrics and high numbers of patients from out-of-area, including Camden and Barnet. Improvement work had taken place with London Ambulance Service colleagues to manage handover delays • One twelve-hour non-mental health breach occurred, which was based on a clinical decision. Two mental health breaches had occurred arising out of mental health bed capacity • Good progress was being achieved in reducing the number of patients who had waited more than 52 weeks for treatment since their referral • The recovery of community services had made good progress despite some workforce challenges in podiatry and some of the children's services • For workforce indicators, there was a slight increase in statutory and mandatory training compliance and further progress was needed to achieve the target going into the Winter period

9.2	Board members discussed performance against cancer targets and noted that the Trust had continued to strive to provide high quality care. Work was progressing to develop a dedicated cancer centre at the Whittington, to be managed in collaboration with University College London Hospitals NHSFT (UCLH).
9.3	Harriet Rudd-Jones advised the Board of the following: • There were ongoing challenges in relation to demand for cancer referrals which had been anticipated following the Covid-19 surge. As a consequence, the Trust had experienced a dip in cancer standards across 62 day waits and two week waits • Mitigating plans included additional clinics to absorb demand, in addition to work around triage interventions. In terms of quality and patient experience, three new joint oncology posts had been filled and Consultants would take up their posts in January 2022 • Nursing and Pharmacy staffing would also be bolstered with the recruitment of additional team members who would commence work at the Trust in January 2022 • Work was taking place around a new cancer standard related to faster diagnosis, which aimed to ensure that 75% of patients received a diagnosis within 28 days
9.4	Siobhan Harrington added that the North Central London system work around cancer was progressing well. Clare Dollery echoed these sentiments and highlighted the entire cancer team as an exemplar of dedicated hard work. She confirmed that, from January 2022, she would chair the Cancer Programme Board for the Cancer Alliance.
9.5	Rob Vincent sought confirmation around the fiscal provision for oncology services and the refurbishment of the maternity block. Jonathan Gardner explained that the long-term provision covered a new building between C Block and Maternity, of which an expanded oncology unit would be a key part. Chetan Bhan advised that the proposed refurbishment of the maternity block would not only benefit patients in both hospitals but would allow UCLH to have flexibility in their resource as a second place for chemotherapy to take place. Additionally, there was a push for more patients to undertake new therapies and trials related to research and development.
9.6	**The Board noted the integrated performance report, in particular the specific work undertaken to improve cancer performance.**
10.	**Digital strategy**
10.1	Jonathan Gardner presented the digital strategy, which had previously been discussed in detail at the Board seminar in October 2021. He confirmed that specific areas had been updated in line with comments from colleagues, covering more detail in the section on research on long term conditions, amendments to the section on paediatrics and increased resource for the remote monitoring of patients.

10.2	**The Board welcomed and approved the Digital strategy.**
11. 11.1 **11.2**	**Audit and Risk Committee** Rob Vincent advised that the Committee had received significant levels of assurance from internal audit reviews of risk management and business continuity. In terms of job planning, it had been agreed an update would be considered at the next meeting. **Board members noted the Chair's assurance report for the Audit and Risk Committee meeting held on 21 October 2021.**
12. 12.1 **12.2**	**Charitable Funds Committee report** Tony Rice highlighted a fall in the amount of charitable funding received generally and outlined that new and future bids for charitable funding should be used to enhance patient experience. He also updated Board members on work that would take place on branding for the Whittington Health Charity **The Board noted the Chair's assurance report for the meeting held on 23 September 2021.**
13. 13.1	**Questions to the Board on agenda items** There were none received.
14. 14.1	**Any other business** There were no items reported.

Action log, 25 November 2021 Public Board meeting

Agenda item	Action	Lead(s)	Progress
Chief Executive's report	Invite Frances O'Callaghan, NCL ICB Chief Executive to a Board meeting or seminar	Siobhan Harrington	To be confirmed
Chief Executive's report	Circulate the joint letter to Hospital consultants regarding support for primary care colleagues	Siobhan Harrington	Completed
Staff Wellbeing and Support	That watching brief be maintained and in the circumstance a progress report on Staff Wellbeing and Resilience would be provided to the Trust Board in February	Norma French	On the Board forward plan for February 2022
Integrated performance scorecard	Bring an update on performance in speech and language therapy services to the April 2022 meeting	Carol Gillen	In hand for April 2022

Meeting title	**Trust Board – public meeting**	**Date: 27 January 2022**
Report title	**Chair's report**	**Agenda item: 4**
Director lead	Julia Neuberger, Chair	
Report author	Swarnjit Singh, Trust Secretary	
Executive summary	This report provides a summary of activity since the last Board meeting held in public.	
Purpose:	Noting	
Recommendation(s)	Board members are asked to note the report and the updated register of interests declared	
Risk Register or Board Assurance Framework	Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.	
Report history	None	
Appendices	1: January 2022 Board members' register of declarations	

Chair's report

This report provides an update to Board members on recent activities:

COVID-19 – I would like to thank all our staff very warmly for continuing to provide such excellent care to our patients at all our healthcare sites. They have shown great dedication in the face of the challenges presented by the pandemic and by all the staffing and isolation pressures experienced over Christmas and the New Year.

Chief Executive and Chief Nurse and Director of Allied Health Professionals
I am sad to confirm to Board members the following impending changes to the executive team:

- Siobhan Harrington, Chief Executive, will leave Whittington Health at the end of May 2022 to become Chief Executive of University Hospitals Dorset NHS Foundation Trust. Siobhan has worked at the Trust in various roles for over 12 years, with the last four and a half years as Chief Executive. She has demonstrated compassionate leadership throughout the pandemic and has secured an Outstanding rating for community services by the Care Quality Commission as part of an overall rating of Good for the organisation
- Michelle Johnson, Chief Nurse and Director of Allied Health Professionals, will also be leaving the Trust this Summer. She has been a great role model and a dedicated advocate for nurses, midwives, health visitors and allied health professionals, both at Whittington Health and across the North Central London region. She has displayed excellent leadership over the last four years and particularly during the pandemic

We will miss both Siobhan and Michelle tremendously. A recruitment exercise is under way for a new Chief Executive who is expected to be in post in June 2022. The recruitment of a new Chief Nurse and Director of Allied Health Professionals will be taken forward too.

Non-Executive Director changes
Following discussion with the Appointments team at NHS England and Improvement, I can report the following changes to our non-executive director membership of the Whittington Health Board:

- First, Tony Rice's term as a Non-Executive Director on the Board has been extended by 12 months and will run from 21 February 2022 until 20 February 2023. This extension will provide Whittington Health with continuity in key areas such as the Whittington Charity and the Finance and Business Development Committee, during a period of significant change
- Secondly, Anu Singh's term of office ends on 13 April 2022. She has provided real leadership to the Board, particularly as Acting Chair of the Trust before I joined, and in successfully promoting the equality, diversity and inclusion agenda, which has already made an enormous impact. While she will remain in the North Central London sector as non-executive director and senior independent director at Camden & Islington NHS Foundation Trust, her contribution will be much missed. Anu's replacement will be Dr Junaid Bajwa, who has been appointed as a Non-Executive Director of the Board for a four-year term from 14 April 2022 until 13 April 2026

Register of interests - Board members have reviewed their declarations as of January 2022 and the updated register of interests is shown in appendix 1 accompanying this report.

External meetings – I attended meetings with colleagues in the North Central London Integrated Care System and with the University College London Health Alliance Board. This is in addition to many informal and one-to-one meetings across the North Central London system and beyond.

Corporate induction – I was pleased to meet new staff recruits at Whittington Health on 13 December 2021 and on 10 January 2022.

Consultant recruitment – I am very grateful to Rob Vincent**,** Non-Executive Director, for participating in the recruitment and selection panel for a Consultant in Integrated Respiratory and General Medicine.

Appendix 1: Trust Board members' 2021/22 register of declarations of interest (January 2022 update)

Voting Board members	Declared interests
Baroness Julia Neuberger DBE, Trust Chair and Non-Executive Director	• Independent, Cross Bench Peer, House of Lords • Chair, University College London Hospitals NHS Foundation Trust • Vice-Chair, University College London Health Alliance Board • Chair, Independent Age • Occasional broadcasting for the BBC • Rabbi Emerita, West London Synagogue • Trustee, Walter and Liesel Schwab Charitable Trust • Trustee, Rayne Foundation • Trustee, Leo Baeck Institute Academic Study of German Jewish relationships • Trustee, Yad Hanadiv Israel • Vice President, Jewish Leadership Council • Consultant, Clore Duffield Foundation • Trustee, Whittington Health Charity <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Professor Naomi Fulop, Non-Executive Director	• Honorary contract, University College London Hospitals NHS Foundation Trust • Professor of Health Care Organisation & Management, Department of Applied Research, University College London • Trustee, Health Services Research UK (Charitable Incorporated Organisation) • Trustee, Whittington Health Charity <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil

Voting Board members	Declared interests
Amanda Gibbon, Non-Executive Director	• Chair, RareCan Limited (start-up company looking to recruit patients with rare cancers into research in their disease areas. This post is currently unremunerated.) • Lay member, NHS Blood and Transplant's National Organ Donation Committee and Regional Chair for London NHSBT Regional Collaborative • Trustee, Whittington Health Charity • Associate Non-Executive Director, Royal Free London NHS Foundation Trust • External member of the Audit and Risk Assurance Committee of the National Institute for Health and Care Excellence • UCLH: Chair of the Biobank Ethical Review Committee for the UCL/UCLH Biobank for Studying Health and Disease and Chair of the UCLH Organ Donation Committee <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • My four (adult) children each have personal shareholdings in GlaxoSmithKline and Smith & Nephew
Tony Rice, Non-Executive Director	• Senior Independent Non-Executive Director, Halma Plc • Chair, Ultra Electronics • Chair of Maiden Voyage Plc • Chair of Shields Environmental Plc • Trustee, Whittington Health Charity <u>Conflicts of interests that may arise out of any known immediate familyinvolvement</u> • Nil
Anu Singh, Non-Executive Director	• Member of HMG's Advisory Committee on Fuel Poverty • Non-Executive Director, Parliamentary & Health Service Ombudsman Board • Trustee, Whittington Health Charity • Non-Executive Director and Senior Independent Director, Camden & Islington NHS Foundation Trust • Non-Executive Director, Barnet, Enfield, and Haringey Mental Health NHS Trust

Voting Board members	Declared interests
	• Chair, Partnership Southwark • Chair, Lambeth Safeguarding Adults Board <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil return
Baroness Glenys Thornton, Non-Executive Director	• Member of the House of Lords, Opposition Spokesperson for Health and Women and Equalities • Member, Advisory Group, Good Governance Institute • Chair and Trustee, Phone Co-op Foundation for Co-operative Innovation • Chair, Advisory Board of Assistive Healthcare Technology Association • Senior Associate, Social Business International • Senior Fellow, The Young Foundation • Council Member, University of Bradford • Emeritus Governor, London School of Economics • Trustee, Roots of Empathy UK • Patron, Social Enterprise UK • Trustee, Whittington Health Charity <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Rob Vincent CBE, Non-Executive Director	• Director, New Ing Consulting • Trustee, Whittington Health Charity • Non-Executive Director, University College London Hospitals NHS Foundation Trust • Electoral Commissioner <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil

Voting Board members	Declared interests
Siobhan Harrington, Chief Executive	• Local Care lead, North Central London Integrated Care System Board • Member, University College London Health Alliance Board • Co-Chair, London People Board • Member, National People Plan Delivery Board <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Daughter-in-law is employed by Whittington Health's Pharmacy department • Son is employed by the Islington re-ablement service
Kevin Curnow, Chief Finance Officer	• Chair, Whittington Pharmacy, Community Interest Company <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Dr Clare Dollery, Medical Director	• Clinical Lead Clinical Medicines Delivery Group – nMAbs and Antivirals, North Central London Integrated Care System • Medical Lead, University College London Healthcare Alliance Board <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Carol Gillen, Chief Operating Officer	• Non-Executive Director, Whittington Pharmacy Community Interest Company <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Michelle Johnson MBE, Chief Nurse & Director	• Trustee on Board of Roald Dahl Marvellous Children's Charity • Independent member of NHS Professionals' Quality Committee • Chief Nurse, Camden & Islington NHS Foundation Trust

Voting Board members	Declared interests
of Allied Health Professionals	<u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Son and daughter are volunteers at Whittington Health

Non-voting members	Declared interests
Junaid Bajwa, Associate Non-Executive Director	• Chief Medical Scientist, Microsoft • Essential Guides UK Limited (Shareholder, GP locum services and educational work) • Merck Sharp and Dohme (shareholder and ex- employee) • NHS England (GP appraiser) • GP, Operose Health • Non-Executive Director, University College London Hospitals NHS Foundation Trust • Non-Executive Director, Medicines and Healthcare products Regulatory Authority • Non-Executive Director, MedicaGroup Plc • Governor, Nuffield Health • Non- Executive Director, Nahdi Medical Corporation • Non- Executive Director, eConsult • Non- Executive Director, Visionable • Visiting Scientist, Harvard School of Public Health • Associate Professor, University College London <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Norma French, Director of Workforce	• Director of Workforce, North Central London Integrated Care System <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Husband is a Consultant Physician at Central & North West London NHS Foundation Trust • A son is employed as a Business Analyst in the Procurement department at Whittington Health

Non-voting members	Declared interests
	• A son is employed through Bank Partners in the Research team
Jonathan Gardner, Director of Strategy and Corporate Affairs	• Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Sarah Humphery, Medical Director, Integrated Care	• GP Partner Goodinge Group Practice, Goodinge Health Centre, 20 North Road, London N7 9EW: General Medical Services • The Goodinge Practice is part of WISH, the GP service in the Whittington Health emergency department and also the Islington N1 Primary Care Network <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Tina Jegede, Joint Director of Race, Equality, Diversity & Inclusion and Lead Nurse, Islington Care Homes	• Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Swarnjit Singh, Joint Director of Race, Equality, Diversity & Inclusion and Trust Secretary	• Secretary to the University College London Health Alliance Board • Secretary to the University College London Health Alliance Chief Executive's Group • Management Side Co-Chair of the Equality, Diversity, and Inclusion subgroup of the NHS Staff Council • Trustee and Board member of a learning disability charity, CASPA, (Children on the Autistic Spectrum Parents Association) in Bromley <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil

Meeting title	**Trust Board – public meeting**	**Date: 27 January 2022**
Report title	**Chief Executive's report**	**Agenda item: 5**
Executive director lead	Siobhan Harrington, Chief Executive	
Report authors	Swarnjit Singh, Trust Secretary, and Siobhan Harrington	
Executive summary	This report provides Board members with updates on developments nationally and locally.	
Purpose	Noting	
Recommendation	Board members are invited to note the report.	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	Report to each Board meeting held in public	
Appendices	1: COVID-19 update report	

Chief Executive's report

Since our last Whittington Health Board meeting held in public in November 2021, we have been through a significant surge of the Omicron variant of COVID-19 across London and the Trust. We have been in a pandemic now for just under two years.

I want to pay tribute to all our fantastic staff for their professionalism and dedication throughout this time in providing high quality, safe care in hospital and community services. In addition, I want to thank our teams for their excellent work in vaccinating both staff and our local community in North Central London.

Our people remain our most vital asset and their health, wellbeing and resilience is paramount. I therefore encourage all staff to ensure they take adequate annual leave to rest and recuperate and to access the advice and support that is available to help them.

Nationally, the NHS continues to operate in a Level 4 National Incident. Our emergency planning command structure has run throughout the pandemic. Face-to-face meetings have been discouraged as advised by guidance, with virtual and shorter meetings used instead. Our infection prevention and control measures remain robust. We have also had to take the difficult decision to suspend visiting across all inpatient areas in order to protect patients, their families, and staff. As we emerge from the current surge, visiting arrangements will be kept under review and relaxed when it is possible to do so.

Covid-19 - as of 18 January 2022, Whittington Health had 51 Covid-19 positive inpatients, including six inpatients in our intensive care unit. An appendix to this report illustrates the current position of Whittington Health in relation to the third wave of COVID-19. It compares Whittington Health with other providers in the North Central London sector and London region in relation to COVID-19 positive patients and patients admitted to intensive care unit on mechanical ventilation. The data illustrates a substantially lower surge than reported at 15/1/2021, this is reflected in lower daily admissions and substantially lower numbers of patients in hospital. There is also data in relation to COVID-19 deaths and the disease profile of current inpatients.

NCL Health & Care partners has maintained its 'Gold' command arrangements through this time. Whittington Health has played a pivotal role in supporting discharge across North Central London and the work of our community services especially our rapid response and virtual ward services have been particularly highlighted.

Staff absence has been of particular concern over recent weeks. Daily monitoring of all forms of absence continues and includes sickness related to COVID-19, non-COVID-related sickness, and self-isolation. We also supported staff to have some well-deserved annual leave over the holiday season. Absence peaked over the New Year weekend and has begun to show some downward trends. As of 19 January, the overall absence rate at the Trust was 5.93%.

Changes to COVID-19 rules
On 19 January, the Prime Minister announced changes to the current restrictions in England. He highlighted an end to working from home guidance from 19 January. In addition, the requirement for face masks to be worn in classrooms would end from 20 January and face masks would be required anywhere else from 27 January. The compulsory use of COVID-19 passes at certain events would also end on 27 January. The Prime Minister also outlined that people who tested positive for COVID-19 would still need to self-isolate for the time being.

Defence personnel
Like many NHS services across the country, Whittington Health is facing significant ongoing pressures from high levels of staff illness including COVID-19 infection and isolation, high demand for urgent and emergency care, and continuing to treat COVID-19 patients. As part of national support announced by the Department of Health and Social Care and NHS England and Improvement, Whittington Health is really pleased that we secured temporary support for our staff from members of the armed forces when 20 Ministry of Defence personnel joined us in early January 2022 to provide support. The service personnel come with a range of backgrounds, experience and skills and they are being deployed in areas of greatest need in line with their skills. Their help is much appreciated at this time.

Vaccination as a condition of deployment
Regulations have come into force which require anyone aged over 18 undertaking Care Quality Commission regulated activities and has face-to-face contact with patients to be fully vaccinated against COVID-19, unless a medical exemption applies, by 31 March 2022. In line with national implementation guidance received from NHS England and Improvement, the Trust's Workforce team and respective managers are ensuring compliance with the new requirements is being taken forward in the most supportive way possible.

Whittington Health's latest Trust Covid-19 vaccination statistics are shown below. In addition, as of 18 January, 81% of our substantive staff had received their winter flu vaccination.

Staff group	%
Substantive staff vaccinated with first jab	89.5 %
Substantive staff vaccinated with second jab	84.0%
Substantive staff vaccinated with booster jab	44.5%
BAME staff vaccinated with first jab	86.5%
BAME staff vaccinated with second jab	81.0%
BAME staff vaccinated with booster jab	40.7%

COVID-19 Public Inquiry
On 15 December 2021, the Prime Minister appointed the Rt. Hon Baroness Heather Hallett DBE as Chair of the forthcoming public inquiry into the COVID-19 pandemic. The Inquiry, set to begin its work in Spring 2022, will be established under the Inquiries Act 2005, with full powers, including the ability to compel the production of documents and to summon witnesses to give evidence on oath. The Inquiry will play a key role in examining the UK's pandemic response and ensuring that we learn the

right lessons for the future. Once the terms of reference have been published in draft in the New Year, Baroness Hallett will take forward a process of public engagement and consultation - including with bereaved families and other affected groups - before the terms of reference are finalised.

In preparation for the statutory public inquiry, Whittington Health, like other NHS organisations, have been told by NHS England and Improvement to focus on four key areas: ensuring robust and comprehensive records management, embedding systematic approaches to log key leavers, carry out exit processes and retain contact details, consider wellbeing support for staff who may have to provide evidence and appoint a named inquiry lead.

NHS 2022/23 priorities and operational planning guidance

On 24 December 2021, NHS England and Improvement published guidance[1] on strategic priorities and operational plans for 2022/23 and beyond. Whittington Health is working through the detailed guidance with Integrated Clinical Service Units and corporate departments producing draft business plans. The guidance outlined the following ten priorities for integrated care systems to deliver on:

Number	Priority
1.	Investing in the workforce and strengthening a compassionate and inclusive culture
2.	Delivering the NHS COVID-19 vaccination programme
3.	Tackling the elective backlog
4.	Improving the responsiveness of urgent and emergency care and community care
5.	Improving timely access to primary care
6.	Improving mental health services and services for people with learning disability and autistic people
7.	Exploiting the potential of digital technologies
8.	Moving back to and beyond pre-pandemic levels of productivity
9.	Developing the approach to population health management, preventing ill-health, and addressing health inequalities
10.	Establishing Integrated Care Boards (ICBs) and enabling collaborative system working

The guidance is clear regarding the need to prioritise the NHS workforce given their experiences during the pandemic and the efforts being asked of them. While the detailed guidance and annexes on contracting, revenue and capital allocations are yet to be published. However, it has been outlined that the financial regime will include:

- Efficiency – going beyond pre-pandemic productivity when "the context allows"
- Financial balance at system level – trusts and ICBs jointly tasked with financial break-even
- A return to signed contracts with locally set payment values
- Capital allocation

[1] https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/

Quality and safety operational performance
The impact of the pandemic and a surge in cases, alongside increased sickness absence in staff is reflected in the integrated performance report. The focus has been on patient safety and the wellbeing of staff. Headlines from operational activity include the following:

- Emergency Department – in December 2021, the emergency care pathway remained challenged across England. At Whittington Health, performance against the four-hour access standard was 73.3%. This was above the national average of 73.2% and the North Central London average of 72.6% but below the London average of 75.2%. There was one non-mental health 12-hour trolley wait
- Cancer – performance against the two weeks wait standard was 69.6% in November 2021 and performance against the 62-day standard was 41.0%
- Referral to Treatment – at the end of December 2021, there were 547 patients waiting more than 52 weeks for treatment
- Elective recovery – during December, performance exceeded the target set and achieved 98% of 2019/20 baseline activity
- Workforce – staff appraisal rates in December were at 66% and compliance against mandatory training requirements was at 82.2%

Financial performance
At the end of 2021, Whittington Health is reporting a deficit of £0.8m, a favourable variance of £1.3m against plan. The deficit position was due to delays in implementing cost improvements schemes and other expenditure not covered by funding arrangements in place for the first six months of the current financial year. The Trust has spent £8.8m of its capital allocation so far this year. While this is £1.8m behind plan, the Trust is still forecasting to spend its capital allocation for 2021/22. In addition, the has developed an initial forecast position of break-even at the end of the financial year which will be £2.6m better than the planned deficit of £2.6m.

Mortuary and body storage
The Trust has reviewed local operational procedures against requirements set out in standards and guidance issued by the Human Tissue Authority. I can report assurance to the Board that Whittington Health is compliant with the following requirements:

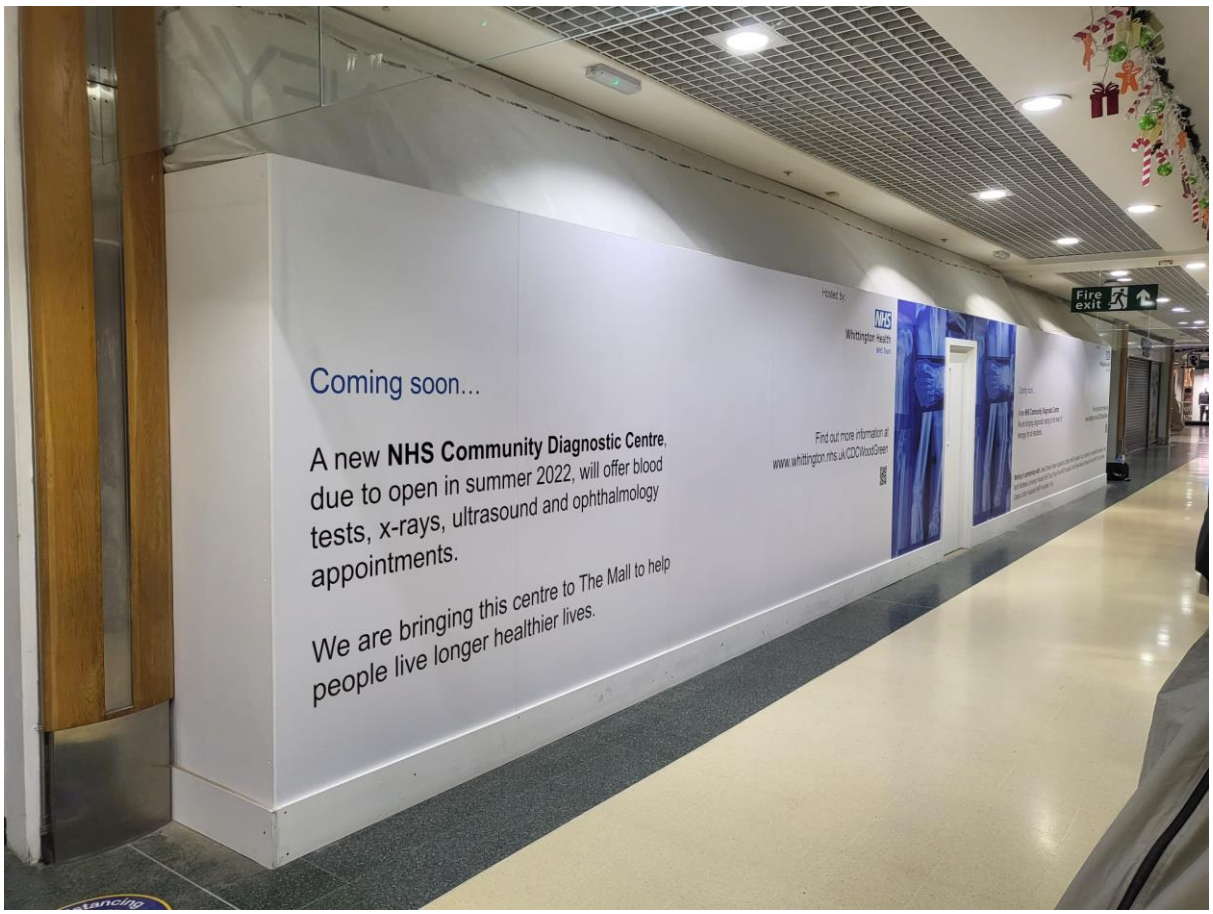
- All access points to the mortuary or body store are controlled by swipe card security access arrangements
- There is effective CCTV coverage in the mortuary/body store area(s) which can be reviewed on a regular basis by an appropriately trained and authorised individual
- A documented risk assessment has been undertaken and is in place for the facilities regarding the operation, security and construction of the mortuary or body store area
- There is consistent application of appropriate levels of Disclosure and Barring Service checks for all Trust and contracted employees, specifically in line with requirements of the NHS Standard Contract

Sickle cell care
The Trust's Management Group is due to discuss Whittington Health's response to the All-Party Parliamentary Group on Sickle Cell and Thalassaemia published inquiry

findings into care for patients with sickle cell disease in February 2022 before this is considered at the March Board meeting.

Community Diagnostic Centre

Jonathan Gardner, Director of Strategy and Corporate Governance, has been appointed as the Senior Responsible Officer for all the community diagnostic centres in North Central London. Whittington Health is progressing with the community diagnostic centre planned in Wood Green, however, £1.8m of costs are likely to shift into the next financial year due to long lead in times for air handling units. This is being mitigated through bringing costs of the phase two business case into this year where appropriate. Whittington Health is working with NHS England and Improvement on the details, and we will be submitting a business case for phase two (magnetic resonance imaging and computerised tomography scans in the basement) in March 2022. In the meantime, we are progressing survey and design work.



Community Health Centre

Further discussions are ongoing with the landlords of the Wood Green Shopping City, with the aim of securing space for an integrated health and wellbeing hub, jointly with primary care, the London Borough of Haringey, North Middlesex University Hospital NHS Trust and Barnet, Enfield, and Haringey Mental Health NHS Trust. We have now started design work, a business case, and public engagement and consultation work.

New Year's Honours
I would like to congratulate Professor Hugh Montgomery, Director for Research and Innovation, who was appointed Officer of the Order of the British Empire (OBE) for services to intensive care medicine and climate change.

Staff excellence awards
I am pleased to congratulate the following recipients for demonstrating the Trust's Excellence value:

- Orla O'Doherty, Self-Management Support and Behaviour Change Manager, was redeployed to support the final push on the housebound vaccination programme over Christmas and the New Year and worked tirelessly to help meet the housebound vaccination targets
- Faye Oliver, Senior Communications and Engagement Officer, was nominated for the always being so responsive to the demands in the communications team while maintaining a high degree of professionalism and resilience
- Paul Stevens, Mechanical and Electrical Supervisor, Estates and Facilities, was commended for his excellent response when responding to a small fire in the patient kitchen area in part of our hospital
- Adheem Moosun, Senior Technical Engineer, Information Management & Technology (IM&T), is a valued member of the team who provides an excellent service when dealing with IM&T problems experienced by staff
- Our Integrated Clinical Service Unit's Associate Directors of Nursing and their Nursing Leadership Teams received a joint award for their dedication, and hard work, going above and beyond coming in during evenings, weekends and supporting our staff

LGBT+ History month and Race Equality Week
Finally, I want to draw attention to two important events taking place next month. First, in February, along with many other organisations Whittington Health will celebrate LGBTQ+ history month. Our LGBTQ+ staff network will be sharing personal stories of colleagues from the lesbian, gay, bisexual, and transgender community and will also launch #HelloMyNameIs badges which offer the opportunity to include each person's pronoun choice. Secondly, Race Equality Week takes place from 7-13 February. This is an annual UK-wide event which brings together UK employers, organisations, trade unions and staff to address barriers to equality in the workplace for ethnic minority employees. At Whittington Health, an open forum event will take place on 9 February to listen to the experiences of staff and to learn of the initiatives being taken forward to advance equality and inclusion.

Appendix 1: COVID-19 Update

Spotlight on: COVID-19 pandemic patient impact in the Trust

1.1 Covid Healthcare figures for NCL – source Gov.uk 04/01/2022

Trust	WH	NMH	RFL (Barnet, CFH, and RFH)	UCLH
Total patients admitted (both surges)	2193	3671	5303	2563
Patients in Hospital	78	101	154	87
Patients on ventilation	6	4	16	10
Latest daily admissions	6	16	32	8

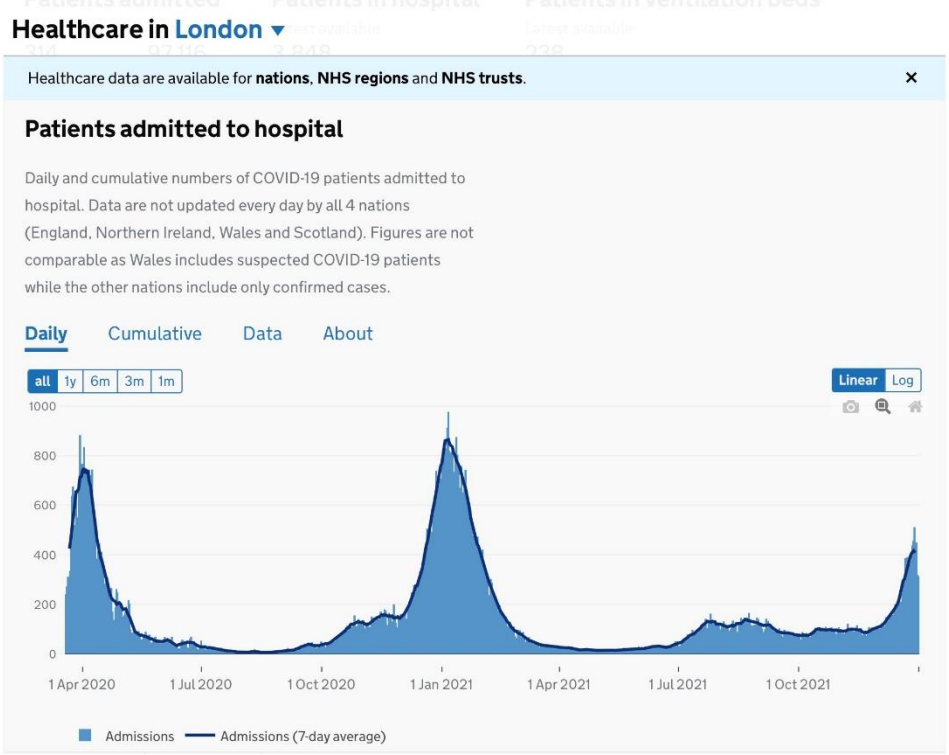
This data illustrates a substantially lower surge than reported at 15/1/2021 reflected in lower daily admissions and substantially lower numbers of patients in hospital see below. There are of course also non COVID-19 winter pressures impacting hospitals as well as the elective programs which were not in place at this time in 2021 and Trusts are feeling significant capacity pressures.

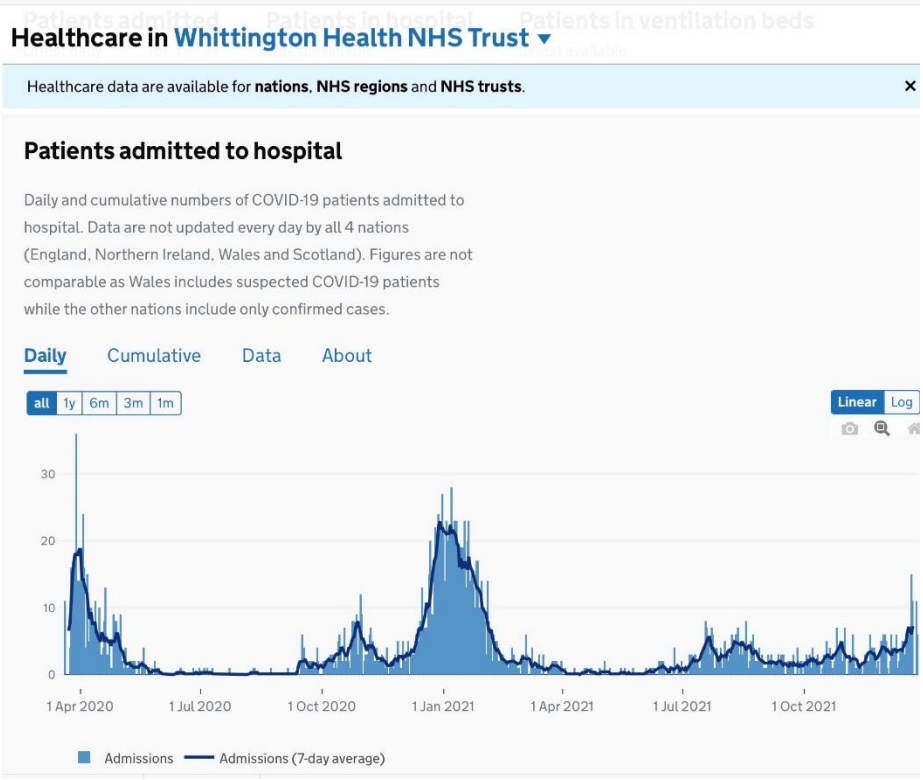
Data for 13/1/2021

Trust	WH	NMH	RFL (Barnet, CFH, and RFH)	UCLH
Total patients admitted (both surges)	1020	1956	2344	1006
Patients in Hospital	179	303	488	193
Patients on ventilation	10	11	85	56
Latest daily admissions	23	28	41	38

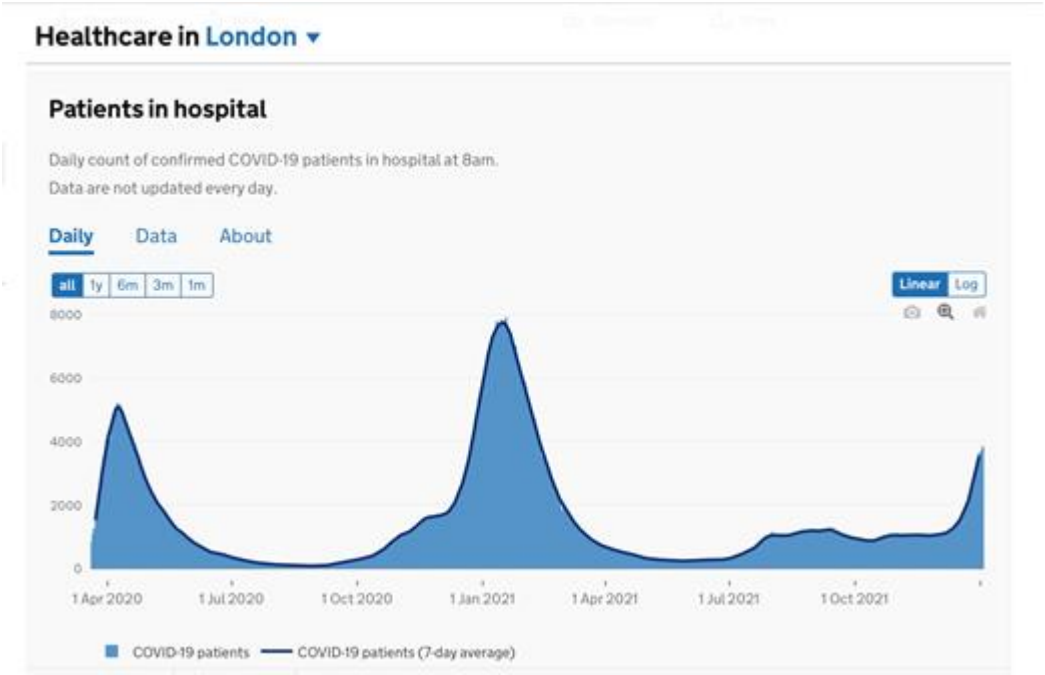
1.2 Whittington Health vs London region - admitted patients

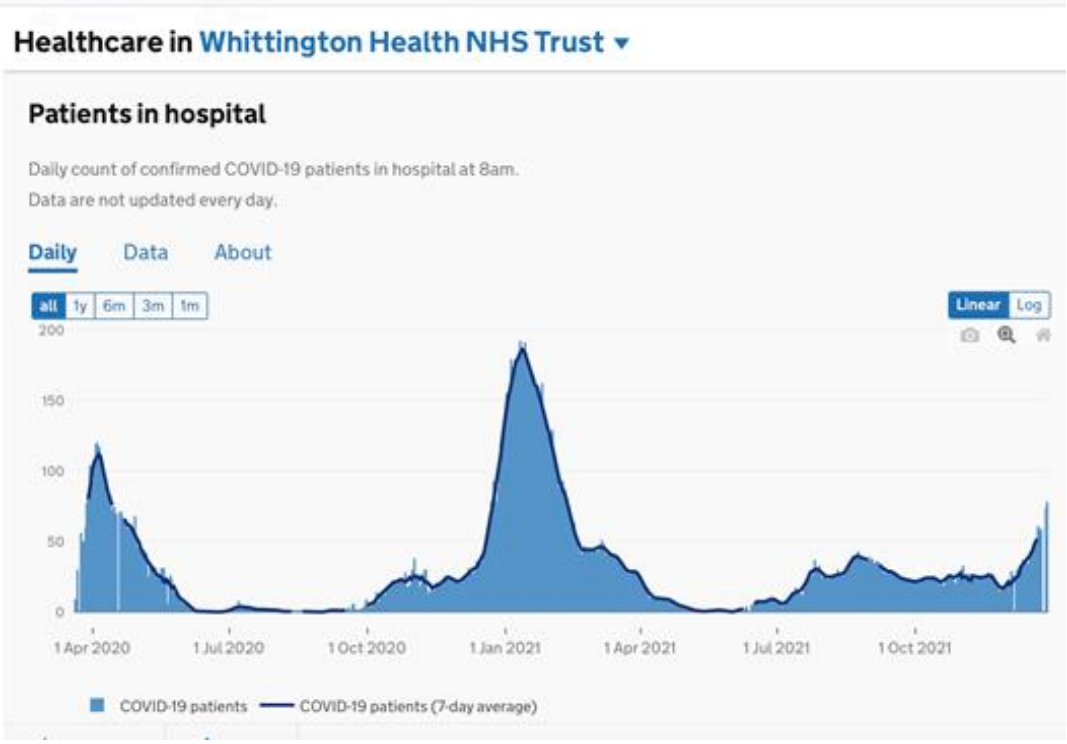
London and Whittington show very similar trends- Whittington Health shows a slightly lower level of admissions which may reflect our embedded pathways to ambulatory care, rapid response and virtual ward.





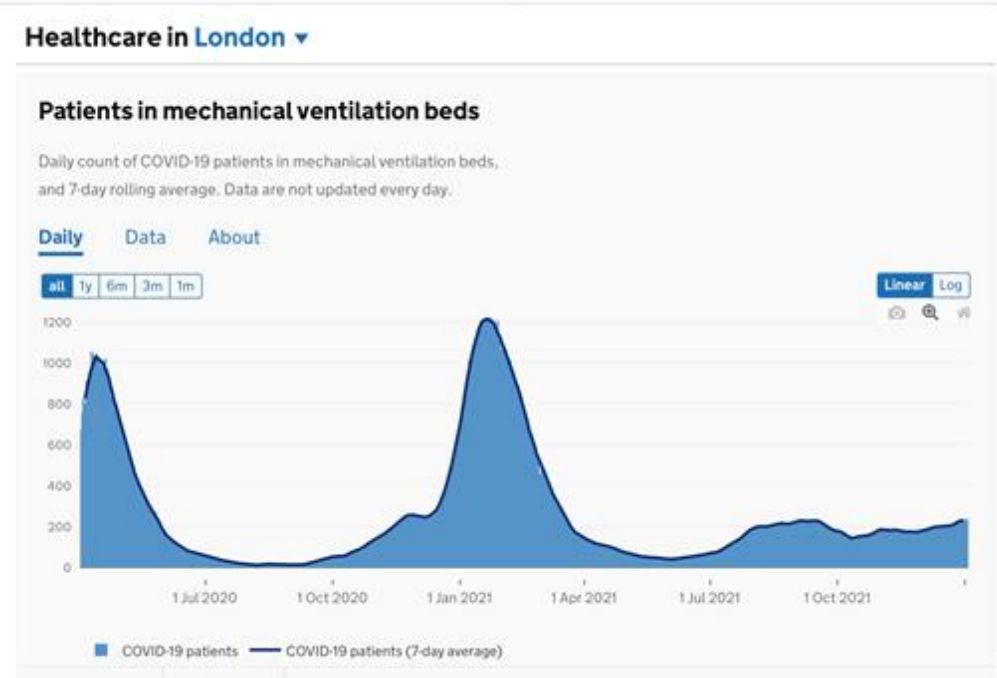
1.3 Whittington Health vs London patients in hospital
London and Whittington show very similar trends



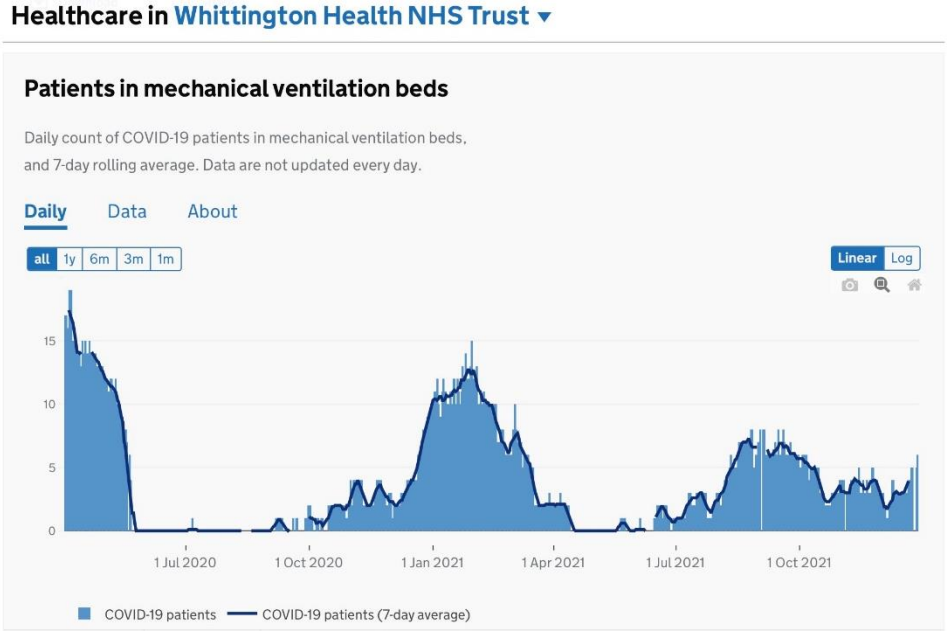


1.4 Whittington Health patients on mechanical ventilation

Whittington Health has seen a different pattern to London. This reflects the small size of our ICU and therefore its relative increase in COVID-19 patients when the unit is transitioned to a predominantly COVID-19 configuration. The ICU team has agreed to transition at earlier times than other units at times in the interest of minimising nonclinical transfers in the sector and keeping all of NCL ICU patients as safe as possible. Of note the quantum of ICU patients in this surge is very much lower than in prior surges reflecting the impact of vaccination, better treatment and the Omicron variant of concern.



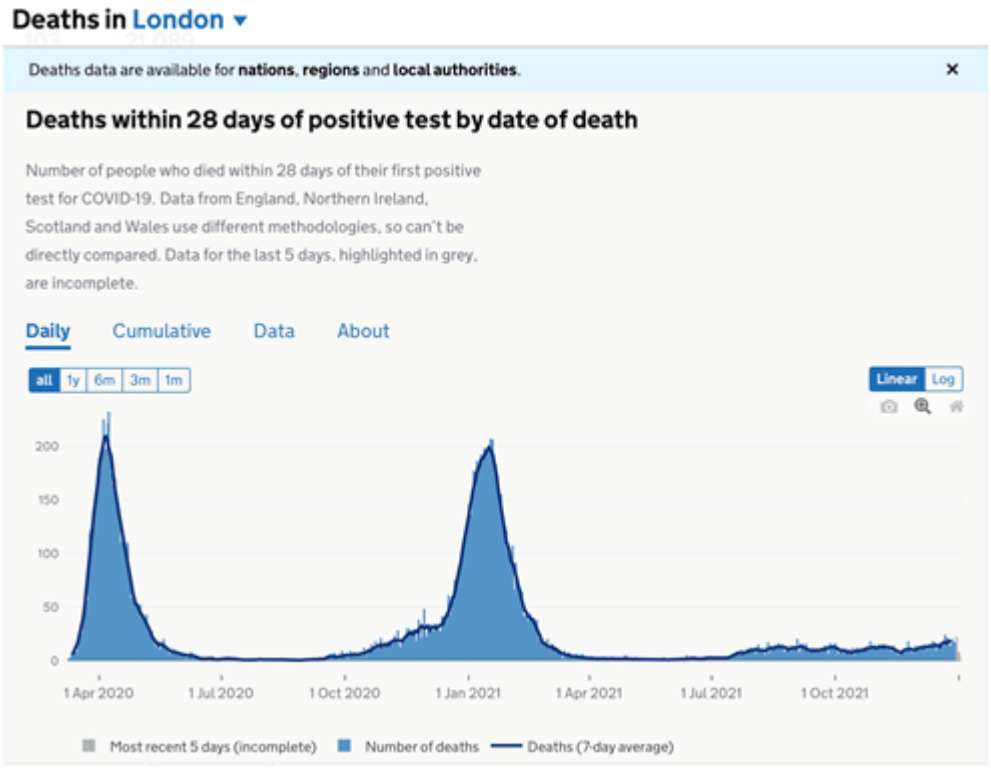
coronavirus.data.gov.uk



1.5 Deaths in London

There has been a very large reduction in deaths in this wave compared with prior waves.

There is no graph for Whittington health because this data is published by borough rather than Trust.



1.6 Third wave COVID deaths at Whittington Health

There have been 44 deaths in patients either within 28 days of a positive COVID-19 PCR or with COVID-19 on part 1 a or b of their Death certificate since July 2021. Of these 8 died in July 8 in August, 6 in September, 4 in October, 3 in November, 11 in December and 4 in the first week in January 2022.

26 were unvaccinated and 17 were partially vaccinated – including those who had two doses prior to the roll out of the booster program or had not yet had a booster and one was triply vaccinated. One had an unknown vaccination status at this time. This number of deaths is much lower than in other waves reflecting the change in the disease and its treatment as well as the hard work of our teams.

1.7 Profile of COVID-19 disease in hospital

In line with national reporting the profile of disease seen since the emergence of the Omicron variant of concern is very different to Delta and prior variants. At 7/1/22 of 90 patients in hospital with COVID-19 73 required no form of oxygen. 4 were on mechanical ventilation, 5 on non-invasive ventilation (CPAP) and 8 were on facemask oxygen.

In prior waves the vast majority of patients were admitted due to hypoxia. Also, at 7/1/22 only 38 of 90 positive patients had a primary diagnosis of COVID-19 – the remaining patients were primarily admitted for other reasons and their care was focused on the underlying condition with the COVID-19 diagnosis being subsidiary. There is a national issue with access to genotyping for COVID-19 as a clinical test due to very high demand. The Trust inpatients have been predominantly Omicron since Christmas and the great majority of admissions are now Omicron. Because

delta appears to cause more severe long-term illness some patients remain in hospital particularly in ICU.

Trust staff are delivering care to patients in face of significant staff absence due to seasonal illness and the surge of omicron infections in the community causing illness or need for isolation. Staff absence was 7.06% at the time of compilation of this report.

1.8 Recommendations

The Board is asked to note the epidemiological trends in COVID-19 through the third wave of COVID-19.

Meeting title	**Trust Board – public meeting**	**Date: 27 January 2022**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 6**
Committee Chair	Naomi Fulop, Non-Executive Director	
Executive director leads	Michelle Johnson, Chief Nurse & Director of Allied Health Professionals and Clare Dollery, Medical Director	
Report authors	Marcia Marrast-Lewis, Assistant Trust Secretary, and Swarnjit Singh, Trust Secretary	
Executive summary	The Quality Assurance Committee met on 12 January 2022 and was able to take significant or reasonable assurance from the following items considered: • COVID-19 update • Elective recovery update • Board Assurance Framework – Quality and People Entries • Risk Register (Quality and COVID-19 risks) • Chair's assurance report, Quality Governance Committee • Learning from Deaths report • Serious Incidents report There are no items for which the Committee is reporting limited assurance to the Board. However, the Committee acknowledged the increased risks to patient safety and patient experience due to higher than usual clinical staff absence and received assurances that concerted efforts were being made to provide safe care. It should be reported that due to significant operational demands the agenda for the meeting was prioritised and some items deferred to the March meeting.	
Purpose	Noting	
Recommendations	Board members are asked to note the Chair's assurance report for the meeting held on 12 January 2022	
Board Assurance Framework	Quality strategic objective entries	
Appendices	1. Q2, 2021/22 Learning from deaths report	

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	12 January 2022

Summary of assurance:

1. The Committee confirms to the Trust Board that it took significant assurance in the following areas:

COVID-19 update

The Committee took good assurance from a report from Clare Dollery who advised that a very different picture had emerged this year for COVID-19 admissions in the surge related to the Omicron variant of concern compared to the same period last year. The Trust was currently treating 96 patients with COVID-19 requiring inpatient care compared to 179 in January 2021 and this mirrored the experience of other providers in the North Central London (NCL) sector. She reflected that, during the last surge the predominant presentation was hypoxia such that commonly only oxygen dependent patients met the threshold for admission. This was in stark contrast to current activity where only 20 out of 81 patients were on oxygen. Additionally, 47 of those patients had a primary diagnosis other than COVID-19.

In terms of staff absence rates, Clare Dollery reported a current sickness absence rate of 7.09%, this was cause for concern for the trust. Outbreaks at care homes and their staffing capacity remained a significant issue for flow of patients in the hospital. A Super Multi Agency Discharge Event (MADE) was taking place across NCL that week and would focus on patient discharges and ensuring that home care support was available through community service teams. Also, to facilitate the discharge of patients to care homes or intermediate care beds.

Elective recovery update

Carol Gillen apprised Committee members of the elective activity performance following the decision to suspend elective recovery in December 2021. The Committee noted the following headlines for week ending 9 January 2022:

- Total activity was 54.7% of 2019/20 activity before all cases were outcomed (reported on the electronic patient record system as care or appointment completed)
- 198 elective/day case surgery cases (39.1% of 2019/20 activity – last year of reporting pre the pandemic)
- 3,894 outpatient attendances (55.9% of 2019/20 activity) were completed with the potential to achieve 64.2% of 2019/20 baseline activity once 581 appointments were outcomed on the system
- There were 577 patients waiting more than 52 weeks for treatment. Clinical teams were reviewing both admitted and non-admitted patients who were urgent and or waiting a long time to ensure that both could be accommodated
- There were eight patients who were approaching 104 week wait breaches in January 2022 of which six patients were under vascular surgery. A decision was made to refer these patients onwards to receive care in the independent sector

Members were assured that, once the reduction of COVID-19 patients stabilised together with improvements in workforce capacity, elective activity would increase. The Committee acknowledged the increased risks to patient safety and patient experience because of higher than normal clinical staff absence and received assurances that concerted efforts were being made to provide safe care.

Board Assurance Framework

Committee members were presented with the Board Assurance Framework (BAF) at the start of quarter four, 2021/22 which detailed the entries for risks to the delivery of Whittington Health's quality strategic objective. The Committee noted that, following review by the Trust's Management Group (TMG) on 11 January 2022, it was agreed to maintain a total score of 16 for both Quality 1 and Quality 2 BAF entries.

The Committee was also informed that the TMG had also agreed to increase risk scores for the BAF's People entries, to reflect current staffing pressures, as follows:

- Increase People 1 from 16 to 20 to reflect the increased number of entries in the risk register resulting from staffing capacity and recruitment and retention issues
- Increase People 2 from 12 to 16 to reflect the continued impact of the pandemic upon staff morale and wellbeing

The Committee discussed the impact of workforce capacity issues during the current wave and the anticipated impact of vaccination as a condition of deployment regulations (VCOD) which required all patient facing staff (in clinical and non-clinical roles) to be double vaccinated by 1 April 2022.

The Committee agreed that risks to the delivery of the Trust's quality strategic objectives were being effectively mitigated. The Committee also agreed to refer BAF entry Quality 1 back to TMG to consider whether the likelihood score should be increased from 4 to 5.

Trust Risk Register

The Committee noted key changes to the risk register since it was last considered by the Committee in November 2021. The Committee noted five new risks, the majority of which related primarily to staffing issues:

- 1242 - Maternity Service Provision (response to the Ockenden report recommendations)
- 1246 - Admissions Pathway/Pre-assessment and booking
- 1255 – Mortuary body store capacity
- 1260 - Shortages in Theatre Staffing - Nursing, Anaesthetists & Administrative services
- 1262 – Adult Community Services (ACS) care home vaccination law and unvaccinated staff
- 1270 - ACS workforce risks
- 1272 - Islington Child Protection Named Doctor post vacancy

The Committee was apprised of an increase in risk score to 20 for non-compliance with national cancer access standards resulting from a continued increase in demand with a significant increase in referrals across NCL, which the system had struggled to manage.

The Committee took reasonable assurance that appropriate mitigating actions had been implemented for the previous reported dental patient transport risk and provided feedback on the capacity risk highlighted for the mortuary including liaison with the Human Tissue Authority, if required.

Chair's report, Quality Governance Committee
The Committee received the report which detailed discussions taken at the meeting held on 14 December 2021 in which significant assurance was received on:

- Adult Community Services (ACS) ICSU report
- Acute Patient Access, Clinical Support Services and Women's Health ICSU report
- Quarter 2 Learning from Deaths report

The Committee noted the report and thanked the ACS vaccination team for their excellent work.

Learning from deaths report
The Committee considered the report from Dr Ihuoma Wamuo which covered Quarter 2, 1 July to 30 September 2021 and noted the following:

- 113 adult inpatient deaths and two neonatal deaths
- 22 adult Structured Judgement Reviews (SJRs) were requested during Quarter 2, 12 of which had been completed and presented at department mortality meetings
- Each SJR had also been reviewed by the Associate Medical Director Patient Safety and Learning from Deaths to ensure all possible learning was captured and shared across the organisation
- There were no deaths of patients with a serious mental illness or with a learning disability
- The majority of the mortality reviews had identified high standards of care and key learning had been shared with the multi-disciplinary team

The Committee noted the plans in place to achieve a rate of 80%-90% of mortality reviews being completed, including the multi-disciplinary team approach which allowed for reviews to be completed by healthcare professionals other than Consultants and doctors.

The Committee agreed that the next quarterly learning from deaths report would highlight the impact of the role of the Independent Medical Examiners and feedback from patients' families.

Serious Incidents
The Committee received an overview of Serious Incidents declared during October and November 2021 and noted the following:

	• Two Serious Incidents were declared for the period including one Never Event • Due to the COVID-19 pandemic, the deadline for completion and submission of investigations had been temporarily suspended, however efforts would be made to complete all investigations as quickly as possible • There were 20 Serious Incident reports open, of which 16 were open longer than 60 days • Four Serious Incident reports were submitted during this period. The learning from these investigations had been shared widely with staff and included matters such as: o ensuring the completion of falls risk assessments and adapting the electronic falls risk assessment tool o ensuring that a child's emergency care plan was included in a patient's electronic notes o improvements made to processes and pathways clarified with other NHS providers for the referral of patients to the Rheumatology and Specialist Cardiothoracic team o an incident related to consent for medical students to participate in intimate examinations had led to review of the policy and learning for teams The Committee noted the report and took good assurance that the Serious Incident process was managed effectively at the Trust and that lessons learned were being shared effectively.
2.	**Present:** Professor Naomi Fulop, Non-Executive Director (Committee Chair) Amanda Gibbon, Non-Executive Director (Vice Chair) Baroness Glenys Thornton, Non-Executive Director Dr Clare Dollery, Medical Director Carol Gillen, Chief Operating Officer Michelle Johnson, Chief Nurse and Director of Allied Health Professionals **In attendance:** Gillian Lewis, Associate Director, Quality Governance Kat Nolan-Cullen, Compliance and Quality Improvement Manager Jessal Palan, Trainee Doctor David Pennington, North Central London ICS Caroline McGirr, North Central London CCG Dr Ihuoma Wamuo, Associate Medical Director, Patient Safety & Learning from deaths Swarnjit Singh, Joint Director, Race, Equality, Diversity and Inclusion and Trust Secretary Marcia Marrast-Lewis, Assistant Trust Secretary Carolyn Stewart, Executive Assistant to the Chief Nurse

Meeting title	**Quality Assurance Committee**	**Date: 12/01/22**
Report title	**Quarterly Learning from Deaths (LfD) report**, Quarter 2, 1 July to 30 September 2021	**Agenda item: 3.1**
Executive director lead	Dr Clare Dollery, Executive Medical Director	
Report author	Dr Ihuoma Wamuo, AMD for Patient Safety & Learning from Deaths Vicki Pantelli, EA to Medical Director and Project Lead for Mortality	
Executive summary	During Quarter 2, 1 July to 30 September 2021 there were 113 adult inpatient deaths reported at Whittington Health. There were also two neonatal deaths. 22 adult structured judgement reviews (SJRs) were requested for Quarter 2 and 12 of these have been completed and presented at department mortality meetings. Each SJR has also been reviewed by the Associate Medical Director (AMD) for Learning from Death to ensure all possible learning has been captured and shared across the organisation. This quarter there were no deaths of patients with a serious mental illness or with a learning disability. In accordance with national guidance, all definite Hospital healthcare associated COVID-19 infections are reported and investigated as a patient safety incident. One patient death relates to a hospital acquired COVID-19 death and is being investigated. The SHMI for the period is 0.85 which is lower than expected. An overarching Mortality Review Group meeting took place on 28 September 2021. The meeting reviewed the learning from death reports and considered the mortality review process as a whole.	
Purpose:	The paper summarises the key learning points and actions identified in the mortality reviews completed for Q2, 1 July to 30 September 2021.	
Recommendation(s)	Members are invited to: • Recognise the assurances highlighted for the robust process implemented to strengthen governance and improved care	

	around inpatient deaths and performance in reviewing inpatient deaths which make a significant positive contribution to patient safety culture at the Trust. • Be aware of the areas where further action is being taken to improve compliance data and the sharing of learning.
Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register
Report history	This quarter's report not previously presented. Previous Quarters from April 2017 onwards have been presented to Trust Board
Appendices	Appendix 1: NHS England Trust Mortality Dashboard

Quarterly Learning from Deaths Report -
Quarter 2, 2021/22: 1 July to 30 September 2021

1. Introduction

1.1. This report summarises the key learning identified in the mortality reviews completed for Quarter 2 of 2021/22. This report describes:

- Performance against local and national expectations in reviewing the care of patients who have died whilst in this hospital. This report focuses on deaths in inpatients;
- The learning taken from the themes that emerge from these reviews;
- Actions being taken to both improve the Trust's care of patients and to improve the learning from deaths process.

2. Background

In line with the NHS Quality Board "National guidance on learning from deaths" (March 2017) the Trust introduced a systematised approach to reviewing the care of patients who have died in hospital.

https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

The Trust requires that all inpatient deaths be reviewed. The mortality review should be by a Consultant not directly involved with the patient's care.

A structured judgement review (SJR) should be undertaken by a trained reviewer who was not directly involved in the patient's care, if the case complies with one of the mandated criteria listed below:

- Bereaved families and carers have raised a significant concern about the quality of care provision;
- Staff have raised a significant concern about the quality of care provision;
- Medical Examiners have identified the case for a SJR;
- All deaths of patients with learning disabilities;
- All inpatient deaths of patients with a severe mental illness (SMI) diagnosis. SMI is defined as schizophrenia, schizoaffective disorders, bipolar affective disorder, severe depression with psychosis, In addition to where these diagnoses are recorded in a patient's records, the use of Clozapine, Lithium and depot antipsychotic medication are indicative of these diagnoses;
- All neonatal, children and maternal deaths;
- Serious incident requiring investigation involving a patient death;
- All deaths in a service where concerns have been raised either through audit, incident reporting processes or other mortality indicators;
- All deaths in areas where deaths would not be expected, for example deaths following elective surgical procedures;
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had sepsis, diabetic ketoacidosis, or a recent fall;
- Deaths that are referred to HM Coroner's Office without a proposed Medical Certificate of Cause of Death (MCCD).

3. Mortality review Quarter 2, 2021/22

- During Quarter 2, 2021/22 there were 113 adult inpatient deaths reported at Whittington Health.
- During Quarter 2, 2021/22 there were 2 neonatal deaths reported at Whittington Health.
- Table 1 shows the distribution of deaths by departments/teams.
- Table 2a shows the total number of mortality reviews and SJRs required and how many of these reviews are outstanding.
- Table 2b provides a breakdown of SJRs required by department.

Table 1: Death by Department/Team

Department/Team	**Number of deaths**
Acute Admissions Unit (Mary Seacole North and South)	15
Cavell	10
Cloudesley	19
Meyrick	18
Critical Care Unit	14
Nightingale	10
Coronary Care Unit	13
Victoria	6
Coyle	6
Mercers	2
Child/neonatal/maternity	2
Total:	**113 Adults 2 neonatal**

Table 2a: Total number of Mortality reviews and SJRs required

	Number of reviews required	**Completed Reviews**	**Outstanding reviews**
Adult Mortality Reviews	91	17	74
Neonatal Mortality Reviews	2	0	2
SJR	22	12	10

Table 2b: SJRs required for each department/team

Department	**Number of SJRs**
Acute Admissions Unit (Mary Seacole North and South)	2
Cavell	2
Cloudsley	3
Meyrick	4
Critical Care Unit	4
Nightingale	0
Coronary Care Unit	2
Victoria	2
Coyle	2
Mercers	1
Child/Neonatal/maternity**	2

****** Investigated as a Serious Incident, Internal Root Cause Analysis, Child Death Overview Panel (CDOP), Healthcare Safety Investigation Branch (HSIB) or perinatal mortality reviews

Table 3: Reasons for deaths being assigned as requiring SJR during Quarter 2, 2021/22

Criteria for SJR	Number of SJRs identified	Completed SJRs	Comments
Staff raised concerns about care	0	0	
Family raised concerns about quality of care	0	0	
Death of a patient with Serious mental illness	0	0	
Death in surgical patients	0	0	
Paediatric/maternal/neonatal/intra-uterine deaths	2	0	Investigated as a Serious incident, internal RCA investigation, HSIB*, CDOP** or perinatal mortality reviews
Deaths referred to Coroner's office	8	1	Excludes deaths in the Emergency Department and in other categories
Deaths related to specific patient safety or QI work e.g. sepsis and falls	6	2	
Death of a patient with a Learning disability	0	0	
Medical Examiner concern	7	7	
Subject to serious incident investigation	1	1	
Unexpected Death	0	1	
Concerns raised through audit, incident reporting or other mortality indicators	0	0	
Total including Neonatal Deaths	**24**	**12**	

*Healthcare Safety Investigation Branch
** Child Death Overview Panel

3.1 Deaths requiring a structured judgement mortality review form (or equivalent tool) are reviewed by a second independent Clinician, not directly involved with the case. The case is then discussed in the department mortality meeting. Each SJR is fully reviewed to ensure all possible learning has been captured and shared.

3.2 The aim of this review process is to:

- Engage with patients' families and carers and recognise their insights as a source of learning, improve their opportunities for raising concerns;
- Embed a culture of learning from mortality reviews in the Trust;
- Identify and learn from episodes relating to problems in care;
- Identify and learn from notable practice;
- Understand and improve the quality of End of Life Care (EoLC), with a particular focus on whether patient's and carer's wishes were identified and met;

- Enable informed and transparent reporting to the Public Trust Board, with a clear methodology;
- Identify potentially avoidable deaths and ensure these are fully investigated through the Serious Incident (SI) process and are clearly and transparently recorded and reported.

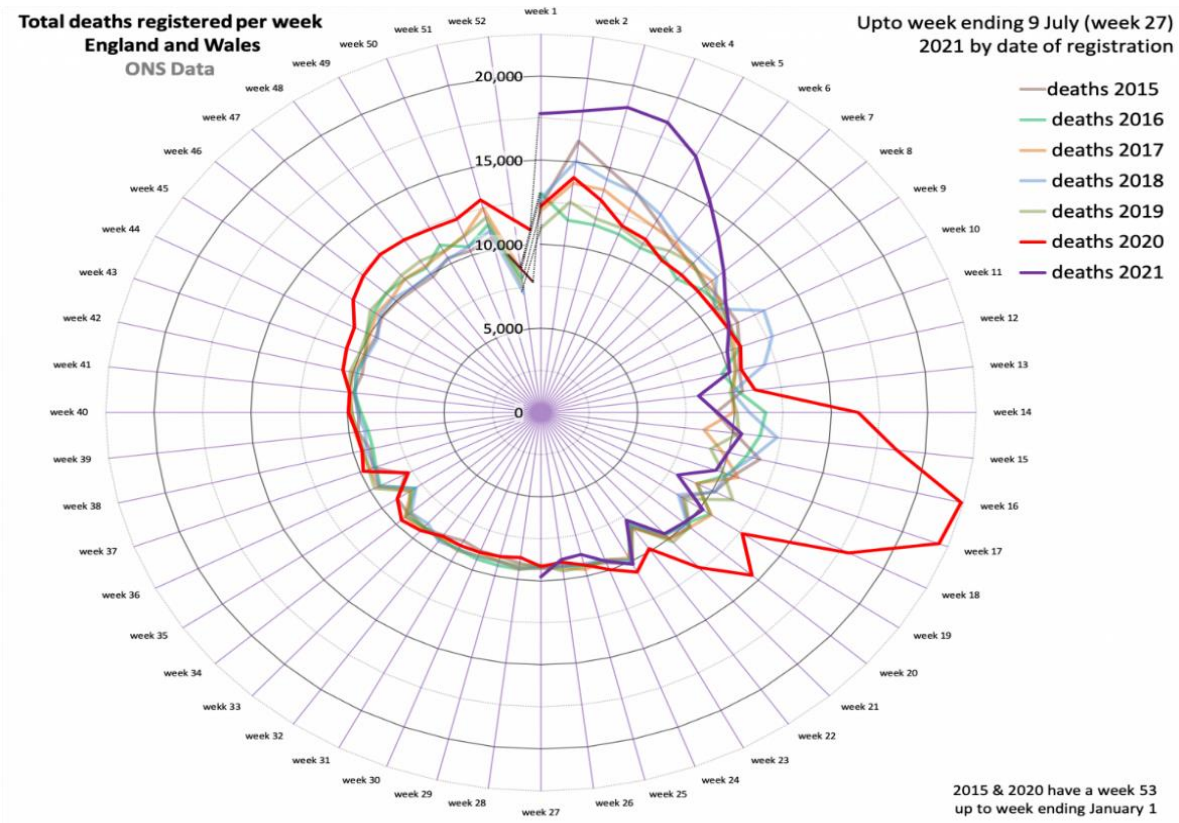
3.3 **Update on Previous Quarter's SJRs**
For Q1 April to June 2021, 18 out of 23 SJRs have now been completed and returned.

4. Q4 Mortality Dashboard

4.1 The National Guidance on Learning from Deaths gives a suggested dashboard which provides a format for data publication by Trusts. Whittington Health has chosen to adopt this dashboard locally. The dashboard is provided in Appendix 1 – NHS England Trust Mortality dashboard. This dashboard shows data from 1 April 2017 onwards.

There were 113 inpatient adult deaths recorded in Quarter 2, 2021/22.

4.2 **Graph 1 Source: Oxford The Centre for Evidence Based Medicine**



4.3 In Week 37, 11,009 deaths were registered in England and Wales; this was 26 less deaths than the previous week (Week 36) and 18.3% above the five-year average (1,703 more deaths).

4.4 Of the deaths registered in Week 37 in England and Wales, 851 mentioned "novel coronavirus (COVID-19)", accounting for 7.7% of all deaths; this was a decrease compared with Week 36 (857 deaths).

4.5 **Graph 2: Crude Adult Mortality comparing previous years**

The radial graph below compares all causes of adult deaths (including ED deaths) in the Whittington hospital in 2018-19, 2019-20 with the year considered in this report 2020 -21.

Table 4 reports the number of deaths each month.

The number of deaths in July 2021 was 44, compared with 24 deaths in July 2020. This is more in line with 38 deaths that occurred in July 2019.

The number of deaths in August 2021 was 43, compared with 20 deaths in August 2020. There were 45 deaths in August 2019.

The number of deaths in September 2021 was 37, compared with 28 in September 2020. There were 33 deaths in September 2019.

Graph 2: Crude Adult Mortality comparing previous years

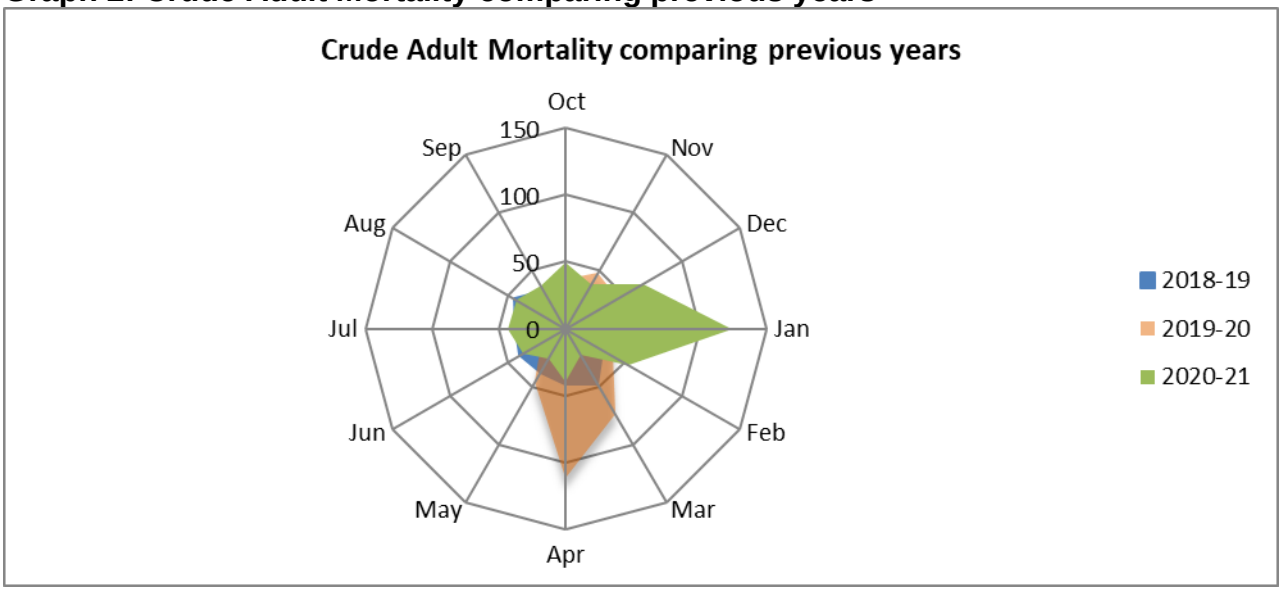


Table 4: number of deaths each month

Month	Oct 18 - Sep 19	Oct 19 - Sep 20	Oct 20 - March 21
Oct	30	37	49
Nov	37	48	38
Dec	44	45	67
Jan	42	43	124
Feb	32	40	54
Mar	48	74	23
Apr	42	112	40
May	38	46	26
Jun	40	22	37
Jul	38	24	44
Aug	45	20	43
Sep	33	28	37

5.0 Summary Hospital-level Mortality Indicator (SHMI)

The SHMI for the period July 2020 to June 2021 is 0.85 which is lower than expected.

6.0 Themes and learning from mortality reviews Quarter 2 of 2021/2022

6.1 Most mortality reviews identified excellent standards of care, with relatives expressing thanks for the care of their loved one. Early end of life care and palliative measures were taken in many cases.

6.2 There were cases of good practice such as the management of a patient with a pulmonary embolism, where local and national guidelines were followed.

6.3 One meeting reminded clinicians that undertaking pleural aspiration in palliative care patients is not of benefit in providing symptom relief. A discussion on escalating concerns to the Consultant if such patients deteriorate also took place.

6.4 One patient died from hospital acquired COVID-19 but despite extensive review no clear source of the infection was identified and screening of staff and the patient's journey did not identify an index case. All of the care of their COVID-19 infection was good and appropriate to up to date guidance.

6.5 A patient who required oxycodone analgesia was not switched to a syringe driver when they became more symptomatic. The Palliative Care Consultant has spoken with the Consultant and team who were caring for the patient. Education and training with signposting to the intranet guidelines has been provided. There is regular teaching through the year to ensure all members of the clinical teams are up to date with palliative care guidelines. Nursing and medical teams are skilled at setting up of syringe drivers, due to regular teaching sessions.

6.6 A joint mortality meeting between Critical Care Unit, Respiratory and Rheumatology identified missed opportunities to review the treatment escalation plan decision in a complex patient but whose prognosis was likely to be poor. Other aspects of their care were noted to be excellent.

6.7 Education for ED staff about improving communication on the handover of patients presenting with an acute kidney injury stage 3 and escalating these patients for senior review was reported. This was communicated to the Clinical Lead in ED and then the wider team

6.8 The acute deterioration of an elderly patient, being treated for sepsis was discussed jointly by the Care of Older People, general surgery and Gastroenterology teams. This review concluded the patient received appropriate care. Another case of sepsis identified excellent care with management of the" Sepsis 6" in the ED. This has been fed back to the ED Clinical Lead.

6.9 Using hospital interpreters for treatment escalation plans and DNACPR decisions was identified as being important, when there are language barriers, to allow better understanding for patients and their relatives.

7. Mortality Review Group

A Trust-wide Mortality Review Group was held on 28 September 2021. The group discussed the Q4 2020/21 and Q1 2021/22 LfD reports.

8. Medical Examiner system

8.1 All Quarter 2 deaths have been reviewed by the Medical Examiners (ME). This is 100% of the 113 deaths reported.

8.2 There is positive feedback from Clinical teams recognising and appreciating the ME role within the Trust.

8.3 The opportunity for families to discuss the care their relatives received with an ME has been positively received.

9. Conclusion and recommendations

The Quality Assurance committee is asked to recognise the significant work from frontline teams, and to recognise the learning from mortality reviews.

Appendix 1: NHS England Trust Mortality Dashboard

NHS Whittington Health: Learning from Deaths Dashboard - September 2021-22

Department of Health

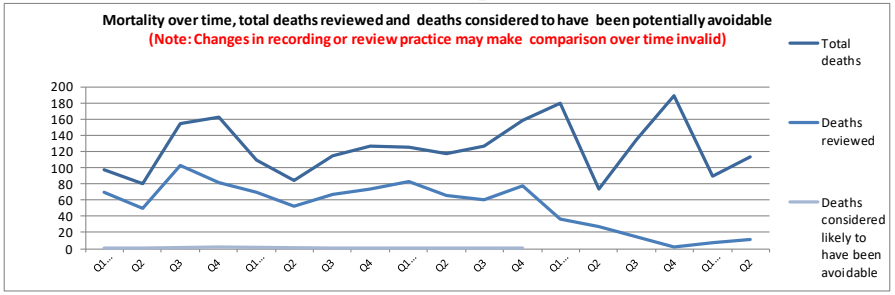
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
35	40	3	7	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
113	90	11	7	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
203	577	18	65	0	0

Time Series: Start date 2017-18 Q1 End date 2021-22 Q2



Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	3	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	9.1%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD	10	90.9%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	9.1%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	10	90.9%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	1	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	4	0	1	0	0

Meeting title	**Trust Board – public meeting**	**Date: 27 January 2022**
Report title	**Patient Safety Specialist and National Patient Safety Strategy Board Briefing**	**Agenda item: 7**
Executive director leads	Dr Clare Dollery, Medical Director, and Michelle Johnson Chief Nurse and Director of Allied Health Professionals	
Report authors	Gillian Lewis, Associate Director of Quality Governance, and Ihuoma Wamuo, Associate Medical Director for Patient Safety and Learning from Deaths	
Executive summary	In August 2021, Dr Aidan Fowler, National Director of Patient Safety in England (NHS England and NHS Improvement) wrote to all Medical and Nursing Directors asking for a dedicated board discussion within the next six months. This paper is to inform Trust Board of the role of patient safety specialists and the request from NHS England/ Improvement for Board's to commit their support to the patient safety specialist initiative. To this end, the Board briefing report outlined the Executive Patient Safety Specialist (PSS) support requirements, and the medium term priorities identified for PSS to deliver as part of the National Patient Safety Strategy. The Associate Director of Quality Governance and the Associate Medical Director for Patient Safety have been working together to fulfil the portfolio requirements of the patient safety specialists since August 2020.This fulfils the requirements to escalate immediate risks, work with others such as the Medication Safety Officer and developing the safety culture it does not allow them to work only and exclusively on patient safety. Therefore, having piloted this approach the Chief Nurse and Medical Director will take an options appraisal to the Trust's Investment Group in February 2022 to consider structures including a full time role of patient safety specialist.	
Purpose	To brief the board on the patient safety specialist role and plans to take this forward.	

Recommendation	Board members are invited to note the briefing document and to commit to the patient safety specialist programme.
Board Assurance Framework	Quality 1 and Quality 2
Appendices	1: Patient Safety Specialist Executive briefing document

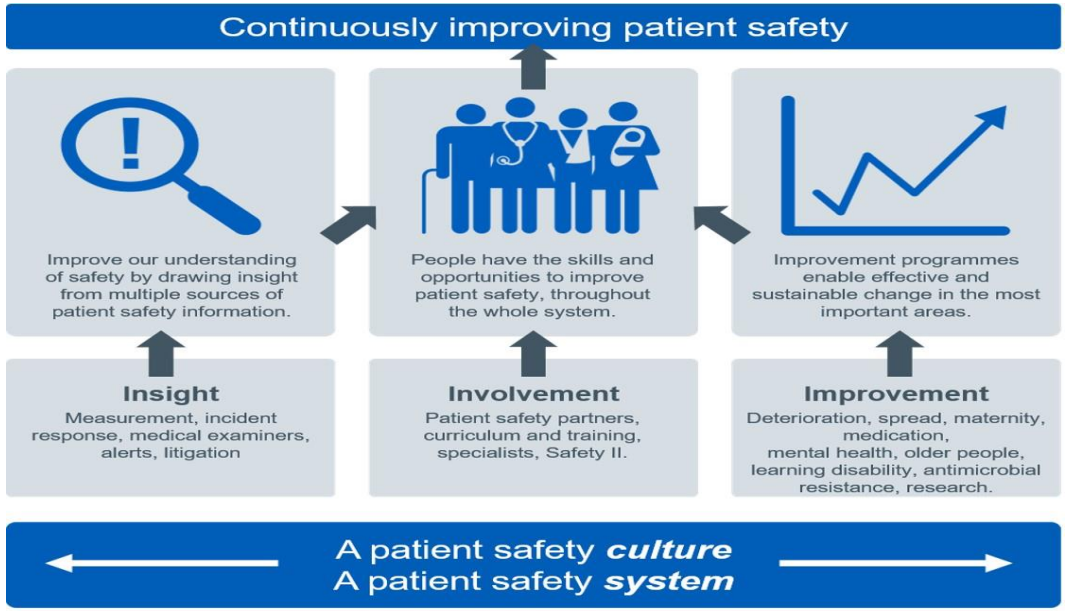
Patient safety specialists (PSS)

Executive briefing document

2021

NHS England and NHS Improvement

Patient safety specialists



Formally creating this role provides status and the expectation that having a patient safety specialist(s) who is fully trained in the national patient safety syllabus is standard across the NHS

Classification: Official

NHS

Identifying patient safety specialists

August 2020

Purpose of the role

The NHS Patient Safety Strategy[1] set the ambition for the new role of patient safety specialist to be introduced in every NHS organisation in England; this includes providers and commissioners of NHS-funded care. We consulted on a draft specification for patient safety specialists earlier in 2020 and this final specification is informed by the views of those who responded.

Patient safety specialists will be the lead patient safety experts in healthcare organisations, working full time on patient safety. They will be 'captains of the team' and provide dynamic, senior leadership, visibility and expert support to the patient safety work in their organisations. They will support the development of a patient safety culture and safety systems, and have sufficient seniority to engage directly with their executive team. They will work in networks to share good practice and learn from each other.

Patient safety specialist role

- Lead patient safety experts in their organisation, working full time on patient safety
- Able to escalate immediate risks or issues to Exec team
- ‘Captains of the team’, provide dynamic senior leadership, visibility and expert support
- Work with others including: Medication safety officer (MSO), Medical device safety officer (MDSO), Maternity safety champions
- Lead /support the local implementation of the NHS patient safety strategy: insight, involvement and improvement
- Support the development of a patient safety culture and safety systems
- Work in networks to share and learn
- Lead, and may directly support, patient safety improvement activity
- Ensure that systems thinking, and just culture principles are embedded
- Support patient safety partners (Framework for involving patients in patient safety)
- Learn and develop, complete the Patient safety syllabus

Key deliverables

- 2019 - Role identified as part of the NHS patient safety strategy
- 2020 Mar - Patient safety specialists made a contractual requirement within the NHS Standard Contract 2021/22 section 33.7
- 2020 Aug/Nov - Identifying Patient Safety Specialists and providing nominations to NHSEI from every NHS organisation by 3011/20
- 2020 Nov – National webinars provided to support patient safety specialist training
- 2021 Apr – patient safety specialists to be full time in post
- 2021 Apr – patient safety specialist priorities document provided
- 2021 Jun - Patient safety syllabus available for patient safety specialists and training for the Board

Early milestones

- Over 700 Patient Safety Specialists representing 96% coverage of relevant organisations
- We have held 16 national meetings – topics including:
  - National patient safety improvement programmes
  - Views on patient safety culture
  - PSIRF progress update
- Involvement in two national safety issues:
  - Beckton Dickinson infusion devices
  - Phillips device recall
- Involvement in national working groups including:
  - National Patient Safety Syllabus
  - Development of NHSX digital strategy
- Development of FutureNHS Collaboration platform (access via patientsafetyspecialists.info@nhs.net)
- Patient safety priorities document provided
- Starting to create region and ICS patient safety specialist networks

PSS priorities (Apr-21)

- Just culture support and advice
- National Patient Safety Alerts advice
- Improving quality of incident recording
- Support transition from NRLS and StEIS to the new Learn from patient safety events (LFPSE) service
- Preparation for implementing the new Patient Safety Incident Response Framework (PSIRF) when it is launched in 2022
- Implementation of the Framework for involving patients in patient safety (published in June 2021)
- Patient safety education and training including the first two levels of the Patient safety syllabus launched in summer 2021
- Supporting involvement in the National Patient Safety Improvement Programmes, working with local AHSNs and Patient Safety Collaboratives
- COVID-19 recovery support – more information will be provided shortly

Short – medium term priorities for Patient Safety Specialists

April 2021

This paper describes how Patient Safety Specialists (PSSs) can support implementation of the NHS Patient Safety Strategy and operational recovery during 2021/22.

We have identified nine key work programmes, with associated actions and timescales where appropriate:

1. Just culture
2. National Patient Safety Alerts
3. Improving quality of incident reporting
4. Support transition from NRLS and StEIS to PSIMS
5. Involvement in implementing the new Patient Safety Incident Response Framework (PSIRF)
6. Implementation of the Framework for Involving Patients in Patient Safety
7. Patient safety education and training
8. National patient safety improvement programmes
9. COVID-19 recovery planning

We appreciate due to current workloads it may not be possible for PSSs to immediately be actively involved in all these work programmes. You should review the programmes identified in this paper with your executive team and agree a phased approach to implementation. For some programmes there may be opportunity to ensure that others in your organisation are already aware and involved and that minimal support from you is needed. There are a number of programmes where, although there are associated timescales, a flexible approach can be taken. For example, it may not be possible to go live with the new patient safety incident management system (PSIMS) immediately if your local risk management system (LRMS) vendor hasn't undertaken the necessary local modifications.

Executive PSS support requirements

1. The Patient Safety Specialist was required to be identified by Apr-21. The expectation is 1FTE at band 8 range, but this may be a shared role, or more than 1FTE across large organisations
2. The PSS's name(s) has been provided to NHSEI by executive lead for patient safety
3. An executive lead for patient safety should be identified as the direct contact point for the PSS. The PSS should also link with the NED who leads on patient safety.
4. All Board members should be aware of and support the PSS's role and discuss as a board agenda item
5. The PSS priorities document (circulated Apr-21) should be reviewed and a PSS work plan agreed with the patient safety executive lead
6. The PSS should be provided with sufficient time and resources to undertake their role, network and complete the patient safety training requirements (to level 5 of the Patient safety syllabus once available)
7. There should be sufficient support/ coaching / mentoring in place for the PSS to progress their personal and leadership development

Meeting title	**Trust Board – public meeting**	**Date: 27 January 2022**
Report title	**Workforce Assurance Committee Chair's report**	**Agenda item: 8**
Committee Chair	Anu Singh, Non-Executive Director	
Executive director lead	Norma French, Director of Workforce	
Report authors	Marcia Marrast-Lewis, Assistant Trust Secretary, and Swarnjit Singh, Trust Secretary	
Executive summary	Trust Board members are presented with the Workforce Assurance Committee Chair's report for the meeting held on 7 December 2021. **Areas of significant assurance:** • Staff story – Apprenticeships Journey • Quarter two workforce report • North London Partners Shared Services – Occupational Health • Staff Survey Update • Just Culture Update • Health & Wellbeing Update • Report from Directors of Race Equality Diversity and Inclusion • Board Assurance Framework – People entries There were no agenda items at the meeting for which the Committee is reporting limited assurance to the Board.	
Purpose	Note	
Recommendation(s)	Board members are invited to note the report, particularly areas of significant assurance.	
Board Assurance Framework	People entries	
Report history	None	
Appendices	None	

Committee Chair's assurance report

Committee name	Workforce Assurance Committee
Date of meeting	7 December 2021
Summary of assurance:	

1. The Committee is reporting significant assurance to the Board on the following matters:

Staff story – Apprenticeship journey

Committee members welcomed Mike Lewendon and Iolanda Pedrosa who informed the Committee that:

- The Trust ran apprenticeship schemes to enable staff to progress their careers from National Vocational Qualifications (NVQ) through to postgraduate and masters level apprenticeships. Candidates ranged from administrative staff through to nursing colleagues
- All three fed back positively about their experiences and the support they received ranging from protected time away from work to study, practical help to augment physical challenges such as dyslexia and spondylitis which included extra information technology support with voice recognition and grammar checking software
- Mike Lewendon praised the Trust for giving him the opportunity to train and develop. He explained that he first joined the Trust as a volunteer and had since completed an NVQ level 3 apprenticeship and was part way through a degree level apprenticeship while working with the smoking cessation team
- Iolanda Pedrosa was recruited from Portugal as a nurse and was currently undertaking a Senior Leaders Master's degree apprenticeship which she felt was the perfect fit for her career aspirations as she was better able to learn away from a formal classroom environment and shadow senior leaders while grasping complex theories and concepts.
- Hazel Hall's testimony was read out by Helen Kent who was training to become a nurse associate her ambition was to become a registered midwife.
- Helen Kent reminded the Committee that apprenticeships were not age restricted so that anyone with the inclination to retrain could embark on an apprenticeship programme at no cost to the individual as the programmes were funded through the Apprenticeship Levy which had been in place for the past four years.

The Committee Chair thanked Mike, Iolanda and Hazel for sharing their inspiring experiences.

Quarter two workforce report

Charlotte Pawsey presented the report highlighting to the following headlines:

- Equality data which provided the basis to take forward the work around variation within employment relation processes with the BAME and the white workforce.
- Vacancy rates in corporate services were higher Estate and Facilities at Band 3 levels. The vacancies were driven by the repatriation of some

services which utilised more bank and agency staff while contracts were finalised.
- A programme of work around the "just culture" had commenced which would address some of the issues around formal and informal disciplinary processes which was a positive step forward.

The Committee challenged the higher-than-average rate of staff turnover seeking assurance that staff turnover would stabilise. Kate Wilson explained that problems impacting employee relations were not new or exclusive to the organisation but were deep rooted.

Anecdotal evidence from Mersey Care, who were the first to implement the just culture concept revealed that informal processes appeared to have a positive impact on the outcome of disciplinary processes when a robust framework built around the just culture programme was in place.

In terms of turnover, it was explained that while the trajectory appeared to be moving upwards, the data that was gathered was across a 12 month period and may not reflect current activity. Additionally, staff were under significant pressures particularly during the winter period and that schemes were in place to support staff retention and talent management.

Norma French confirmed that currently recruitment was taking place at a faster rate than staff attrition and a significant number of staff had been recruited to hot spot areas.

Committee members welcomed the report and noting the measures in place to support recruitment and retention.

North London Partners Shared Services – Occupational Health
Committee members received the report on the reconfiguration of Occupational Health services in North Central London (NCL) which had also been considered in detail at the Trust Management Group (TMG) where a number of queries around sustainability, business partners, quality control and authorisations were raised, TMG agreed that the business case required more scrutiny through the Trust's governance processes.

Dennis Carlton talked through the financial case noting that primary consideration for the business case was a need to standardise the quality and general provision of occupational health services across the Integrated Care System (ICS). A new framework for occupational health had been designed which sought to provide a more accessible approach and increase the psychological and MSK provision available for all staff within the ICS.
In terms of governance, Kevin Curnow advised that the final sign off of the proposal in a private meeting of the Trust Board his preference was for non-executive colleagues to have full and informed discussion around the business case and the wider implications for the ICS in due course.
Norma French noted that the planned roll out of the model was 1st May 2022 subject to completion of discussions and negotiations with partner organisations.

	The Committee noted their support for the proposed model of Occupational Health services. **Staff Survey** The Committee received a verbal update on early results of the NHS staff survey and noted that the full survey outcome would be reported in March 2022. **Health & Wellbeing** The Committee considered a report on the range of support offered to staff to support their health and wellbeing as well an evaluation of the services. Kate Wilson advised that a number of staff had struggled to take up the resources made available and to address the issues, managers were advised to maintain a watchful eye to help staff access the resources and support. Michelle Johnson acknowledged that there were challenges particularly for nursing staff as a result of shift patterns and the need for cover to release staff to access the various health and wellbeing resources. The Committee noted progress made. **Report from Directors of Race, Equality, Diversity and Inclusion** The Committee received the report which reflected the findings from engagement and consultation by the joint directors across Whittington Health. The Committee noted good commitment and engagement by senior leaders at the Trust to take the work forward and a request for a better guidance on the policy framework for the Organisation was noted which was designed to give managers and leaders more confidence on their management of diverse teams. The Committee noted challenges around the need for meaningful data to help shape WRES action plans. Rob Vincent welcomed the report and noted the many actions being taken forward in the plan. Tina Jegede confirmed that a national dashboard was in development and would reflect WRES indicators by each Integrated Clinical Support Unit (ICSU) and would facilitate the development of support and actions according to the needs of each ICSU. Anu Singh commended the joint directors of EDI for the efforts and undertakings to progress the EDI agenda at Whittington Health. **Board Assurance Framework (BAF) – people entries** Committee members reviewed the BAF which had been updated since the September 2021 Board meeting. They discussed the risk score against People 2 objective would be increased from 12 to 16 as a result of the increase in the rate of staff turnover.
2.	**Other meeting agenda items** In addition, the Committee noted members that a programme to roll out vaccinations as a condition of deployment would be developed and implemented to ensure that all patient facing staff were vaccinated by 31 March 2022.

3.	**Present:** Anu Singh, Non-Executive Director (Committee Chair) Kevin Curnow, Chief Finance Officer Clare Dollery, Medical Director Norma French, Director of Workforce Carol Gillen, Chief Operating Officer Michelle Johnson, Chief Nurse and Director of Allied Health Professionals Rob Vincent, Non-Executive Director **In attendance:** Dennis Carlton, Programme Director North London Partners Hazel Hall, Nursing Associate Tina Jegede, Joint Director, Race, Equality, Diversity & Inclusion and Lead Nurse, Islington Care Homes Helen Kent, Assistant Director, Learning & Organisational Development Mike Lewendon, Smoke Free City and Hackney Triage Assistant Marcia Marrast–Lewis, Assistant Trust Secretary Iolanda Pedrosa, Chief Nursing Midwifery and AHP Information Officer Swarnjit Singh, Joint Director, Race, Equality, Diversity & Inclusion and Trust Secretary Kate Wilson, Associate Director Workforce

Meeting title	**Trust Board – public meeting**	**Date: 27.01.2022**
Report title	Finance Report December (Month 9) 2021/22	**Agenda item: 9**
Executive director lead	Kevin Curnow, Chief Finance Officer	
Report author	Finance Team	
Executive summary	The Trust is reporting an actual deficit of £0.8m at the end of December 2021. This is a favourable variance of £1.3m against a planned deficit of £2.0m. The deficit position is being driven by slippage in expected savings and other expenditure overspends not covered by the H1 (April 2021 to September 2021) funding. Cash position at the end of December was £75.5m The Trust has spent £8.8m of its capital allocation year to date December 2021 which is £1.8m behind plan. This is largely due to phasing of the plan and the Trust is still forecasting to spend its capital allocation for 2021-22. The Trust has developed an initial forecast position of break-even at the end of the financial year which will be £2.6m better than the planned deficit of £2.6m.	
Purpose:	Review	
Recommendation(s)	Board members are asked to note the year-to-date financial performance, recognising the need for improve savings delivery.	
Board Assurance Framework	BAF risks Sustainability 1 and Sustainability 2	
Report history	Trust Management Group	
Appendices	None	

Trust reporting £0.8m actual deficit at the end of December – £1.3m better than plan

The Trust is reporting an actual deficit of £0.8m at end of December which is £1.3m better than plan. The planned deficit to end of December was £2.0m.

Key drivers for the £0.8m actual deficit are

- Slippage of Cost Improvement Programmes across the trust
- Additional costs relating to ongoing legal challenges relating to the Private Finance Initiative (PFI)
- Other cost pressures not covered by H1 (April 2021 to September 2021) funding including increased staffing for additional beds and agency premium.

Included in the year to date (YTD) actuals is £4.8m of Elective Recovery Fund (ERF) income. This is currently offsetting slippage in expected savings and other expenditure overspends not covered by H1 funding.

Cash of £75.5m at end of December

As at the end of December, the Trust's cash balance stands at £75.5m – an increase of £14.0m from the 31st of March 2021. The Trust's ongoing cash requirements have not changed materially in terms of staff pay and capital expenditure, and the Trust is striving to pay suppliers early in the current economic climate.

Capital plan for 2021/22 is £17.1m. YTD spend is £8.8m.

The Trust has a capital plan of £17.1m. This plan is in line with North London Partners Integrated Care System (ICS) allocation. At end of December the Trust has spent £8.8m of its capital allocation which is £1.8m behind plan. The Trust is still forecasting to spend its capital allocation for 2021-22.

Better Payment Practice Performance – 93.4% for non-NHS by value

The Trust is signed up to the NHS commitment to improve its Better Payment Practice Code (BPPC) whereby the target is to pay 95% of all invoices within the standard credit terms. Overall, the Trust's BPPC is 89.8% by volume and 90.0% by value. The BPPC for non-NHS invoices is 93.4% by value and 91.6% by volume.

Draft Forecast Outturn – Trust is forecasting a break-even position.

The Trust has developed an initial forecast position of break-even at the end of the financial year which will be £2.6m better than the planned deficit of £2.6m. This is due to some non-recurrent reductions in expenditure run rate and elective recovery income with lower additional spend than planned.

1. Summary of Income & Expenditure Position – Month 09

	In Month			Year to Date			
	Plan	Actual	Variance	Plan	Actual	Variance	Annual Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income							
NHS Clinical Income	25,446	24,604	(842)	222,647	220,237	(2,410)	299,354
High Cost Drugs - Income	667	1,347	680	6,138	8,156	2,018	8,140
ICS Funding M7-12	3,241	3,290	49	22,815	22,815	0	32,538
Non-NHS Clinical Income	1,050	1,068	18	9,992	9,976	(16)	13,226
Other Non-Patient Income	2,155	2,480	325	19,266	19,319	53	25,825
Elective Recovery Fund	0	(199)	(199)	5,544	4,765	(778)	6,942
	32,559	**32,591**	**32**	**286,401**	**285,268**	**(1,132)**	**386,025**
Pay							
Agency	(43)	(1,565)	(1,522)	(79)	(9,329)	(9,250)	(70)
Bank	(892)	(2,156)	(1,264)	(4,716)	(21,228)	(16,512)	(6,240)
Substantive	(22,211)	(19,012)	3,199	(200,218)	(170,349)	29,869	(269,166)
	(23,146)	**(22,733)**	**413**	**(205,013)**	**(200,906)**	**4,107**	**(275,476)**
Non Pay							
Non-Pay	(7,331)	(7,166)	165	(63,714)	(64,017)	(303)	(84,795)
High Cost Drugs - Exp	(843)	(869)	(26)	(6,060)	(7,628)	(1,568)	(10,118)
	(8,174)	**(8,035)**	**139**	**(69,774)**	**(71,645)**	**(1,871)**	**(94,913)**
EBITDA	**1,238**	**1,822**	**584**	**11,613**	**12,716**	**1,103**	**15,637**
Post EBITDA							
Depreciation	(946)	(929)	17	(8,510)	(8,438)	72	(11,348)
Interest Payable	(61)	(49)	12	(549)	(430)	119	(733)
Interest Receivable	0	0	0	0	0	0	0
Dividends Payable	(511)	(511)	0	(4,599)	(4,600)	(1)	(6,132)
	(1,518)	**(1,489)**	**29**	**(13,659)**	**(13,468)**	**190**	**(18,213)**
Reported Surplus/(deficit)	**(280)**	**333**	**613**	**(2,045)**	**(752)**	**1,293**	**(2,577)**

- The Trust reported a year-to-date deficit of £0.8m (excluding donated asset depreciation) at the end of December which is £1.3m better than plan.
- The planned deficit to the end of December was £2.0m excluding donated asset depreciation.
- YTD actuals includes £4.8m of ERF income that is currently mitigating unachieved CIPs and other expenditure overspends.
- There is a need for the Trust to manage some slippage against the non-recurrent Accelerated and Transformation funds awarded by the ICS, arising from difficulties in recruiting temporary staff into some areas.

2.0 Income and Activity Performance

2.1 Income Performance

Income was £0.03m favourable to plan in December and £1.1m adverse year to date.

- In month overperformance is mainly driven by other operating income (mainly R&D grant - £0.2m), offset by underperformance of £0.2m in ERF and £0.1m NHS Clinical for Ortho-Hub provision.
- Income from patient care activities is reporting £1.2m year to date adverse to plan which is mainly driven by £0.8m ERF and £0.3m accelerated funds.
- Other operating income is reporting £0.1m year to date favourable to plan. This includes £0.8m adverse position for education & training and £0.1m COVID-19 Reimbursement, offset by £0.5m other revenue and £0.5m non-patient care services to other bodies.

Income	In Month Income Plan £000's	In Month Income Actual £000's	In Month Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Variance £000's
A&E	1,558	1,370	(188)	12,702	13,202	500
Elective	1,458	1,216	(241)	13,125	14,482	1,356
Non-Elective	4,322	4,017	(305)	41,461	40,927	(535)
Critical care	593	664	71	5,263	5,171	(91)
Outpatients	3,004	2,457	(547)	24,153	25,867	1,714
Direct Access	846	963	116	8,375	8,194	(181)
Community	6,144	6,144	0	55,294	55,294	0
Other Clinical income NHS	11,429	12,411	982	91,226	88,072	(3,154)
NHS Clinical Income	**29,354**	**29,242**	**(112)**	**251,599**	**251,208**	**(391)**
Non NHS Clinical Income	1,050	1,068	18	9,992	9,976	(16)
Elective recovery fund (ERF)	0	(199)	(199)	5,544	4,765	(778)
Income From Patient Care Activities	**30,404**	**30,111**	**(293)**	**267,135**	**265,950**	**(1,185)**
Other Operating Income	**2,155**	**2,480**	**325**	**19,266**	**19,319**	**53**
Revised Total	32,559	32,591	32	286,401	285,268	(1,132)

2.2 Activity Performance

- Compared to November there was a reduction in both admitted and non-admitted care activity which was mainly due to the holiday period.
- Increase in activity compared to month 8 was recorded in Critical care 8% (14% above plan) and direct access 8% (18% under plan). Decreases seen in elective 19% (9% below plan), A&E activity 10% (17% below plan) and 9% in non-elective (5% below plan).
- Underperformance compared to plan in Elective activity driven mainly by general surgery 60%, T&O 49%, gastroenterology 9% and gynaecology 45%. This is offset by 75% above plan in Paediatrics. Outpatients was 11% under plan and similar across the ICSUs. Outpatient data is consistently underreported due to late outcoming.

Activity	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	Activity Diff	Activity Diff%
A&E	9,877	8,179	(1,698)	80,535	81,673	1,138	1%
Elective	1,664	1,519	(145)	14,804	16,785	1,981	13%
Non-Elective	1,613	1,540	(74)	15,477	15,716	239	2%
Critical care	462	526	64	4,094	4,127	33	1%
Outpatients	25,578	22,735	(2,843)	217,546	236,750	19,204	9%
Direct Access	78,261	92,325	14,064	781,825	765,412	(16,413)	(2%)
Other Clinical income	4,970	5,346	376	47,010	50,571	3,561	8%

2.3 Month 9 Elective Recovery Fund (ERF) Performance

- The basis for ERF payment changed for months seven to twelve. It is now based on weighted RTT clock-stops performance against a baseline of 89% of 2019/20 levels.

- In month ERF of £0.2m adverse position is due to retrospective adjustments relating to prior periods following validations from NHSE.

- The Trust did not achieve the target 89% of 2019/20 weighted RTT clock-stops in December and hence no ERF income was recorded for the month. Any improvements due to late outcoming will reflected in M10 reporting.

- Admitted activity was 66% level of 2019/20 activity level and 23% lower than the 89% weighted target. All the specialties were below the 89% target.

- Non admitted was 95% of 2019/20 activity level and met the 89% weighted target. All specialties below 89% weighted target, except for general surgery, T&O and cardiology.

Month	Admitted /Non-Admitted	Specialty	Activity Base	Activity Actual	Activity Diff	Weight Baseline	Weight Actual	Weight Diff	Performance %
9	ADM	Dermatology	2	1	(1)	3,269	1,715	(1,553)	52%
		General Surgery	3	2	(1)	4,525	3,352	(1,173)	74%
		Gynaecology	4	2	(2)	10,283	4,760	(5,522)	46%
		Oral Surgery	0	1	1	0	1,051	1,051	0%
		Other	0	1	1	274	3,132	2,858	1143%
		Rheumatology	0	0	0	0	57	57	0%
		Thoracic Medicine	0	0	0	0	0	0	0%
		Trauma & Orthopaedics	4	2	(2)	26,269	15,678	(10,591)	60%
		Urology	3	2	(1)	6,664	4,062	(2,602)	61%
	ADM Total		**16**	**11**	**(5)**	**51,283**	**33,807**	**(17,476)**	**66%**
	NADM	Cardiology	7	9	1	5,575	6,510	935	117%
		Dermatology	21	9	(12)	13,418	5,727	(7,692)	43%
		Ear, Nose & Throat (ENT)	13	8	(5)	6,297	3,838	(2,459)	61%
		Gastroenterology	13	8	(5)	6,877	4,297	(2,580)	62%
		General Medicine	0	0	(0)	368	234	(134)	63%
		General Surgery	19	45	26	4,863	11,566	6,703	238%
		Geriatric Medicine	2	1	(1)	1,213	564	(649)	47%
		Gynaecology	23	13	(9)	12,569	7,387	(5,182)	59%
		Interface Services (Rheumat	-26	0	26	-30,375	0	30,375	0%
		Neurology	5	4	(1)	2,463	2,142	(321)	87%
		Ophthalmology	7	5	(2)	5,391	3,831	(1,560)	71%
		Oral Surgery	0	0	0	0	137	137	0%
		Other	85	53	(32)	101,152	63,226	(37,927)	63%
		Plastic Surgery	1	0	(0)	365	253	(112)	69%
		Rheumatology	4	3	(1)	3,358	2,432	(926)	72%
		Thoracic Medicine	0	7	7	0	5,114	5,114	0%
		Trauma & Orthopaedics	14	18	4	8,409	10,688	2,279	127%
		Urology	21	15	(6)	11,719	8,303	(3,416)	71%
	NADM Total		**208**	**198**	**(10)**	**153,662**	**136,248**	**(17,414)**	**89%**
9 Total			**223**	**208**	**(15)**	**204,945**	**170,055**	**(34,891)**	**83%**

3. Expenditure – Pay & Non-pay

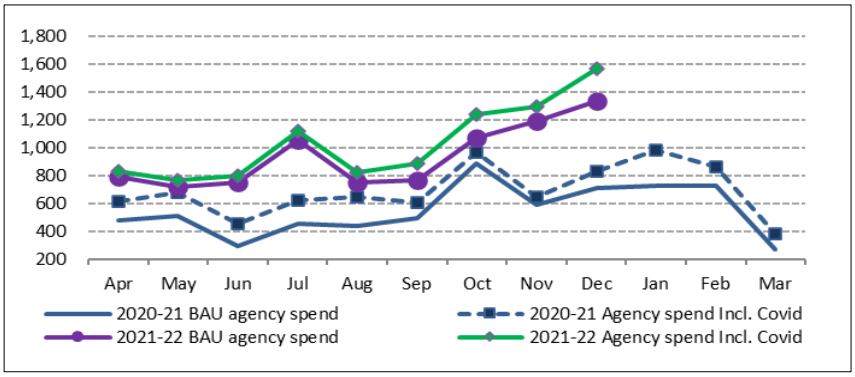
3.1 Pay Expenditure

Pay expenditure for December was £22.7m including £0.6m of costs coded to Covid-19. September substantive pay costs include 3% pay uplift and back pay uplift for April – August. The run rate analysis indicates no obvious areas of concern.

	2020-21		2021-22									
	Average	Average Uplifted	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Mov^t
Agency	731	731	785	622	879	1,034	749	770	1,068	1,189	1,054	(134)
Bank	1,806	1,806	2,072	1,875	2,287	1,759	2,136	2,166	2,003	2,104	2,137	34
Substantive	18,069	18,159	18,201	18,259	18,336	17,970	18,218	20,942	18,841	18,788	18,864	76
Total Operational	**20,606**	**20,696**	**21,057**	**20,756**	**21,502**	**20,763**	**21,104**	**23,879**	**21,912**	**22,080**	**22,056**	**(24)**
Covid Costs			271	240	282	348	288	306	427	345	615	270
Non Operational Costs			221	1,007	498	458	194	639	211	(615)	63	677
Total Pay Costs			**21,549**	**22,004**	**22,282**	**21,569**	**21,586**	**24,824**	**22,549**	**21,810**	**22,733**	**923**

** (Excludes Chair & Non-Exec Directors)*

Agency Spend



Agency spend for December was £1.6m which was £0.3m higher than previous months, and the highest so far in 2021/22. The increase was related to the surge in Covid infections.

In July agency spend was higher compared to other months mainly due to increase in Child Care

3.2 Non-pay Expenditure

Non-pay expenditure in December was £7.2m and included £0.05m of costs coded to Covid-19. The £1.3m movement from previous month is mainly driven by previous month adjustments which reversed in December.

	2020-21	2021-22									
Excluding Covid	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Mov^t
Supplies & Servs - Clin	2,175	2,023	2,380	2,543	2,366	2,311	2,463	2,324	2,704	2,684	(21)
Supplies & Servs - Gen	169	226	217	253	245	225	262	282	810	(271)	(1,081)
Establishment	216	209	156	217	233	218	241	261	242	248	6
Healthcare From Non Nhs	161	265	568	(249)	185	201	426	84	234	218	(16)
Premises & Fixed Plant	2,292	1,952	2,138	2,151	1,972	1,859	2,361	1,256	2,437	2,547	110
Ext Cont Staffing & Cons	220	166	273	206	196	164	106	137	568	(221)	(789)
Miscellaneous	2,271	1,411	1,880	1,516	1,511	1,672	2,174	1,457	1,422	1,900	478
Chairman & Non-Executives	10	10	10	10	17	11	12	12	12	12	
Grand Total	**7,514**	**6,263**	**7,623**	**6,649**	**6,725**	**6,660**	**8,044**	**5,813**	**8,429**	**7,116**	**(1,312)**
Covid Costs		100	106	80	31	58	90	86	77	49	(28)
Total non-pay costs		**6,363**	**7,729**	**6,728**	**6,756**	**6,719**	**8,134**	**5,899**	**8,506**	**7,166**	**(1,340)**

Excludes high-cost drug expenditure and depreciation.
Included in miscellaneous is CNST premium, Transport contract, professional fees, and bad debt provision

3.3 Cost Improvement Programmes (CIP)

Year to date CIP delivery is predominantly in pay reductions, currently achieving £2,681k of savings (40% of target). The devolved CIP targets to ICSUs and corporate areas to the end of December is £6,750k, so savings are currently £4,069k behind target.

	YTD				Annual			
ICSU	Trust CIP Target £'000	Trust CIP Actual Delivery £'000	Trust CIP Actuals Variance to Target (Shortfall) £'000	% CIP Actuals of Target	Trust CIP Target £'000	Trust CIP Forecast Delivery £'000	Trust CIP Forecast Variance to Target (Shortfall)	% CIP Forecast of Target
ACS	788	**400**	(388)	51%	1,050	**563**	(487)	54%
ACW	1,193	**295**	(898)	25%	1,590	**436**	(1,154)	27%
CYPS	1,199	**1,010**	(188)	84%	1,598	**1,354**	(244)	85%
EIM	1,115	**416**	(700)	37%	1,487	**554**	(933)	37%
S&C	1,084	**35**	(1,049)	3%	1,445	**72**	(1,373)	5%
Corporate	694	**354**	(340)	51%	925	**627**	(298)	68%
E&F	679	**171**	(507)	25%	905	**302**	(603)	33%
Total	**6,750**	**2,681**	**(4,069)**	**40%**	**9,000**	**3,908**	**(5,092)**	**43%**

The Trust's 2021/22 forecast savings are £3,908k as at Month 9 (43% of annual trust target). Further savings proposals are continuing to be worked up, though fewer 2021/22 starting schemes are likely to be delivered as the Trust works through Covid-19 and Winter.

H1 and H2 CIP Actuals/Forecast

The Trust's external financial plan required savings to the end of September (H1) of £1,808k. H2 CIP Plans submitted to NHSIE were based on the then forecasted CIPs for month 7 to 12 of £2,243k, which was lower than the NHSIE required efficiencies for H2 of £3,212k. Month 9 H2 forecast CIPs total of £2,379k is £833k lower than NHSIE required plan.

	Actual H1 £'000	Actual/Forecast H2 £'000	Actual YTD H2 £'000
Pay efficiencies	1,060	1,372	704
Non-pay efficiencies	281	813	350
Income efficiencies	188	195	98
Total net efficiencies	**1,529**	**2,379**	**1,152**
NHSIE CIP Plan	**1,808**	**3,212**	**1,606**
Variance from Plan	**(279)**	**(833)**	**(454)**

3.4 Additional Non-Recurrent Funding Received

The Trust is currently managing spend of non-recurrent Accelerated and Transformation monies:

Additional Funding Received	YTD Ledger £'000	Deferred (Reduction) /Increase £'000	H1 £'000	H2 £'000	H1+H2 £'000
Ageing Well Programme	311	(329)	256	768	1,024
Barnet Integrated Therapies MOBILISATION	16	16	0	16	16
Children's Integrated Therapies	254	(196)	450	0	450
CYP Therapies	122	(912)	690	690	1,379
Elective Accelarator Fund- Integrated Discharge Team (IDT)	210	101	0	219	219
Extended Same Day Emergency Care (SDEC)	399	(114)	343	343	685
Health & Wellbeing contribution	17	0	17	0	17
High-Volume Low Complexity Surgical Hub	0	0	0	197	197
HVLC Day Case Hub M1-6	671	(89)	507	507	1,013
Interim Supply Chain Lead role - non pay programme	8	0	8	0	8
Key worker funding (LD & Autism)	0	(234)	156	156	312
Maternity Transformation Lead (0.2 WTE band 7 midwife)	3	(6)	6	6	12
MHIS and SR: IAPT (phasing per workstream)	325	(26)	205	291	496
MSK Community Services – Backlog Recovery	82	(48)	87	87	174
NCL International Nurse Retention Fund 20/21	0	(63)	0	125	125
NCL ITU Nurse Training	32	(56)	59	59	118
PCS funding to Community Providers	47	(220)	178	178	355
SR: CYP community and crisis (HTT investment, Crisis Line and Crisis N	48	(198)	164	164	328
SR: CYP DBT Service	0	(150)	100	100	200
Whittington Health Dermatology Service	118	(40)	105	105	210
Winter Pressure - Islington virtual ward - boosting current capability t	0	(20)	0	40	40
Winter Pressure-1. BEH/WH virtual ward to support NMUH discharges	0	(63)	0	276	276
Grand Total	2,664	(2,645)	3,329	4,324	7,653

4.0 Statement of Financial Position

The net balance on the Statement of Final Position as at 31st December 2021 is £217.3m, £0.8m down from March 2021, as shown in the table below.

Statement of Financial Position as 31st December 2021

	BFWD 31 MAR 2021 (£000)	IN MONTH BALANCE (£000)	MOVEMENT IN YR (£000)
NON-CURRENT ASSETS:			
Property, Plant And Equipment	223,962	225,734	1,773
Intangible Assets	9,789	8,326	(1,463)
Trade & Other Rec -Non-Current	401	427	25
TOTAL NON-CURRENT ASSETS	**234,152**	**234,487**	**335**
CURRENT ASSETS:			
Inventories	2,195	2,298	103
Trade And Other Receivables	18,251	14,286	(3,965)
Cash And Cash Equivalents	61,527	75,516	13,989
TOTAL CURRENT ASSETS	**81,973**	**92,100**	**10,127**
CURRENT LIABILITIES			
Trade And Other Payables	(52,365)	(62,318)	(9,953)
Borrowings: Finance Leases	(182)	(155)	27
Borrowings: Dh Revenue and Capital Loan - Current	(118)	(131)	(13)
Provisions for Liabilities and Charges	(769)	(339)	430
Other Liabilities	(1,685)	(3,981)	(2,297)
TOTAL CURRENT LIABILITIES	**(55,119)**	**(66,925)**	**(11,806)**
NET CURRENT ASSETS / (LIABILITIES)	**26,854**	**25,175**	**(1,679)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**261,007**	**259,663**	**(1,344)**
NON-CURRENT LIABILITIES			
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,856)	(1,798)	58
Borrowings: Finance Leases	(4,754)	(4,087)	667
Provisions for Liabilities & Charges	(36,235)	(36,437)	(200)
TOTAL NON-CURRENT LIABILITIES	**(42,845)**	**(42,322)**	**525**
TOTAL ASSETS EMPLOYED	**218,161**	**217,341**	**(820)**
FINANCED BY TAXPAYERS EQUITY			
Public Dividend Capital	106,191	106,191	0
Retained Earnings	20,575	19,755	(820)
Revaluation Reserve	91,395	91,395	0
TOTAL TAXPAYERS EQUITY	**218,161**	**217,341**	**(820)**

- Total assets less current liabilities have decreased by £1.3m since 31 March 2021.

- Total assets employed have decreased by £0.8m; of which
    - Non-current assets are £0.3m higher than at 31st March 2021.

        - Additions to the PPE portfolio, net of depreciation, have driven a £1.8m increase in value
        - Depreciation in excess of additions to Intangible assets has driven a decrease of £1.5m.
    - Inventory has remained stable.
    - Receivables are £4.0m lower than at March 2021.
    - Cash held is now £75.5m, up by £14m from the closing balance at 31st March.

- Total Liabilities (Current & Non-Current) have increased by £11.3m
    - Borrowings and loans continue along their repayment trajectory with modest decrease on the borrowings following capital repayments in M6.
    - Provision balances have decreased by £0.2m since year end.
    - Trade & Other payables make up the most significant element of the increase at £9.9m.
    - Other liabilities have increased by £2.3m.

4.1 Cash & Cash Equivalents

As at the end of December, the Trust's cash balance stands at £75.5m – an increase of £14.0m from 31 March 2021. The Trust's ongoing cash requirements have not changed materially in terms of staff pay and capital expenditure, although the Trust is striving to pay suppliers early in the current economic climate.

The National Loan Fund remains closed to Investments due to Covid 19, therefore the Trust is not able to generate any significant income on these cash balances.

5.0 Capital Expenditure

Cumulative capital expenditure at 31st December 2021 is £8.8m. The overall capital programme is £1.8m behind plan.

Discussions continue to be held monthly with the capital projects teams, so that they can manage their programmes effectively and deliver to budget over the course of the financial year.

The Trust has a forecast outturn of £22.67m including £5.57m relating to the Community Diagnostic Centre. There is currently a waiting list of business cases in the pipeline to utilise any slippage identified within the current capital programme, and these are prioritised in relation to the Trust's risk register.

Meeting title	**Trust Board – public meeting**	**Date: 27 January 2022**
Report title	**Integrated performance report**	**Agenda Item: 10**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Paul Attwal, Head of Performance and Roxanne Stevenson-Brown, Performance Team	
Executive summary	**Areas to draw to Board members' attention are:** **Emergency Department (ED) four hours' wait:** During December 2021, performance against the 4-hour access standard was 73.3%, higher than both the national average at 73.26% and the NCL average at 72.69%, but lower than the London average which was 75.26%. There was 1 non-mental health 12-hour trolley wait. There were 97 sixty-minute ambulance handover delays. **Cancer** Compliance against the national cancer standards has not been achieved since April 2020. 62-day performance was at 41.0% for November 2021. The 2 week wait (2WW) standard was not achieved in November 2021 with 69.6% against a target of >93%, predominately as a result of increase in referrals for Breast and the impact of reduced capacity for Breast cancer at North Middlesex since October 2021. **Referral to Treatment: 52 + week waits** At the end of December 2021 there were 547 patients waiting more than 52 weeks for treatment. This is 27 patients behind the December 2021 trajectory. Elective capacity has been impacted by covid and has contributed to the increase in patients over 52 weeks as compared to November 2021. **Elective recovery** December 2021 performance against the Elective Recovery Clock Stop target of 89% has been exceeded by achieving 98% of 2019/20. Overall activity declined in the last 2 weeks of December 2021 due to patient cancellations and workforce challenges due to wave three of the pandemic. **Workforce** Appraisal rates for December 2021 are at 66.0% against a target of >90%. The compliance against Mandatory Training was 82.2% in December 2021, an increase of 1% from November 2021, against a target of >90% and continues to maintain an upward trend in improvement.	

Purpose:	Review and assurance of Trust performance compliance
Recommendation	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan
Board Assurance Framework	The following BAF entries are linked: Quality 1; Quality 2; People 1; People 2.
Report history	Trust Management Group
Appendices	Appendix 1: Community Performance Dashboard Appendix 2: Community Waiting Times Dashboard Appendix 3: Cancer Performance – 62D and 2WW by Tumour Group Appendix 4: Trust Level Activity

Performance Report
January 2022

Month 09 (2021 – 2022)

Scorecard

Deliver outstanding safe, compassionate care

Indicator	21_22 Target	Reporting Mth	Step Change	Control Limit	Prev. Month	Reporting Mth	2021-2022
Emergency Department waits (4 hrs wait)	>95%	Dec			76.0%	73.3%	79.9%
Cancer - 14 days to first seen	>93%	Nov			79.3%	69.6%	77.1%
Cancer - 62 days from referral to treatment	>85%	Nov			56.9%	41.0%	64.9%
DM01 - Diagnostic Waits (<6 weeks)	>99%	Dec			96.46%	93.10%	94.48%
RTT - Incomplete % Waiting <18 weeks	>92%	Dec			76.7%	74.2%	74.6%
Referral to Treatment 18 weeks - 52 Week Waits	0	Dec			514	547	6150
Community - FFT % Positive	>90%	Dec			98.0%	98.2%	97.1%
% seen <=2 hours of Referral to District Nursing Night Service	>80%	Dec			93.8%	95.0%	94.1%
% seen <=48 hours of Referral to District Nursing Service	>95%	Dec			98.1%	95.9%	96.0%

Transform and deliver innovative, financially sustainable services

Indicator	21_22 Target	Reporting Month	Step Change	Control Limit	Prev. Month	Reporting Month	2021-2022
Theatre Utilisation	>85%	Dec			70.62%	69.54%	69.34%
Acute DNA % Rate	<10%	Dec			10.1%	11.0%	10.1%
Community DNA % Rate	<10%	Dec			7.4%	7.5%	7.3%
Outpatients New:FUp Ratio	2.3	Dec			1.82	1.85	1.83
Elective and Daycase		Dec			1954	1601	17145
Outpatient Attendances		Dec			27207	23270	235229
Community Face to Face Contacts		Dec			42900	34160	342722

Integrate care with partners and promote health and wellbeing

Indicator	21_22 Target	Reporting Mth	Step Change	Control Limit	Prev. Month	Reporting Mth	2021-2022
Breastfeeding Initiated	>90%	Dec			93.4%	91.7%	91.7%
% e-Referral Service (e-RS) Slot Issues	<4%	Dec			31.2%	35.2%	31.4%
% of MSK pts with Improvement in function (PSFS)	>75%	Dec			79.1%	81.0%	87.4%
Rapid Response - % of referrals with an improvement in care		Dec			78.7%	78.0%	81.5%

Empower, support and develop engaged staff

Indicator	21_22 Target	Reporting Month	Step Change	Control Limit	Prev. Month	Reporting Month	2021-2022
Appraisals % Rate	>90%	Dec			65.5%	66.0%	68.5%
Mandatory Training % Rate	>90%	Dec			81.2%	82.2%	77.6%
Permanent Staffing WTEs Utilised	>90%	Dec			88.0%	88.1%	88.1%
Staff FFT % recommended work	>50%	Dec					62.6%
Staff FFT response rate	>20%	Dec					18.4%
Staff sickness absence %	<3.5%	Nov			4.32%	5.50%	4.25%
Staff turnover %	<13%	Dec			12.4%	12.4%	12.0%
Vacancy Rate against Establishment	<10%	Dec			12.0%	11.9%	11.9%

Step Change	Where a new step change has been triggered by five consecutive points above or below the mean (average).
Control Limit	The Control Limit is where the latest reported month is above the upper confidence limit or below the lower confidence limit.

	If the step change or control limit icon is green, this suggests performance in changing in a positive
	If the Step change or Control Limit icon is red, this suggests performance is changing a negative

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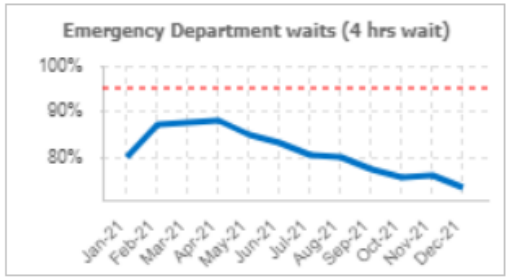
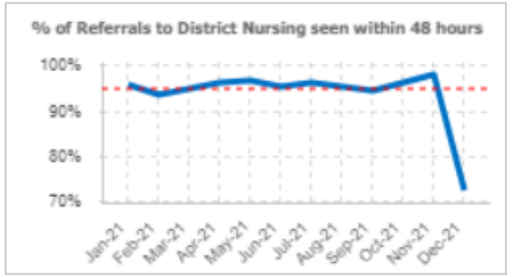
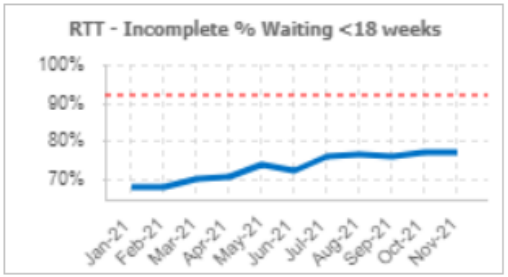
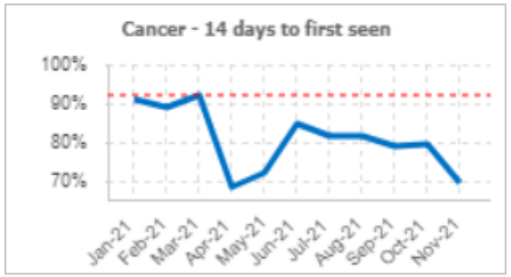
Summary

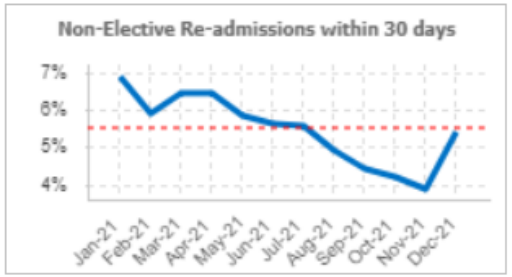
Category	Indicator	20_21 Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	2021-2022	
ED	Emergency Department waits (4 hrs wait)	>95%	79.8%	86.9%	87.6%	87.8%	84.7%	83.0%	80.5%	80.1%	77.4%	75.6%	76.0%	73.3%	79.9%	!
Cancer	Cancer - 14 days to first seen	>93%	91.2%	89.0%	91.9%	68.4%	72.0%	84.7%	81.4%	81.8%	79.1%	79.3%	69.6%		77.1%	!
Cancer	Cancer - 62 days from referral to treatment	>85%	67.4%	74.4%	77.5%	61.5%	69.4%	82.7%	72.2%	77.6%	64.1%	56.9%	41.0%		64.9%	!
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.93%	5.91%	6.45%	6.46%	5.83%	5.62%	5.56%	4.92%	4.40%	4.22%	3.90%	5.41%	5.16%	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%														
Access	RTT - Incomplete % Waiting <18 weeks	>92%	67.8%	67.6%	69.8%	70.5%	73.3%	71.9%	75.5%	76.1%	76.0%	76.7%	76.7%	74.2%	74.6%	!
Outpatients	Outpatients - FFT % Positive	>90%	94.3%	96.9%	92.3%	89.5%	97.4%	97.0%	97.5%	97.7%	96.3%	75.0%	88.9%	90.0%	93.5%	
Community	Community - FFT % Positive	>90%	98.0%	99.3%	99.6%	99.1%	99.1%	95.4%	97.1%	97.0%	95.1%	96.5%	98.0%	98.2%	97.1%	
Staff	Staff - FFT % Recommend Care	>70%			77.3%			78.3%							78.3%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	92.5%	95.8%	92.7%	85.7%	90.2%	100.0%	100.0%	100.0%	94.4%	100.0%	93.8%	95.0%	94.1%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	95.6%	93.4%	95.0%	96.4%	96.7%	95.1%	96.1%	95.1%	94.6%	96.3%	98.1%	95.9%	96.0%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	95.1%	96.6%	91.4%	95.1%	93.5%	93.7%	94.1%	91.0%	91.5%	93.6%	91.9%		93.0%	!
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	96.5%	97.0%	98.4%	96.4%	96.1%	94.1%	95.2%	97.6%	94.3%	94.0%	95.1%		95.3%	

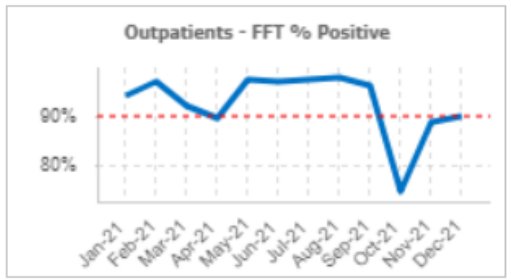












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Indicator	20_21 Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	2021-2022	Performance
Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI C Difficile	<16	2	0	0	1	0	1	0	2	0	0	0	1	5	
Actual Falls	400	34	18	27	27	31	24	30	34	27	23	21	33	250	
Category 3 or 4 Pressure Ulcers	0	14	14	21	21	10	13	13	14	20	3	4	10	108	
Medication Errors causing serious harm	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
MRSA Bacteraemia Incidences	0	1	0	1	0	0	0	0	0	0	0	0	0	0	
Never Events	0	0	0	0	0	0	0	0	1	0	1	0	0	2	
Serious Incidents	N/A	1	2	1	5	1	1	1	1	3	1	1	3	17	
VTE Risk Assessment %	>95%	66.4%	74.9%	76.9%	76.4%	73.1%	75.1%	73.9%	76.3%	77.0%	77.8%	80.7%	84.1%	77.0%	
Mixed Sex Accomodation Breaches	0	0	0	0	0	0	0	0	0	0	2	14	7	23	
Summary Hospital Level Mortality Indicator (SHMI)	1.14			0.84			0.85							0.85	

**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, Unstageable, Deep Tissue Injury and Devise Related Pressure Ulcers reported in 2021/2022 **Pan Trust Standard** 10% reduction in the total number of attributable PUs during 2020/21 compared to 2019/20 including a breakdown of Pressure Ulcers by category	**Variance against Plan: 10** **Total Trust numbers of all reported Pressure Ulcers in December 2021:** 81 (+ 17 deep tissue injuries). A total number of 65 patients were affected. There were 23 medical device related pressure ulcers. **Breakdown:** Category 2: 59 (32 in hospital, 27 in community) Category 3: 10 (5 in hospital, 5 in community) Category 4: 0 Mucosal: 1 (hospital) Unstageable: 11 (6 in hospital, 5 in community). Deep Tissue Injury: 17 (7 in hospital, 10 in community). In the hospital there was a rise across several clinical areas due to increased acuity and capacity; there was a specific rise in pressure damage attributable to the Critical Care Unit who have reported 14 pressure ulcers Category 2+, 8 of them related to medical devices; these have largely developed in Covid 19 patients. In the community setting 37 pressure ulcers and 10 deep tissue injuries developed, 23 of the 37 pressure ulcers developed in the Islington borough. **Action to Recover:** The target reduction will not be met in 2021/2022. This is as a result of the impact of Covid-19 on skin health and the need for invasive devices/treatment regimes causing unavoidable pressure on patient's skin, as well as significant staffing challenges over the past 2 years. The target will be reset for 2022/3.	**Named Person:** Lead Specialist Nurse – Tissue Viability **Time Scale to Recover Performance:** Taget not achievable in remaining timescale
VTE Risk Assessments	**Update** The results have improved but fall short of the target. This reflects positively on the electronic system introduced in November 2021 with good clinical feedback. There have been some initial issues indenftied with the surgical template, this was rectified in December 2021 and ongoing work is now in place to address the final areas where assessments are missing.	**Named Person:** Associate Medical Director for Quality Improvement and Clinical Effectiveness

		Time Scale to Recover Performance: Ongoing
Mixed Sex accommodation	**Variance against Plan: 7 against 0** **Action to Recover:** All breaches were reported in CCU. Two were as a result of ward beds not being available within four hours of fit to transfer from the unit.Five were as a result of side rooms not being available for patients requiring isolation on transfer from the unit	**Named Person:** Deputy Chief Nurse **Time Scale to Recover Performance:** March 2022
Summary Hospital-level Mortality Indicator (SHMI)	SHMI figure is 0.85 reflecting period July 2020 to June 2021	**Named Person:** Medical Director
Serious Incidents	There was three serious incidents (SIs) declarted in December 2021 1. 2021.25003 EIM - Blood product/ transfusion incident meeting SI criteria (Delay in patient with sickle cell (HBSS) receiving a blood transfusion). 2. 2021.25707 ACW- (Gynaecology) - Diagnostic incident including delay meeting SI criteria (including failure to act on test results) (Delayed Diagnosis (metastatic endometrial cancer). 3. 2021.25951 ACW - Maternity/Obstetric incident meeting SI criteria: mother and baby (this includes foetus. neonate and infant) (Intra uterine death (IUD))	**Named Person:** Quality Assurance Officer & SI Co-ordinator

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Indicator	20_21 Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	2021-2022	Performance
ED - FFT % Positive	>90%	89.0%	87.6%	84.5%	83.9%	77.6%	76.1%	75.5%	77.8%	77.7%	78.0%	74.7%	77.1%	77.6%	
ED - FFT Response Rate	>15%	10.8%	11.1%	10.1%	11.1%	11.0%	10.5%	11.0%	11.5%	10.6%	10.6%	10.5%	11.3%	10.9%	
Inpatients - FFT % Positive	>90%	99.0%	98.0%	94.6%	95.9%	95.8%	95.2%	95.9%	96.4%	94.1%	94.7%	95.9%	96.5%	95.6%	
Inpatients - FFT Response Rate	>25%	4.8%	12.6%	17.6%	17.0%	17.1%	15.1%	16.6%	13.8%	18.8%	18.1%	23.9%	16.0%	17.4%	
Maternity - FFT % Positive	>90%	100.0%	100.0%	100.0%	98.5%	100.0%	99.6%	100.0%	100.0%		99.0%	94.9%	97.8%	98.6%	
Maternity - FFT Response Rate	>15%	2.8%	8.2%	3.9%	10.2%	16.7%	22.3%	24.6%	2.2%	0.0%	16.1%	20.1%	8.4%	13.5%	
Outpatients - FFT % Positive	>90%	94.3%	96.9%	92.3%	89.5%	97.4%	97.0%	97.5%	97.7%	96.3%	75.0%	88.9%	90.0%	93.5%	
Outpatients - FFT Responses	400	123	32	26	19	38	100	40	43	27	20	54	60	401	
Community - FFT % Positive	>90%	98.0%	99.3%	99.6%	99.1%	99.1%	95.4%	97.1%	97.0%	95.1%	96.5%	98.0%	98.2%	97.1%	
Community - FFT Responses	1500	149	270	285	226	340	457	383	367	509	567	611	547	4007	
Staff - FFT % Recommend Care	>70%			77.3%			78.3%							78.3%	
Complaints responded to within 25 or 40 working days	>80%	85.7%	76.2%	83.3%	78.3%	78.9%	80.0%	66.7%	66.7%	45.7%	63.0%	78.3%		68.5%	
Complaints (including complaints against Corporate division)	N/A	7	21	24	23	19	35	24	36	35	27	23		222	

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

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - FFT % Positive Response and Response Rate : 77.1%	**Variance against Plan:** The Emergency Department has seen an improved response rate by 0.8% and has seen a larger increase in positive responses (2.4%) which is encouraging, however, department is still currently performing below target on this metric. **Action to Recover:** Plan to provide support from patient experience team continues.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** March 2022
Inpatients FFT Response Rate :	**Variance against Plan:** Inpatients showing consistent positive responses yet we have seen a sharp drop in response rate due to the increased pressure of the pandemic throughout December 2021. Improvements in response rates in maternity areas following targeted interventions from Patient Experience team. **Action to Recover:** Patient Experience team to provide support to areas with low/nil response rates, and address statistical anomalies identified on Ifor ward.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** March 2022
Community FFT Responses:	**Variance against Plan:** Response rate remains very low, although has risen steadily throughout 2021. **Action to Recover:** QR codes rolling out for community FFT, as well as more automated text messaging, particularly with MSK. The patient experience team have recruited an additional volunteer to help upload paper FFT cards in the interim, but the long term approach remains to have more accessible digital solutions.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** March 2022
Complaints responded to within 25 or 40 days:	**Complaints** The Trust had 19 complaints requiring a response in December 2021. Due to the ongoing pandemic and available staff having to prioritise patient care, with the agreement of the Chief Nurse these responses have been delayed. Any urgent issues identified in these complaints have been addressed. Those few responses that were sent in December will be reflected in the performance figures for January 2022.	**Named Person:** PALS & Complaints Manager **Time Scale to Recover Performance:** Ongoing

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Indicator	20_21 Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	2021-2022	Performance
Hospital Cancelled Operations	0	0	0	1	0	6	7	4	4	16	14	5	1	56	
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	0	0	0	0	2	0	0	2	
Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Theatre Utilisation	>85%	64.62%	50.19%	65.73%	68.80%	76.23%	75.13%	63.01%	63.23%	67.86%	69.25%	70.62%	69.54%	69.34%	
Breastfeeding Initiated	>90%	92.6%	90.2%	93.5%	93.8%	91.9%	91.3%	90.2%	89.3%	91.5%	92.0%	93.4%	91.7%	91.7%	
Mortality rate per 1000 admissions in-months	14.4	28.2	11.7	4.2	6.9	4.8	6.8	8.0	8.8	7.3	8.1	7.8	7.9	7.4	
Community DNA % Rate	<10%	7.1%	6.7%	6.6%	6.6%	6.6%	7.2%	7.5%	8.2%	7.6%	7.1%	7.4%	7.5%	7.3%	
Community Services - Provider Cancellations	<8%	17.7%	7.7%	6.2%	6.6%	6.5%	7.3%	8.1%	7.7%	7.3%	7.7%	7.7%	10.9%	7.7%	
Acute DNA % Rate	<10%	8.3%	7.5%	8.1%	8.7%	9.2%	9.4%	10.2%	11.0%	11.2%	10.5%	10.1%	11.0%	10.1%	
% e-Referral Service (e-RS) Slot Issues	<4%	27.4%	30.3%	44.2%	37.0%	29.7%	27.0%	31.1%	28.5%	35.7%	28.8%	31.2%	35.2%	31.4%	
Outpatients New:FUp Ratio	2.3	2.06	1.93	1.93	1.93	1.88	1.87	1.88	1.83	1.75	1.69	1.82	1.85	1.83	
Delayed Transfers Of Care % of Occupied Bed Days	<2.4%														
Non Elective Re-admissions within 30 days	<5.5%	6.93%	5.91%	6.45%	6.46%	5.83%	5.62%	5.56%	4.92%	4.40%	4.22%	3.90%	5.41%	5.16%	
Rapid Response - % of referrals with an improvement in care		83.2%	85.5%	81.1%	84.7%	82.6%	84.3%	82.5%	83.3%	81.2%	80.4%	78.7%	78.0%	81.5%	

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

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Theatre Cancellations On The Day :	**Variance against Plan:** 1 cancellation against a standard of zero 1 Patient was cancelled due to running out of time –the patient had surgery on the following day. **Action to Recover:** Continue planning of lists to manage prospectively. Continue to review lists in advance to evaluate what can reasonably be achieved	**Named Person:** General Manager Theatres and ITU **Time Scale to Recover Performance:** March 2022
Theatre Utilisation % Rates :	**Variance against Plan:** Theatre Utilisation was 69.54% in December 2021 compared with a target of a minimum of 85%. This is a drop of 1.08% from November 2021. As a result of the pandemic, a decision was made on the 17th December 2021 to only carry out urgent and Priority 2 surgery had an impact on overall delivery. Individual specialities have seen variable performance: • Breast 92% (increase 21% from November 2021) • Gen Surgery 78% (increase of 1% from November 2021) • Gynaecology 65% (decrease of 3% from November 2021) • Trauma & Orthopaedics 71% (decrease of 3% from November 2021) • Urology 62% (decrease of 8% from November 2021) **Action to Recover:** • Relaunch Project Hydra, a regular review meeting looking at theatre list productivity • Identify “Golden patient” to ensure theatres start on time • Start using Consultant average times by procedure to book lists • Analysis of early finish times • Recruitment drive in Admissions team to get increase substantive staff • Planning of lists is critical to ensure staffing appropriate and hence lists are well utilised	**Named Person:** General Manager Theatres and ITU **Time Scale to Recover Performance:** March 2022
Acute DNA % Rate:	**Variance against Plan:** 11% against <10% Acute DNA rates have increased in December 2021. Rates remain higher than planned as a result of the impact of Covid 19.	**Named Person:** Head of Performance

	Action to Recover: This will continue to be monitored as part of the elective recovery programme.	**Time Scale to Recover Performance:** Ongoing
Appointment Slot Issues (ASIs)	**Variance against Plan:** Performace was at 35.2% against a target of <4%. There has been an decline in performance in ASIs as a result of outpatient capacity being reduced due to the covid outbreak. Services continue to reduce the number of patients waiting more than 13 weeks on the ASI list. There are 162 patients over 13 weeks, a reduction of 100 patients. All patients on the ASI list are validated to ensure they receive their appointments in a timely way. There are no clinical concerns in this group of patients. **Action to Recover:** Data validation is ongoing to ensure the Trust maintains having no patients waiting more than 13 weeks on the ASI list.	**Named Person:** Head of Performance **Time Scale to Recover Performance:** February 2022

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Indicator	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	2021-2022	Performance
Emergency Department waits (4 hrs wait)	>95%	79.8%	86.9%	87.6%	87.8%	84.7%	83.0%	80.5%	80.1%	77.4%	75.6%	76.0%	73.3%	79.9%	
ED Indicator - median wait for treatment (minutes)	<60 mins	35	39	58	64	92	91	90	82	97	107	102	96	90	
Ambulance handovers waiting more than 30 mins	0	7	4	13	12	21	30	18	12	8	16	59	103	279	
Ambulance handovers waiting more than 60 mins	0	1	1	2	0	0	7	0	2	0	2	27	96	134	
12 hour trolley waits in A&E - Non Mental Health	0	10	0	0	0	0	0	0	0	1	1	4	1	7	
12 hour trolley waits in A&E - Mental Health	0	1	3	0	1	0	0	3	3	3	2	3	0	15	
Cancer - 14 days to first seen	>93%	91.2%	89.0%	91.9%	68.4%	72.0%	84.7%	81.4%	81.8%	79.1%	79.3%	69.6%		77.1%	
Cancer - 14 days to first seen - breast symptomatic	>93%	91.3%	60.0%	95.2%	62.5%	96.7%	88.9%	95.1%	97.6%	90.9%	93.5%	92.5%		92.9%	
Cancer - 62 days from referral to treatment	>85%	67.4%	74.4%	77.5%	61.5%	69.4%	82.7%	72.2%	77.6%	64.1%	56.9%	41.0%		64.9%	
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%	63.8%	68.9%	77.1%	60.9%	70.2%	80.8%	69.8%	76.6%	63.2%	55.8%	39.3%		63.7%	
Cancer ITT - % of Pathways sent before 38 Days	>85%	36.4%	50.0%	60.0%	50.0%	45.5%	40.0%	16.7%	28.6%	37.5%	28.6%	11.1%		33.8%	
Cancer - % Pathways received a Diagnosis within 28 Days of Referral		71.6%	82.8%	83.4%	80.7%	80.7%	80.5%	80.3%	79.3%	72.4%	72.6%	67.7%		77.0%	
Cancer - 31 days to first treatment	>96%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	92.9%	95.7%	96.6%	100.0%		97.6%	
Cancer - 31 days to subsequent treatment - surgery	>94%														
Cancer - 62 Day Screening	>90%	100.0%	50.0%		100.0%	100.0%			100.0%	60.0%	100.0%	100.0%		87.5%	
DM01 - Diagnostic Waits (<6 weeks)	>99%	68.70%	81.96%	83.52%	92.23%	94.60%	93.73%	91.71%	92.17%	96.97%	98.96%	96.46%	93.10%	94.48%	
RTT - Incomplete % Waiting <18 weeks	>92%	67.8%	67.6%	69.8%	70.5%	73.3%	71.9%	75.5%	76.1%	76.0%	76.7%	76.7%	74.2%	74.6%	
Referral to Treatment 18 weeks - 52 Week Waits	0	793	1213	1324	1050	872	750	651	639	569	558	514	547	6150	
% seen <=2 hours of Referral to District Nursing Night Service	>80%	92.5%	95.8%	92.7%	85.7%	90.2%	100.0%	100.0%	100.0%	94.4%	100.0%	93.8%	95.0%	94.1%	
% seen <=48 hours of Referral to District Nursing Service	>95%	95.6%	93.4%	95.0%	96.4%	96.7%	95.1%	96.1%	95.1%	94.6%	96.3%	98.1%	95.9%	96.0%	
Haringey New Birth Visits - % seen within 2 weeks	>95%	95.1%	96.6%	91.4%	95.1%	93.5%	93.7%	94.1%	91.0%	91.5%	93.6%	91.9%		93.0%	
Islington New Birth Visits - % seen within 2 weeks	>95%	96.5%	97.0%	98.4%	96.4%	96.1%	94.1%	95.2%	97.6%	94.3%	94.0%	95.1%		95.3%	
% of Rapid Response Urgent referrals seen within 2 Hours of R...							72.7%	50.0%	89.7%	94.2%	84.1%	88.7%	79.3%	84.4%	

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - 4 Hour Wait **Performance:** 95% of patients attending ED to be seen within 4 hours	**Variance against Plan:** During December 2021, performance against the 4-hour access standard was 73.3%, higher than both the national average at 73.26% and the NCL average at 72.69%, but lower than the London average which was 75.26%. December 2021 saw 8,179 presentations compared to 7,748 attendances in December 2020. The volume of LAS conveyances was similar to the previous month (1567). Admission rates for conveyed patients however remains stable at 39%. December 2021 saw a 13.7% increase in majors patients and a 18.2% drop in Urgent Treatment Centre patients compared to previous month. Paediatric Performance was at 89.3% against 1909 attendances. The paediatric department achieved a great than 95% performance on 11 days of the month and 100% performance on Christmas day. **Action to Recover:** The trust piloted the role of Same Day Emergency Care (SDEC) flow clinician on the week ending 5th December 2021. The aim of the pilot was to increase streaming from ED to SDEC. The pilot saw an 80% (28) increase in referrals to SDEC. This pilot has now been extended for another three months. The ED to pharmacy streaming SOP was approved at the Trust Management Group and will be rolled out in January 2022 As part of Flow Improvement Programme, ED continues to focus on Streaming and Direction, Point of care testing, optomising Rapid Assessment Treatment and SDEC and escalation.	**Named Person:** General Manager, ED **Time Scale to Recover Performance:** April 2022 January 2022 Ongoing

ED – 12 Hour Trolley Waits : 0 patients waiting more than 12 hours for a bed from a decision to admit	**Variance against Plan:** The month of December 2021 saw 1 acute 12 hour breach. The acute 12 hour breach related to management of a neurological patient awaiting bed at a tertiary referral centre. **Action to Recover:** 72 hour reports have been completed and action plans have been reviewed.	**Named Person:** General Manager, ED **Time Scale to Recover Performance:** Ongoing
ED Indicator – median wait for treatment (minutes): <60 Minutes	**Variance against Plan:** Time to treatment was at 96.3 minutes, which is a 6-minute drop compared to previous month. **Action to Recover:** The continued flow improvement work will support the reduction in median time to treat and look to improve times through January 2022.	**Named Person:** General Manager, ED January 2022
Ambulance Hand Overs:	**Variance against Plan:** There were 103 thirty minute breaches and 96 sixty minute breaches in December 2021. **Action to Recover:** The roll out of point of care (POC) COVID testing for the admission pathway has now been rolled out. The POC tests take 13 minutes to confirm COVID status compared to a minimum of 2 hours for the fast SAMBA test result. The ED and Infection Prevention Control teams are in the process of finalising POC testing for high suspicious patients at the point of entry (both walk in and LAS) to enable efficient use of isolation spaces, chairs for fit to sit patients in both red and green areas in the department. It is envisaged that both pathways will have a positive impact on LAS hand over times.	**Named Person:** General Manager, ED **Time Scale to Recover Performance:** January 2022
Cancer Performance	**November Performance** **2WW Performance =** 69.6% against the standard of 93% due to • 2WW capacity challenges in gynaecology, urology, breast & colorectal services. • Breast with a continued high level of referrals. North Middlesex currently have an alert on their breast service since October 2021 **Action to Recover:** • Continued extra clinic capacity being conducted in gynaecology	**Named Person:** GM Surgery & Cancer **Time Scale to Recover Performance:** Review Monthly

- Additional nursing support for gynaecology has been requested from NCL for support with hysteroscopy and colposcopy
- Extra breast clinics to be conducted with radiology support in planning
- Additional support from the admin urology service with booking prostate MRI's to handle high level of referrals

28 day FDS Performance = 66.4% against the standard of 83%

- Continued capacity challenges within gynaecology, breast, colorectal and urology
- Additional virtual results clinic for colorectal being set up to target 28 day performance

62 day Performance = 41% against the standard of 85%

- 32.5 treatments in November 2021
- 19 breaches - Urology 10 breaches, breast 3 due to surgical pressures, residual 6 mixed.
- Over 62 day patient waiting - volume is fairly static but is reviewed on a weekly basis
- 104 days + the trust has 30 patients waiting more than 104 days from referral to definitive treatment, these patients are reviewed regularly. Reasons for the long delays are:

  I. Reduced surgical capacity has made quick turnaround of treatment more difficult
  II. 33% of the patients are awaiting treatment at other Trusts
  III. Challenges with the colorectal pathway in October and November 2021 has resulted in days lost in the pathway
  IV. Slow to respond patients due to impact of the pandemic and patient choice

Action to Recover:

- Urology treatment pathway with Guys & St Thomas being reviewed in light with continued challenges within the pathway
- Outsourcing to Princess Grace to support surgical pressures within the breast surgical team. Only one surgeon currently operating. Another surgeon on sabbatical for 12 months and another going on maternity leave February 2022. New surgeons starting in April & May 2022
- Continued close review of cancer PTL with weekly senior management review of over 62 & 104 day long waiters
- Continued escalation to Director of Operation with any concerns

DM01 Diagnostics	**Update**: Performance against the national diagnostic waiting target for December 2021 has not been achieved. Performance was 93.1% against the 99% target. As a result of the pandemic, there was there was a reduction in capacity across diagnostic services from the 17th December 2021. This particularly impacted endoscopy and has been contributing factor to overall delivery of the DM01 indicator. Services continue to manage capacity to achieve DM01 diagnostic targets. The Community Audiology backlog is on track against against its recovery plan to be compliant from December 2022.	**Named Person:** Head of Performance **Time Scale to Recover Performance:** Ongoing
Referral to Treatment: Incomplete % waiting < 18 weeks **52 + week waits**	**Update:** Performance against the national standards for referral to treatment incomplete pathways below 18 weeks for December 2021 has not been achieved with performance at 74.24%. At the end of December 2021 there were 547 patients waiting more than 52 weeks for treatment. The majority of patients are within the Surgery and Cancer ICSU, which has an ongoing plan to support compliance by the end of the financial year. Elective capacity has been impacted by covid and has contributed to the increase in patients over 52 weeks as compared to November 2021. There are no 104-week breaches on the Trust PTL. As part of the H2 Elective Recovery, the Trust clock-stop position is compliant against the required threshold of 89%. This will be monitored on an ongoing basis as part of H2 Recovery. Performance for December 2021 was 98.0%. **Action to Recover:** Independent sector capacity continues to support the delivery of elective recovery activity including patients waiting more than 52 weeks. Vascular Surgery patients are now being treated at Hendon BMI.	**Named Person:** Head of Performance **Time Scale to Recover Performance:** Ongoing
Haringey New Births Visits - % seen within 2 weeks	**Update:** 91.6% against target of >=95% There were 25 new birth visits not completed within 14 days in Haringey in November. Of these 20 have now been completed – reasons for delay were patient choice and babies still in hospital. Of the 5 showing as not yet completed 2 babies are still in hospital, 1 has left Haringey and 2 are data quality issues that have been corrected. Service leads continue to work with teams to ensure visits are booked on time and that processes for following up with families are robust	**Named Person:** Director of Operations, CYP **Time Scale to Recover Performance:** Ongoing

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Indicator	20_21 Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	2021-2022	Performance	
Appraisals % Rate	>90%	66.6%	66.2%	66.9%	69.9%	71.9%	70.6%	70.1%	70.1%	65.3%	66.8%	65.5%	66.0%	68.5%		!
Mandatory Training % Rate	>90%	75.6%	76.2%	76.6%	75.3%	75.5%	76.1%	76.8%	74.7%	77.3%	78.8%	81.2%	82.2%	77.6%		!
Permanent Staffing WTEs Utilised	>90%	88.6%	89.0%	89.1%	88.1%	88.7%	88.0%	87.6%	87.7%	88.1%	88.6%	88.0%	88.1%	88.1%		!
Staff FFT % recommended work	>50%			68.6%			62.6%							62.6%		
Staff FFT response rate	>20%			6.6%			18.4%							18.4%		
Staff sickness absence %	<3.5%	5.62%	3.98%	3.46%	3.43%	3.82%	4.33%	4.12%	4.20%	4.34%	4.32%	5.50%		4.25%		!
Staff turnover %	<13%	9.9%	10.0%	9.9%	10.2%	11.1%	11.0%	12.8%	11.6%	14.3%	11.9%	12.4%	12.4%	12.0%		
Vacancy % Rate against Establishment	<10%	11.4%	11.0%	10.9%	11.9%	11.3%	12.0%	12.4%	12.3%	11.9%	11.4%	12.0%	11.9%	11.9%		!
Average Time to Hire (Days)	<63 Days	58	58	62	62	62	60	62	64	63	59	66	59	62		
Nursing Staff Average % Day Fill Rate - Nurses		89.7%	89.4%	85.0%	67.8%	93.9%	95.9%	95.3%	92.4%	83.8%	74.9%	85.9%	79.2%	83.8%		
Nursing Staff Average % Night Fill Rate - Nurses		93.2%	100.3%	95.5%	66.0%	91.4%	95.2%	94.5%	94.1%	91.3%	81.8%	93.1%	88.2%	86.4%		
Safe Staffing Alerts - Number of Red Shifts			19	16	5	8	5	3	33	33	36	34	36	193		
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		9.2	10.7	10.9	5.9	10.1	9.9	10.0	11.0	11.7	9.1	9.1	9.6	9.3		

! **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 : 66%	**Variance against Plan: -24%** This is a 1% improvement on last month's rate returning the Trust to the November rate. **Action to Recover:** The slow rate of recovery is likely to be a combination of refocus on the pandemic and delay in an elev8 solution to appraisal recording which continues to be strived for.	**Named Person:** Assistant Director, Learning & Organisational Development **Time Scale to Recover Performance:** 6-12 months with the latter being more likely should another surge occur. Also, given a timely solution.
Mandatory Training % Rate : 82.2%	**Variance against Plan: -7.8 %** This is a 1% improvement on last month's rate and adds to the upwards trend since November 2021. **Action to Recover:** elev8 has been well received by those who have logged in to it and makes completing courses very accessible and easy to follow. The pandemic presents an obstacle to finding time to log in to complete mandatory training. Staff are being encouraged to log in to experience the improved system.	**Named Person:** Assistant Director, Learning & Organisational Development **Time Scale to Recover Performance:** July 2022
Permanent Staffing WTEs Utilised: 88.0% Target > 90%	**Variance against Plan: 2.0%** **Action to Recover:** Permanent staff utilisation has decreased slightly in comparison to last month. The sector workforce remains unstable and work continues across NCL to address.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** June 2022
Staff Sickness Absence %: 5.49% Target < 3.5%	**Variance against Plan: 1.99%** **Action to Recover:** Absence rates continues to increase in line with the increase of community transmission of covid-19. This continues to be monitored. Recovery is a main focus, which includes support to staff at work who are already fatigued.	**Named Person:** Deputy Director of Workforce **Time Scale to Recover Performance:** June 2022

Staff Turnover Rates: 12.45% Target < 13%	**Variance against Plan: 0.55%** **Action to Recover:** Turnover rate has maintained from last month. This will continue to be monitored alongside the vacancy rates.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** June 2022
Vacancy Rates: 11.87% Target < 10%	**Variance against Plan: 1.87%** **Action to Recover:** Vacancy rate has decreased slightly from last month but is still over the Trust target. NCL continues to see a higher rate of vacancies and hard to fill posts. This will be monitored along side turnover rates.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** June 2022
Safer Staffing **Aim for:** Zero Red shifts Trust CHPPD 9.6* *Peer Trusts Median (March 2021)	**Variance against Plan:** 36 shifts were reported as Red in December 2021, which is a consistently high since August 2021. The Emergency and Integrated Medicine ICSU had 28 red shifts across all inpatient wards. 8 red shifts were recorded in Surgery & Cancer (Coyle ward). The main reasons for staffing challenges were sickness, unfilled vacant shifts, inadequate sourcing of additional staff for escalation beds due to staff unavailability, and inability to cover for enhanced care and increased acuity. Care Hours per Patient Day (CHPPD) in December 2021 improved to 9.6 which is close to the median figure of Peer Trusts. The average CHPPD on the adult wards was 8.3. Fill rate for registered staff (79%) corelates with the number of red shifts. The fill rate for unregistered staff exceeds 100% and is associated with enhanced care requirement as well as cover of nursing vacant shifts that could not be filled with registered staff. **Action to Recover:** • Senior Staff continue to address high risk staffing issues as recommended in the Staffing Escalation policy. Army volunteers supporting the areas with high activity. Clinical education team increased hours of student support in clinical settings and reduced their non-clinical activity. • Recruitment is ongoing for all nursing staff. Recruitment process streamlined and introduced KPIs to ensure swift allocation and start of new recruits. Reviewing capacity to retain qualified Nursing Associates. Continuing to support all routes into nursing projects and programmes for staff development and retention (i.e. HCAs development, preceptorship EQIPT programme)	**Named Person:** Lead Nurse for Safer Staffing **Time Scale to Recover Performance:** Ongoing

	• Lead Nurse for Safer Staffing continues to monitor the activity of the wards and assess effectiveness of staff deployment	

Appendix 1. Community Performance Dashboard

Indicator	20_21 Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	2021-2022	Performance
IAPT Moving to Recovery	>50%	50.5%	48.1%	45.0%	51.8%	49.6%	54.7%	54.8%	51.3%	53.4%	53.9%	51.4%		52.5%	
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	96.2%	92.2%	92.5%	94.2%	88.8%	92.6%	91.9%	92.1%	94.6%	90.9%	90.0%		91.7%	
Haringey - 8wk Review % carried out before child aged 8 weeks	N/A	79.9%	88.7%	92.3%	79.2%	85.3%	80.7%	86.7%	81.6%	78.0%	83.5%	82.4%		82.2%	
Haringey - HR1 % carried out before child aged 15 months	N/A	68.4%	81.2%	81.6%	79.0%	77.3%	76.3%	74.6%	73.1%	73.0%	71.2%	67.1%		74.0%	
Haringey - HR2 % carried out before child aged 30 months	N/A	70.1%	67.5%	70.1%	72.6%	72.4%	71.1%	74.5%	77.1%	75.5%	74.0%	66.1%		72.7%	
Islington - 8wk Review % carried out before child aged 8 weeks	N/A	87.5%	94.5%	90.7%	91.1%	92.8%	89.6%	87.1%	87.4%	86.6%	91.2%	91.9%		89.7%	
Islington - HR1 % carried out before child aged 15 mths	N/A	81.8%	82.0%	84.3%	80.0%	79.4%	85.0%	86.2%	85.2%	85.5%	76.1%	82.5%		82.5%	
Islington - HR2 % carried out before child aged 30 mths	N/A	81.1%	81.3%	81.6%	79.1%	83.1%	76.5%	82.1%	78.2%	75.5%	84.1%	82.7%		80.1%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	100.0%		66.7%	100.0%	88.2%	89.5%	91.1%	89.7%	90.6%	93.8%	79.1%	81.0%	87.4%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%					100.0%	100.0%	92.3%	66.7%	100.0%	100.0%	100.0%	100.0%	95.7%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	83.6%	70.7%	81.8%	83.8%	71.7%	78.0%	71.0%	79.3%	80.6%	77.0%	77.9%	70.0%	76.2%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	92.2%	93.6%	91.7%	90.9%	94.4%	92.2%	93.9%	93.8%	96.3%	93.0%	96.3%	94.9%	94.0%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	66.7%	100.0%	100.0%	100.0%	85.7%	85.7%	0.0%	100.0%	88.9%	50.0%	100.0%	66.7%	70.4%	
Nutrition and Dietetics - % Weight Loss Achieved at Discharge	>65%	100.0%			0.0%	50.0%	50.0%	100.0%	100.0%	100.0%	37.5%	83.3%	100.0%	65.4%	
Nutrition and Dietetics - % Weight Maintained or Gained at Discharge	>70%	100.0%	80.0%	83.3%	92.3%	88.9%	92.9%	85.7%	100.0%	100.0%	85.7%	100.0%	100.0%	92.8%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 we...	>45%			68.0%			183.9%			181.9%				183.0%	
Islington Self-Management - Average Increase in PAM Score	>=9														
Haringey Self-Management - Average Increase in PAM Score	>=9														

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Children community waiting times	**Overall summary:** **Haringey community paediatrics** Waits for Neuro-developomental clinics are longer due to a reduction in staff available for clinics. The team continue to prioritise urgent referrals. There is additional temporary staffing in place and vacant posts are being recruited to. **Haringey community paediatrics – SCC (autism assessment)** The impact of covid-19 continues to exacerbate existing challenges for this service. Providers and commissioners are working to reduce waits, with renewed focus following the Haringey SEND inspection in July 2021. Some short term funding has been allocated to help reduce long waits, the impact of this will be seen by June 2022. **Haringey Speech and Language Therapy (SLT):** Waits for initial appointments and provision of therapy in SLT continue to be challenging. Short term funding is helping to reduce waits for initial appointments. The key challenge is securing temporary staff to deliver additional blocks of therapy for children and young people. Trust service leads continue to work with partners in the Council and CCG to develop a longer term plan for meeting speech, language and communication needs in Haringey. **Haringey Occupational Therapy (OT):** The OT service continues to experience longer waiting times due to gaps/changes in staffing and an increase in EHCP advice requests. A plan to reduce waits is in place and is starting to have an impact, as shown by the waiting times report **Islington Children Looked After (CLA):** Increase in waiting times due to an increase in number of Unaccompanied Asylum Seeking Children (UASC) residing in refugee hotels in Islington. The service is in discussions with the CCG and Local Authority in relation to additional funding arrangements. The service is moving some community paediatric capacity to cover additional 5 clinics for UASC needed per week for the next 2 months which may negatively impact on overall CLA performance. **Islington Social Communication Team (SCT):** Continued rise in waiting time for SCT due to further increase in referrals and 2 WTE vacancies within the team. The overall waiting time this month has dropped to 30 weeks due to an increase in clinics. The service will continue to use a blended offer of virtual and face to face.	**Named person:** Director Operations CYP

	Islington Occupational Therapy (OT): This service is on the ICSU risk register due to recruitment issues. The service is moving the clinical specialist 8a when recruited to this team, to support junior clinical staff who are covering all schools in the borough. **Islington Speech and Language Therapy (SLT):** This service has 6 vacancies and 12 schools currently not covered. This issue has been raised with Local Authorities who have agreed additional funding to support the service. **Islington Community Child and Adolescent Mental Health Services (CAMHS):** The service continues to have significant waits in the Neurodevelopmental Pathway (NDP) and in Core CAMHS Therapy Team. In all other areas services are being delivered at under 8 weeks. NDP, has now mobilised and is utilsing additional capacity from Healios, who provide a digital platform for undertaking ASD assessments, which is supporting the reduction of waiting times. Additional funding secured as part of recovery planning has now been utilised and additional posts are fully recruited to.	
Adult community waiting times	**Overall summary:** By the end of December 2021 some services were paused and others reduced to essential services only to allow for redeployment to: a) The roving and hub vaccination programme b) Rapid Response Virtual Ward (RRVW) a new virtual ward (VW) service was developed with Barnet, Enfield & Haringey Mental Health Trust for North Middlesex University Hospital and VW capacity has had a threefold increase. c) The Integrated Discharge Teams with a focus on accelerating discharge from Hospital. Staff who were released for the vaccination programme have since returned to their substantive roles in to restart services on 10th January 2022. Community Matrons and the administartors for the MDT remain in the RRVW and IDT respectively. Redeployment for the vaccination programme was short lived and therefore services have not been significantly disirupted. There remains however a focus of 3 key areas for recovery : MSK, Podiatry, Pulmonary Rehabiliation (PR). <u>MSK</u> : 50% of the MSK therpists were redeployed for vaccination. Due to the high referrals rates there weill be some slippage in the recovery trajectory. The service continues to experience workforce issues but continue to actively recruit.	**Named person:** Director of Operations, ACS

	Average waiting time :CATS – 8.7 weeks, down from 8.8 weeks in November 2021 : Routine – 8.6 weeks, up from 8.5 weeks in November 2021 <u>Podiatry</u> : Workforce issues continue to be the main issue with this service. However the service has implemented some service redesign and prioritisation which showed an improving position for December. Average waiting time : 7.6 weeks, down from 8.8 weeks in November 2021 <u>Pulmonary Rehabiliation</u> : The respiratory service was paused in the recent surge as instructed by the London Respiratory Network. However it has only been closed for 4 weeks and will reopen mid January. The team have also been cleansing the waiting list. Average waiting time: 26.8 weeks down from 35.1 weeks in November 2021	

Appendix 2. Community Waiting Times Dashboard

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Oct-21	Nov-21	Dec-21	Avg Wait (Dec)	No. of Pts Seen	% Threshold	Target Weeks	Oct-21	Nov-21	Dec-21	Avg Wait (Dec)	No. of Pts Seen
CAMHS	>95%	8	54.1%	71.1%	76.9%	10.0	78	>95%	2	83.3%	100.0%	88.9%	1.1	9
Child Development Services	>95%	12	100.0%	100.0%	100.0%	1.4	7	>95%	-				-	0
IANDS	>95%	18	73.7%	77.6%	75.0%	11.4	92	>95%	2		0.0%		-	0
Community Children's Nursing	>95%	2	70.8%	79.7%	82.5%	1.3	63	>95%	1	93.1%	75.0%	100.0%	0.1	12
Community Paediatrics Services	>95%	18	58.9%	56.5%	71.7%	11.4	92	>95%	1				11.4	0
Family Nurse Partnership	>95%	12	100.0%	100.0%	100.0%	2.6	4	>95%	-				-	0
Haematology Service	>95%	12		100.0%		-	0	>95%	-				-	0
Looked After Children	>95%	4	65.2%	75.0%	73.7%	3.4	19	>95%	2				-	0
Occupational Therapy	>95%	18	42.1%	33.3%	80.0%	13.6	10	>95%	2				-	0
Physiotherapy	>95%	18	100.0%	81.6%	95.5%	7.5	44	>95%	2				-	0
PIPS	>95%	12	93.8%	100.0%	100.0%	1.3	7	>95%	-				-	0
School Nursing	>95%	12	86.8%	97.1%	99.1%	1.4	108	>95%	-				-	0
Speech and Language Therapy	>95%	8	73.5%	54.4%	72.2%	11.2	97	>95%	2	0.0%	16.7%	0.0%	6.2	3
Bladder and Bowel - Children	>95%	12				-	0	>95%	-				-	0
Community Matron	>95%	6	93.8%	95.7%	100.0%	0.6	10	>95%	2		100.0%		-	0
Adult Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	2.2	22	>95%	2	100.0%	100.0%	100.0%	1.3	4
Community Rehabilitation (CRT)	>95%	12	87.1%	89.7%	75.5%	8.7	53	>95%	2	50.0%	60.7%	47.8%	3.7	23
ICTT - Other	>95%	12	72.5%	87.3%	99.0%	3.5	101	>95%	2	53.0%	63.5%	59.7%	2.2	67
ICTT - Stroke and Neuro	>95%	12	57.9%	59.3%	81.8%	8.6	22	>95%	2	27.6%	26.7%	25.0%	3.4	24
Paediatric Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	3.7	5	>95%	2				-	0
Bladder and Bowel - Adult	>95%	12	62.1%	45.2%	69.2%	7.6	91	>95%	2				-	0
Musculoskeletal Service - CATS	>95%	6	34.8%	35.8%	40.2%	9.1	241	>95%	2	5.0%	33.3%	38.9%	3.6	18
Musculoskeletal Service - Routine	>95%	6	37.3%	29.7%	25.0%	9.0	699	>95%	2	15.2%	13.3%	16.7%	4.4	60
Nutrition and Dietetics	>95%	6	60.3%	60.8%	58.8%	5.6	148	>95%	2	100.0%	100.0%	100.0%	0.4	4
Podiatry (Foot Health)	>95%	6	27.7%	29.8%	44.5%	7.6	245	>95%	2			0.0%	3.0	1
Lymphodema Care	>95%	6	100.0%	100.0%	85.7%	3.9	7	>95%	2				-	0
Tissue Viability	>95%	6	98.0%	98.4%	100.0%	1.7	41	>95%	2				-	0
Cardiology Service	>95%	6	100.0%	96.4%	91.8%	3.1	49	>95%	2	66.7%	100.0%	50.0%	1.6	2
Diabetes Service	>95%	6	94.1%	92.0%	94.2%	4.3	52	>95%	2				-	0
Respiratory Service	>95%	6	51.7%	85.3%	29.4%	21.6	163	>95%	2		100.0%	100.0%	0.0	1
Spirometry Service	>95%	6	94.0%	91.8%	43.8%	5.6	16	>95%	2				-	0

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Appendix 2. Community Waiting Times Dashboard

Haringey

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Oct-21	Nov-21	Dec-21	Avg Wait (Dec)	No. of Pts Seen	% Threshold	Target Weeks	Oct-21	Nov-21	Dec-21	Avg Wait (Dec)	No. of Pts Seen
CAMHS	>95%	8	0.0%	0.0%	100.0%	2.7	1	>95%	-				-	0
Child Development Services	>95%	12	100.0%	100.0%	100.0%	1.4	7	>95%	-				-	0
IANDS	>95%	18	100.0%	100.0%	100.0%	10.1	2	>95%	2				-	0
Community Children's Nursing	>95%	2	85.7%	100.0%	90.0%	1.0	10	>95%	1	100.0%	100.0%	100.0%	0.0	1
Community Paediatrics Services	>95%	18	51.6%	44.7%	63.3%	14.6	60	>95%	1				14.6	0
Family Nurse Partnership	>95%	12				-	0	>95%	-				-	0
Haematology Service	>95%	12				-	0	>95%	-				-	0
Looked After Children	>95%	4	70.0%	66.7%	40.0%	4.7	5	>95%	2				-	0
Occupational Therapy	>95%	18	41.2%	31.3%	77.8%	15.1	9	>95%	-				-	0
Physiotherapy	>95%	18	100.0%	82.2%	97.7%	7.0	43	>95%	2				-	0
PIPS	>95%	12	92.9%	100.0%	100.0%	1.3	5	>95%	-				-	0
School Nursing	>95%	12	84.6%	95.2%	94.4%	2.8	18	>95%	-				-	0
Speech and Language Therapy	>95%	8	47.5%	34.7%	69.8%	11.7	53	>95%	2	0.0%	0.0%	0.0%	2.4	2
Bladder and Bowel - Children	>95%	-				-	0	>95%	-				-	0
Community Matron	>95%	6	100.0%	100.0%		-	0	>95%	-				-	0
Adult Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	2.3	21	>95%	2	100.0%	100.0%	100.0%	1.3	4
Community Rehabilitation (CRT)	>95%	12	100.0%		0.0%	12.1	1	>95%	2			0.0%	9.5	2
ICTT - Other	>95%	12	71.4%	87.2%	98.9%	3.5	91	>95%	2	56.7%	63.0%	61.3%	2.2	62
ICTT - Stroke and Neuro	>95%	12	58.8%	61.5%	81.8%	8.6	22	>95%	2	26.9%	26.7%	23.8%	3.5	21
Paediatric Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	3.8	4	>95%	2				-	0
Bladder and Bowel - Adult	>95%	12	50.0%	42.0%	72.2%	7.2	36	>95%	2				-	0
Musculoskeletal Service - CATS	>95%	6	39.3%	42.8%	42.7%	8.6	143	>95%	2	14.3%	47.1%	54.5%	2.9	11
Musculoskeletal Service - Routine	>95%	6	36.0%	27.5%	26.9%	8.9	331	>95%	2	11.1%	20.6%	22.7%	3.5	22
Nutrition and Dietetics	>95%	6	60.7%	54.8%	58.9%	5.7	95	>95%	2		100.0%	100.0%	0.4	2
Podiatry (Foot Health)	>95%	6	25.9%	26.1%	45.5%	7.5	112	>95%	2			0.0%	3.0	1
Lymphodema Care	>95%	6	100.0%	100.0%	100.0%	4.4	1	>95%	2				-	0
Tissue Viability	>95%	6	97.0%	97.2%	100.0%	1.7	21	>95%	2				-	0
Cardiology Service	>95%	6	100.0%	94.1%	92.9%	3.0	28	>95%	2				-	0
Diabetes Service	>95%	6	93.9%	100.0%	97.4%	4.3	38	>95%	2				-	0
Respiratory Service	>95%	6	37.9%	70.6%	22.4%	24.1	85	>95%	2			100.0%	0.0	1
Spirometry Service	>95%	6	93.9%	91.8%	43.8%	5.6	16	>95%	2				-	0

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Appendix 2. Community Waiting Times Dashboard

Islington

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Oct-21	Nov-21	Dec-21	Avg Wait (Dec)	No. of Pts Seen	% Threshold	Target Weeks	Oct-21	Nov-21	Dec-21	Avg Wait (Dec)	No. of Pts Seen
CAMHS	>95%	8	53.1%	72.9%	73.1%	11.4	67	>95%	2	100.0%	100.0%	87.5%	1.1	8
Child Development Services	>95%	12		100.0%		-	0	>95%	-				-	0
IANDS	>95%	18	73.8%	78.1%	73.6%	11.8	87	>95%	2		0.0%		-	0
Community Children's Nursing	>95%	2	69.2%	76.8%	78.3%	1.5	46	>95%	1	92.0%	73.9%	100.0%	0.1	11
Community Paediatrics Services	>95%	18	76.0%	96.7%	88.9%	5.3	27	>95%	1				5.3	0
Family Nurse Partnership	>95%	12	100.0%	100.0%	100.0%	2.6	4	>95%	-				-	0
Haematology Service	>95%	12				-	0	>95%	-				-	0
Looked After Children	>95%	4	58.3%	72.7%	83.3%	3.2	6	>95%	2				-	0
Occupational Therapy	>95%	18		0.0%		-	0	>95%	-				-	0
Physiotherapy	>95%	18	100.0%	0.0%	0.0%	28.7	1	>95%	-				-	0
PIPS	>95%	12			100.0%	1.3	2	>95%	-				-	0
School Nursing	>95%	12	87.5%	98.3%	100.0%	1.0	69	>95%	-				-	0
Speech and Language Therapy	>95%	8	92.1%	80.3%	73.3%	10.3	30	>95%	2			0.0%	13.7	1
Bladder and Bowel - Children	>95%	12				-	0	>95%	-				-	0
Community Matron	>95%	6	93.1%	95.3%	100.0%	0.6	10	>95%	2		100.0%		-	0
Adult Wheelchair Service	>95%	8		100.0%		-	0	>95%	-				-	0
Community Rehabilitation (CRT)	>95%	12	89.3%	90.1%	76.5%	8.7	51	>95%	2	53.8%	63.0%	50.0%	3.3	20
ICTT - Other	>95%	12	90.0%	100.0%	100.0%	4.1	4	>95%	2	0.0%	100.0%	0.0%	3.2	3
ICTT - Stroke and Neuro	>95%	12	100.0%	0.0%		-	0	>95%	2	100.0%	-	50.0%	1.6	2
Paediatric Wheelchair Service	>95%	8			100.0%	3.3	1	>95%	-				-	0
Bladder and Bowel - Adult	>95%	12	70.6%	47.6%	66.7%	7.9	54	>95%	2				-	0
Musculoskeletal Service - CATS	>95%	6	28.0%	28.1%	37.2%	9.6	94	>95%	2	0.0%	0.0%	0.0%	6.0	5
Musculoskeletal Service - Routine	>95%	6	38.4%	31.2%	21.8%	9.2	335	>95%	2	27.3%	10.3%	12.9%	5.0	31
Nutrition and Dietetics	>95%	6	58.3%	69.2%	56.0%	5.7	50	>95%	2	100.0%	100.0%	100.0%	0.1	1
Podiatry (Foot Health)	>95%	6	30.3%	33.8%	43.5%	7.7	131	>95%	2				-	0
Lymphodema Care	>95%	6	100.0%	100.0%	80.0%	4.5	5	>95%	2				-	0
Tissue Viability	>95%	6	100.0%	100.0%	100.0%	1.7	17	>95%	2				-	0
Cardiology Service	>95%	6	100.0%	100.0%	90.0%	3.1	20	>95%	2	66.7%	100.0%	50.0%	1.6	2
Diabetes Service	>95%	6	100.0%	81.0%	85.7%	4.5	14	>95%	2				-	0
Respiratory Service	>95%	6	65.5%	100.0%	38.4%	18.7	73	>95%	2		100.0%		-	0
Spirometry Service	>95%	6	100.0%			-	0	>95%	2				-	0

Children's Community Waits Performance

SERVICE	ROUTINE REFERRALS							URGENT REFERRALS						
	% Threshold	Target Weeks	Oct-21	Nov-21	Dec-21	Avg Wait (Dec)	No. of Pts Seen	% Threshold	Target Weeks	Oct-21	Nov-21	Dec-21	Avg Wait (Dec)	No. of Pts Seen
CAMHS	>95%	8	54.1%	71.1%	76.9%	10.0	78	>95%	2	83.3%	100.0%	88.9%	1.1	9
Community Children's Nursing - Haringey	>95%	2	100.0%	100.0%	66.7%	2.3	3	>95%	1				-	0
Community Children's Nursing - Islington	>95%	2	69.6%	79.5%	83.3%	1.2	60	>95%	1	93.1%	75.0%	100.0%	0.1	12
Community Paediatrics - Haringey (SCC)	>95%	18	20.8%	7.7%	15.4%	40.8	13	>95%	1				-	0
Community Paediatrics - Haringey (NDC)	>95%	18	21.4%	23.8%	36.8%	18.1	19	>95%	1				-	0
Community Paediatrics - Haringey (Child Protection)	>95%	18	100.0%	100.0%	100.0%	0.7	28	>95%	1				-	0
Community Paediatrics - Haringey (Other)	>95%	18	100.0%	100.0%	100.0%	2.7	3	>95%	1				-	0
Community Paediatrics - Islington	>95%	18	77.3%	96.7%	89.3%	5.2	28	>95%	1				-	0
Family Nurse Partnership - Islington	>95%	12	100.0%	100.0%	100.0%	2.6	4	>95%	-				-	0
Haematology Service - Islington	>95%	12		100.0%		-	0	>95%	-				-	0
IANDS	>95%	18	92.9%	100.0%	100.0%	3.4	6	>95%	2		0.0%		-	0
IANDS - SCT	>95%	20	0.0%	5.3%	0.0%	29.6	22	>95%	2				-	0
Looked After Children - Haringey	>95%	4	70.0%	85.7%	71.4%	3.5	7	>95%	2				-	0
Looked After Children - Islington	>95%	4	61.5%	75.0%	80.0%	3.3	10	>95%	2				-	0
Occupational Therapy - Haringey	>95%	18	42.1%	33.3%	87.5%	11.2	8	>95%	2				-	0
Occupational Therapy - Islington	>95%	18	33.3%	27.3%	80.0%	8.4	5	>95%	2				-	0
Paediatrics Nutrition and Dietetics - Haringey	>95%	12	100.0%	100.0%	100.0%	3.0	3	>95%	-				-	0
Paediatrics Nutrition and Dietetics - Islington	>95%	12	85.7%	100.0%	100.0%	1.0	2	>95%	-				-	0
Physiotherapy - Haringey	>95%	18	100.0%	81.6%	95.5%	7.5	44	>95%	2				-	0
Physiotherapy - Islington	>95%	18	98.3%	100.0%	100.0%	6.9	44	>95%	2				-	0
PIPS	>95%	12	100.0%	100.0%	100.0%	1.3	7	>95%	-				-	0
SALT - Haringey	>95%	13	51.0%	37.1%	71.4%	11.5	56	>95%	2	0.0%	16.7%	0.0%	6.2	3
SALT - Islington	>95%	13	91.9%	84.7%	73.9%	10.0	23	>95%	2				-	0
SALT - MPC	>95%	18	88.0%	73.1%	72.2%	12.0	18	>95%	-				-	0
School Nursing - Haringey	>95%	12	84.8%	94.2%	94.4%	2.7	18	>95%	-				-	0
School Nursing - Islington	>95%	12	88.1%	98.6%	100.0%	1.2	89	>95%	-				-	0

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

Cancer - 62D Performance by Tumour Group

Indicator	20_21 Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	2021-2022	Performance
Breast	>85%	75.0%	100.0%	66.7%	50.0%	86.7%	100.0%	57.1%	76.5%	25.0%	60.0%	0.0%		60.4%	
Gynaecological	>85%	0.0%	100.0%	33.3%	100.0%	100.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%		26.7%	
Haematological (Excluding Acute Leukaemia)	>85%	100.0%		100.0%	50.0%	100.0%	0.0%	100.0%		100.0%		100.0%		80.0%	
Lower Gastrointestinal	>85%	80.0%	71.4%	86.7%	70.0%	60.0%	100.0%	75.0%	71.4%	100.0%	0.0%	50.0%		65.2%	
Lung	>85%	33.3%	100.0%	100.0%	37.5%	100.0%	100.0%	66.7%	100.0%	50.0%		100.0%		66.7%	
Other	>85%	100.0%									100.0%			100.0%	
Skin	>85%	100.0%	100.0%	96.3%	100.0%	100.0%	100.0%	100.0%	100.0%	95.2%	88.2%	66.7%		95.0%	
Testicular	>85%			100.0%	100.0%			100.0%						100.0%	
Upper Gastrointestinal	>85%	0.0%	75.0%	75.0%	100.0%	66.7%	100.0%	0.0%	100.0%	66.7%	0.0%			58.8%	
Urological (Excluding Testicular)	>85%	66.7%	33.3%	33.3%	28.6%	16.7%	66.7%	88.9%	85.7%	54.2%	35.3%	33.3%		47.7%	

Cancer - 2WW Performance by Tumour Group

Indicator	20_21 Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	2021-2022	Performance
Breast	>93%	85.4%	67.2%	84.0%	37.6%	31.9%	80.2%	96.7%	96.1%	96.0%	98.2%	91.1%		77.9%	
Childrens	>93%		100.0%				0.0%							0.0%	
Gynaecological	>93%	85.4%	94.7%	89.7%	94.7%	96.3%	88.3%	74.2%	91.5%	91.3%	93.1%	68.7%		88.4%	
Haematological	>93%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	96.2%	95.7%	95.0%	75.0%		94.5%	
Lower Gastrointestinal	>93%	93.2%	94.0%	88.9%	48.7%	78.2%	84.8%	61.8%	35.1%	21.8%	2.8%	5.8%		45.9%	
Lung	>93%	83.3%	100.0%	100.0%	33.3%	75.0%	80.0%	50.0%	100.0%	66.7%	80.0%	91.3%		79.7%	
Skin	>93%	98.6%	98.8%	99.6%	97.9%	96.1%	96.4%	95.6%	96.2%	92.9%	96.7%	88.0%		94.6%	
Upper Gastrointestinal	>93%	82.6%	87.5%	98.6%	98.6%	100.0%	91.7%	96.2%	98.5%	96.6%	98.1%	100.0%		97.1%	
Urological	>93%	97.4%	100.0%	98.0%	58.0%	46.0%	52.7%	58.9%	68.0%	52.4%	56.9%	67.2%		58.5%	

Appendix 4. Trust Level Activity

Category	Indicator	20_21 Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Activity
ED	ED Attendances	8285	6409	6304	8890	8861	9291	9663	9352	8532	9274	9432	9089	8179	
ED	ED Admission Rate %		21.8%	19.4%	15.9%	15.6%	13.8%	13.4%	13.7%	13.2%	12.6%	12.5%	12.1%	12.8%	
Community	Community Face to Face Contacts		31561	31887	39687	37222	41092	39055	36726	32956	38018	40274	42759	33675	
Admissions	Elective and Daycase		978	1167	1778	1815	1873	2052	2047	1944	2003	1856	1953	1592	
Admissions	Emergency Inpatients		2138	2025	2281	2234	2043	2180	2058	1937	1940	1972	1931	1777	
Referrals	GP Referrals to an Acute Service		8963	10007	12891	11995	12743	13880	13364	12328	12617	14685	14945	12001	
Referrals	% of GP Referrals that were completed via ERS		82.3%	85.3%	87.1%	88.1%	88.5%	86.4%	86.7%	86.1%	84.4%	86.8%	85.6%	85.8%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	27.4%	30.3%	44.2%	37.0%	29.7%	27.0%	31.1%	28.5%	35.7%	28.8%	31.2%	35.2%	
Maternity	Maternity Births	320	285	290	331	329	288	315	309	323	288	319	324	279	
Maternity	Maternity Bookings	377	397	359	391	458	356	322	369	306	327	319	326	339	
Outpatients	Outpatient DNA Rate % - New	<10%	8.8%	7.8%	8.8%	9.3%	10.1%	9.7%	10.8%	11.9%	11.9%	10.9%	10.5%	11.4%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	8.0%	7.4%	7.6%	8.3%	8.4%	9.2%	9.8%	10.3%	10.8%	10.2%	9.8%	10.7%	
Outpatients	Outpatient New Attendances		7279	7950	9437	8927	8719	9841	9330	8303	9817	9797	9459	8042	
Outpatients	Outpatient FUp Attendances		14962	15349	18223	17245	16368	18365	17554	15371	17481	16931	17540	14933	
Outpatients	Outpatient Procedures		4361	4690	5934	5571	5412	6165	5826	5258	5777	5718	5747	5184	

Meeting title	**Trust Board – public meeting**	**Date: 27 January 2022**
Report title	**2021/22 Quarter three delivery of Corporate Objectives**	**Agenda item: 11**
Director leads	Michelle Johnson, Chief Nurse & Director of Allied Health Professionals, Clare Dollery, Medical Director, and Carol Gillen, Chief Operating Officer (Quality entries); Norma French, Director of Workforce, (People entries); Siobhan Harrington, Chief Executive, and Jonathan Gardner, Director of Strategy, Development and Corporate Affairs (integration entries); and Kevin Curnow, Chief Finance Officer (sustainability entries),	
Report author	Jonathan Gardner	
Executive summary	Board members are presented with the quarter three outcomes for performance indicators linked to the delivery of Whittington Health's annual corporate objectives (see appendix 1). The Board is asked to note the obvious COVID context to this update of progress against our strategic objectively. In particular, it is worth noting the different RAG ratings between this paper and our risk paper. This paper shows a RAG rating based on progress towards objectives, it is not indicating the risk to outcomes or staff morale as that is covered by our risk register	
Purpose	Note	
Recommendation	Trust Board members are asked to receive and note the outcomes against performance indicators for delivery of Whittington Health's corporate objectives in quarter three 2021/22.	
Board Assurance Framework	All entries	
Report history	Trust Management Group, Executive team	
Appendices	1: Q3 delivery of corporate objectives	

2021/22 objectives
QUARTER THREE
UPDATE
V6

Deliver outstanding safe and compassionate care in partnership with patients

Exec: Chief Nurse / MD

Committee: Quality

worse
better
Same

Key metrics	Target	Score	RAG
SHMI score		0.85 June 2021	
Readmission rate	5.5%	4.5%	
Pressure ulcers grd. 4 and 3	Reduce	Average 4.5 in q2 Average 15.67 in q1	
FFT % satisfaction	90%	Average q 1 90.3%	

Key metrics	Target	Score	RAG
RTT	92%	75%	
ED 4hr	95%	75%	
Adult community metrics green	Improve	8 /23	
Child community	Improve	10/25	

Key metrics	Target	Score	Direction and RAG
PALS response time	80%	45.7%	
48hrs DN referral	95%	72.3%	
2hr referral (pending)	N/A	95%	

Objective	Progress in last quarter (Q2)
Complete CQC action plan and improving trust safety rating to "good" • Embedding role and function of learning from deaths with medical examiners • Learning from serious incidents and never events • Medicine management	• Learning from Never Event in Acute Admission Unit in relation to inadvertent connection of a patient to oxygen instead of air; no harm to patient and action shared to ensure air flowmeters were replaced with nebuliser machines across Trust to mitigate future risk. • Perfect Ward audits in progress for Medicines Management. Immediate actions taken on one of the medical wards to improve medicines management following poor compliance with audit. • Internal Audit review of CQC Action Plan: table top review in progress, on site peer reviews postponed due to Covid pressures • Most mortality reviews identified excellent standards of care, with relatives expressing thanks and early end of life and palliative measures taken.
Develop an effective Better Never Stops programme, incorporating actions from previous CQC inspections, focused on maintaining CQC readiness, following our QI strategy, and listening to patients	• CQC requested a remote monitoring meeting with Emergency Department services to review patient flow, winter pressure planning and actions from previous CQC inspection. Positive verbal feedback received from CQC. • Haringey SEND inspection report received in Q3: Inspectors recognised recent improvement in Haringey and praised the leadership and joint commissioning arrangements. Work in progress to address actions highlighted include using additional funding to increase number of assessments offered to reduce autism assessment waiting times, and accelerator funding to reduce therapy backlog. • Work ongoing to maintain CQC preparedness, particularly in maternity areas. An observation week was undertaken in Maternity in December to review patient flow and identify any bottlenecks in care delivery.
Deliver on Year 2 objectives of 3 year quality priorities • Improving communication =Reducing harm from hospital acquired deconditioning • Improving blood transfusion safety culture at the hospital • Improving understanding of human factors	• Human factors approach to learning from serious incidents used with a focus on systems thinking to address patient safety risks • Multi-disciplinary training on 'Dear patient' letters continued in Q3 and 'leadership boards' developed to show progress within services; 100% of sampled Respiratory letters explained medical language and used clear language, with Diabetes and Endocrinology also showing significant improvement in making letters accessible for our patients. • Work ongoing to improve compliance with blood transfusion training on one -learning platform 'Elev8'
Deliver on Year 3 objectives of the Patient Experience Strategy	• Consultation for launch of new Patient Experience Strategy 2022-5 scheduled for Patient Experience Group on 26th January 2022 • Key updates on progress against Year 3 Patient Experience Strategy 2019-22; • Complaint response performance improved from 47% fall in October to 78% in November. Complaint responses paused for December/ January. • Funding being sought to purchase suitable software to provide key templates in Easy Read formats; Ambitious about Autism will format Easy Read information for Complaints leaflet • PALS and Facilities Leads revised pathway to deal with patient transport concerns with DHL lead
Maintain expanded rapid response services across adult and CYP and re-start other community services	• Expanded SDEC continues. Next step is to embed LAS to SDEC pathway (January) • Children's services continue to progress reduction in backlog using a combination of face to face and virtual platforms.
Deliver our part in the roll-out of the COVID-19 vaccine to staff and public	• Flu and Covid-19 Booster Programme in progress, launched 4/10/21

Empower support and develop engaged staff

Exec: Workforce Director / COO

Committee: WAC

worse
better
Same

Key metrics	Target	Score	Direction and RAG
Turnover rate	13%	12.3%	
Vacancy rate	10%	11.5%	
Appraisal rate	90%	66.1%	
Mandatory training	90%	80.7%	

Key metrics	Target	Score	Direction and RAG
Staff Sickness	3.5%	6%	
Likelihood BAME candidate being appointed	1	1.64	
Staff FFT/Pulse response rate	20%	51% staff survey	

Key metrics	Target	Score	Direction and RAG
Relative likelihood of disciplinary for BAME	1	1.57	
% staff recommending WH as place to work	65%	*(57.3% 2nd qtr)*	

Objective	Progress last quarter
Protect our staff by following National infection control and prevention guidance and using the right Personal Protective Equipment (PPE) with special focus on supporting vulnerable staff	The focus on training staff in standard precautions, ensuring that staff maintain competence in respiratory precautions has continued throughout this quarter. This includes supporting staff with accessing the available fit testing for FFP3 masks. The infection prevention and control team have been visible across the hospital and available for consultation and advice to all areas of the community. A focus on managing COVID-19 outbreaks in staff and clinical areas a priority.
Continually improve our culture in line with the People Plan by implementing the Cultural and WRES/WDES action plans focussing on engagement and bullying and harassment Promote inclusive, compassionate leadership, accountability and team working	- Directors of REDI in post for 3 months and update to WAC , TMG and Trust Board. - Equality Strategy under development and negotiation with Staff Side - Inclusion Committee in Place - EDI Action Plan Approved for 12 months - Disability Confident - Review of learning and development interventions - Bid for resourcing Staff Networks underway
Work with NCL to continually improve recruitment, talent management and occupational health	North London Partners Shared Service approved by NCL CEOs – hosted by RFL approved. Recruitment shared services planned to go live in December 2021. Employment law tender awarded October 2021 . Collaborative Bank in place. OH hub and spoke model approved in principle for May 2022 launch
Care for staff and support staff recovery through mental health work, celebrations, and time to reflect and recuperate	Health and wellbeing offerings consistently updated on Trust intranet with corporate Communications ensuring wide dissemination. Director visibility continues with a focus on health and wellbeing Health and wellbeing discussions with all staff being promoted through Manager's Forum and to be captured on Elev8. TMG receiving update on H&WB offerings in November 2021
Develop and support clinical leads and middle managers, and improve professional standards and ways of working – hospital and community – PDN and CNS leadership development	Manager's Forum now an active part of Trust architecture with programme of events in place. Managers Drop In sessions in place in readiness for vaccination as a condition of deployment (VCOD) legislation.
Roll-out agile working and ensuring that we support working safely in offices, at home and clinical environments	Additional 200 laptops rolled out across the Trust in q3 A piece of work to reconfigure offices in Jenner and Highgate wing to support a more hot-desking type approach has begun.
Staff Networks - Resourcing and supporting staff networks	Following networks in place: B.A.M.E., Whitability, Women's, LGBTQ+ EDI Lead post advertised Business case to resource staff networks being developed Increased resources within the EDI structure will provide some much needed support

Integrate care with partners and promote health and well-being

Exec: Director of Strategy / COO

Committee: Board

worse
better
Same

Key metrics	Target	Score	RAG
DTOC rate (no longer available)	2.5%	N/A	N/A
Oncology project status	Green	Green	
Anchor institution self assessment metrics	Improve	Approx 2.6	

Key metrics	Target	Score	RAG
Percentage of staff local	Trend up	*(51% 2nd qtr)*	
Dermatology project	Green	Red	

Objective	Progress last quarter
Be a beacon for integrated care, leading models in NCL, expanding and improving the new model of care in localities with our primary care, PCN, council and voluntary sector partners to proactively care for vulnerable people in the community	We currently have the following ARRS roles a). 4 MSK FCP's with N1 PCN in Islington b) Paramedic employed by GP fed in Islington will start in our Rapid Response in February c. Contract negotiations underway for 2-3 nursing associates to work across 2 Haringey PCN's as well as our DN service. Community Hub in Wood Green system SOC approved. Opportunity in the shopping city is possibly less likely, although an interim business case review for a non-binding offer by the end of January could lead to progress and then public consultation. Community Diagnostic Hub in Wood Green approved and progressing fast although delay to opening until July 2022. Business case for phase 2 has begun.
Play our role as an anchor institution to prevent ill-health and empower self-management by making every contact count, engaging with the community, becoming a source of health advice and education and **tackling inequalities**, including inequalities facing people with learning disabilities and/or Autism and serious mental ill-health	Action plan being monitored through Integrated Forum and TMG. Working on streams around employment, procurement, buildings and environment. We are working with Islington and Haringey on mentoring schemes for young people and with the Health and Social care Academy in our development work for employing and developing local residents as Healthcare workers. The Salary sacrifice scheme was agreed at TMG and will support staff with access to electronic equipment for their families. Work on di-biasing interviews in being put in place. Social value as a domain for evaluating bids through procurement currently at 5% will increase to 10% from April 22 as per legislation. The Green plan to be ratified at Trust board March 22. The WH has tested access to HealtheIntent and planning to live by end of March 22. The development work for HEI to access to WH data by Cerner with a view to be live Q2.
Deliver the **orthopaedic hub** with UCLH, a **joint oncology** model with UCLH, and **a joint dermatology** model with NMUH, support system changes in **paediatrics**, work with **C&I on development of new hospital**	Orthopaedic hub now fully embedded but activity numbers sent to WH from UCLH remain low. However, WH are providing mutual aid in other areas – Orthopaedic and General Surgery support to RF, plus Urology support to UCLH. Oncology service considerably strengthened by the recent arrival of three new shared oncology posts with UCLH, additional nursing and pharmacy posts to start soon funded by the cancer alliance. Work underway to finalise the commissioning/partnership arrangements for the joint Oncology service. Dermatology with NMUH is still on hold although Siobhan is now NCL lead.
Shape and steer borough partnerships, ICS board and Provider Alliance, develop response to community review	We continue to be on all the relevant committees, with strong representation on the Provider Alliance. Community review is drawing to a close, concerns for us about the scope of the 'core offer' and what happens to funding and services outside of that core offer.

Transform and develop financially sustainable innovative services

Exec: Finance Director / COO

Committee: TMG

worse
better
Same

Key metrics	Target	Score	RAG
% CIP delivery against target	100% (£9.2m)	£3.9m Forecast (42%) £2.7m YTD delivered.(29%) £1.1m Further Identified (12%)	
Average beds used	197	212	
Financial position	Annual Plan (£2,460k deficit)	YTD Actual - (£742k deficit) FOT - Break Even	
Capital spend against plan	Annual Plan (£17.1m)	YTD Actual - £8.4m (49%) FOT - £17.1m	
Average LOS Non-elective	4	4.8	
Predicted versus actual discharges		174%	

Key metrics	Target	Score	RAG
% super stranded pts	18%	16.74%	
Elective activity against recovery plan	85% ERF in December	85.6% in December	
Theatre utilisation	>85%	69.3%	
Virtual vs face to face outpatients	25%	23.3%	
Innovation project status	Green	Green	
Maternity project status	Green	Green	
Estates transformation plan	Green	Green	

Objective	Progress since last quarter
• Transform maternity and neonatal services including starting refurbishment and models of care	Maternity phase 1 business case approved. CofC delayed due to covid staffing issues. IT programme rolling out this month. Ockenden business case still going through internal process. Culture work improvement being seen.
• Transform outpatients including virtual by default	Progress with PIFU (Patient initiated follow up) – we will have extended to 5 clinical specialties. The percentage of Virtual clinics for Q3 was 20% - it is expected that this will improve as the non admitted backlog reduces. There are three services who fully implemented PIFU – rheumatology and Haematology are due to follow over January 22
• Continue to build on our strengths in community dentistry and our outstanding community services	The Dental recovery plan implemented to tackle backlog in services. Community services are continuing to work with the system on the 'core offer' for the review. The Rapid Response Virtual Ward offer in collaboration with BEH was rolled out in December replicating services provided at WH
• Design financial recovery plan with system partners to achieve financial sustainability	H1 financial position met. Trust is forecasting to achieves its H2 and combined H1 & H2 financial position for 21/22. Financial planning for 2022/23 to be developed at ICS level.
• Deliver in year financial targets	On plan at Month 9
• Deliver community estate transformation plans (Tynemouth Road)	Tynemouth slightly over budget but managed within capital availability this year. On track for delivery in time for move from St Anns.
• Complete fast follower, create a new digital strategy and deliver agile working	Digital Strategy progress is now being monitored through the Digital and Innovation Group and Committee. A total of 200 devices were rollout to in Q3 to support agile working including WFH
• Improve and innovate in digital, data, and analytics, using data to transform services	Celebration event was very successful in November further one planned. Meetings have been held with UCLH as BRC hosts for how we can play a bigger role in the next BRC
• Conclude PFI deal and begin rectification of PFI	Survey work of the building ongoing until 21/22 Q4/Q1 22/23 21/Q4. Legal dispute remains. Fire door remediation work complete. Fire Door replacement completion due Q4
• Full realisation of new WEC facilities to develop education and research	The WEC build has been delayed. Completion date Q4 21/22.

Meeting title	**Trust Board – public meeting**	**Date: 27 January 2022**
Report title	**Audit & Risk Committee Chair's Assurance report**	**Agenda item: 12**
Committee Chair	Rob Vincent, Non-Executive Director	
Executive director lead	Kevin Curnow, Chief Finance Officer	
Report authors	Marcia Marrast-Lewis, Assistant Trust Secretary, and Swarnjit Singh, Joint Director, Race, Equality, Diversity & Inclusion and Trust Secretary	
Executive summary	This report details areas of assurance from the items considered at the Audit and Risk Committee meeting held on 20 January 2022. **Areas of significant assurance:** • Internal audit reviews – Capital Planning; Business Planning • Board Assurance Framework • 2021/22 Annual Report timetable and draft Annual Governance Statement • Annual review of the risk management strategy and risk appetite statement **Areas of moderate assurance:** • Corporate risk register • Internal audit plan and progress report • Internal audit review – Postgraduate Medical Education In addition, the Committee also considered an update on counter fraud activity and the draft external audit plan.	
Purpose:	Approval	
Recommendation(s)	Board members are invited to note the Chair's assurance report for the meeting held on 20 January 2022 and to agree the Risk Management Strategy and Risk Appetite Statement following its annual review	
Board Assurance Framework	All entries	
Report history	Public Board meetings following each Committee meeting	
Appendices	Risk Management Strategy and Risk Appetite Statement	

Committee Chair's Assurance report

Committee name	Audit and Risk Committee
Date of meetings	20 January 2022
Summary of assurance:	

1. The Committee can report significant assurance to the Trust Board in the following areas:

Internal audit reviews

The Committee took significant assurance from the successful outcome of internal auditors' reviews, as follows:

- The review of Whittington Health's capital planning arrangements achieved a rating outcome of significant assurance. The Committee noted that the review identified good processes in place for the processing of capital bids and the submission of business cases. The Committee were apprised of the one low level recommendation from the review which highlighted the creation of an overarching policy document to cover all aspects of the capital planning process which should be put in place by 31 March 2022
- The review of the Trust's business planning arrangements also achieved an outcome of significant assurance. The internal auditors found there was good alignment between Whittington Health's strategic objectives and priorities and the new NHS 2021/22 planning guidance and system developments. They also identified that the Trust's governance arrangements ensured that key business planning processes were followed in line with good practice and the Trust Management Group's terms of reference. The Committee noted the one low level recommendation for improvement which highlighted the inclusion of work to transform and improve estates and information technology systems in the business planning priorities of all Integrated Clinical Service Units

Committee members noted the outcome of these successful reviews and that the minor recommendations for implementation following each review would be included on the standing committee item - the recommendations' tracker to help monitor progress.

Board Assurance Framework (BAF)

The Committee discussed and approved the updated BAF. Committee members agreed with the increase in likelihood score for entries People 1 from 4 to 5 which would increase the risk score to 20 to reflect challenges around Vaccination as a Condition of Deployment (VCOD) and People 2 to be increased from 12 to 16 to reflect the impact on staff morale of the ongoing pandemic. The Committee received good assurance in relation to the measures implemented to encourage relevant staff to receive their COVID-19 vaccinations by the stipulated deadlines and that an update on the numbers of staff affected by the VCOD regulations would be discussed at the January Board meeting. In addition, the Committee agreed the recommendation from the Trust Management Group to increase the likelihood score for BAF entry, Quality 1, to a 5 and the total risk score for this entry to 20.

	2021/22 Annual Report timetable and draft Annual Governance Statement Committee members reviewed the timetable for production of the 2021/22 annual report with the aim to have approval by the Trust Board at its 27 May 2022 meeting. Members welcomed sight of the draft annual governance statement for inclusion in the report and fed back drafting amendments. The Committee would see the next iteration of the annual governance statement at its 31 March 2022 meeting. **Review of the Risk Management Strategy and Risk Appetite Statement** The Committee considered a report on the annual review of the risk management strategy and risk appetite statement. They noted the significant assurance outcome from two reviews completed by the internal audit team in the previous 18 months on the Board Assurance Framework and on risk management. As a result, minor changes were made to the risk management strategy to further embed good risk management practice and to clarify the roles of Board Committees in the oversight of risks and their mitigations. The Committee noted that the revised risk management strategy and risk appetite statement had been discussed and approved by both the Trust Management Group and Quality Assurance Committee. The Committee approved the risk management strategy and risk appetite statement and agreed they would be appended to the Chair's report for final approval by the Trust Board.
2.	**The Committee is reporting moderate assurance to the Board on the following matters:** **Corporate risk register** The Committee reviewed the risk register entries scored at 16 or higher and took moderate assurance that effective mitigations were in place. Committee members welcomed the graph showing the movement of individual risk entries' scores during the current financial year and asked that future reports made clear which committee was leading on oversight of respective risk register entries. **Internal audit plan** Committee members were updated on good progress with the internal audit plan with three reviews being considered at this meeting and that, for two further reviews – cyber security and data security and protection toolkit – a significant amount of work had been completed to ensure those reviews would be issued on time. The Committee was informed that three reviews on consultant job planning, serious incidents and the Care Quality Commission follow up had been delayed but would be completed by the end of the financial year. The Committee received a verbal assurance from the internal audit team that, while there were reviews yet to be completed, Grant Thornton had sufficient resources in place to deliver the reviews expected in this quarter.

	Internal audit recommendations' tracker The Committee reviewed and received updates on items included in the recommendations' tracker. Following discussion, Committee members agreed that the only item remaining on the tracker would be the recommendation to ensure that statutory and mandatory training arrangements were aligned to the latest version of the Core Skills Training Framework. **Internal audit review – Postgraduate Medical Education Review** The review considered the Trust's arrangements for the provision of, and governance around, postgraduate medical education and the Trust's interaction with Health Education England, since the onset of the Covid-19 pandemic. The review outcome was a rating of partial assurance with improvement required. The report highlighted two medium priority and three low priority recommendations for implementation. The medium recommendations were policy and process driven.
3.	**Other key items covered:** **Counter fraud progress report** The Committee received an update report from the local counter fraud specialist and took assurance from the responsiveness of the Finance team when they were alerted to a potential mandate fraud case last week. Committee members were apprised of developments in two cases and agreed that reports to future meetings set out the learning identified and shared with staff from cases. **External audit plan** The Committee received a report from KPMG LLP on the material issues identified and the timetable for the production and submission of the 2021/22 annual accounts. It noted that the deadline for submission was 22 June 2022 and received assurance that this deadline would be met. The Committee also noted the small increase in external auditor fees. **Tender waivers and breaches** The Committee noted a report for the three months to 30 November 2021. They welcomed a 29% reduction in waiver applications compared to the previous three month period but also noted that the total value of applications waivers had increased. Committee members also noted the increase in the number of breaches during the reporting period covered and received assurance that this benchmarked well against other North Central London providers. **Special payments and losses** The Committee was informed of overpayments and actions being taken to recover them. **Debtors' report** The Committee welcomed a report which outlined progress in recovering debts from NHS and non-NHS organisations.

4.	**Attendance:** **Present:** Rob Vincent, Non-Executive Director (Committee Chair) Amanda Gibbon, Non-Executive Director **Apologies:** Glenys Thornton, Non-Executive Director **In attendance:** Vivien Bucke, Business Support Manager Andy Conlan, Grant Thornton Kevin Curnow, Chief Finance Officer Martin Linton Assistant Director of Financial Services Jerry Francine, Operational Director of Finance Jonathan Gardner, Director of Strategy and Corporate Affairs Ciaran McLaughlin, Director, Public Assurance, Grant Thornton Phil Montgomery, Procurement Business Partner Fleur Nieboer, Director, KPMG Swarnjit Singh, Trust Secretary Craig Waterman, Manager, KMPG Raphael Atoyebi, Assistant Manager, Grant Thornton James Shortall, Local Counter Fraud Specialist Gillian Lewis, Associate Director, Quality Governance Marcia Marrast-Lewis, Assistant Trust Secretary

Appendix 1: Risk management strategy

Version	Date	Author/Lead	Changes made
1.0	01.11.2021	Swarnjit Singh, Trust Secretary	Updated strategy for review and feedback by Quality Assurance Committee
1.1	20.01.2022	Swarnjit Singh, Trust Secretary	Changes incorporated following consideration by the Audit and Risk Committee

1. Introduction

1.1 Whittington Health recognises that effective risk management arrangements need to be in place and embedded in the organisation's practices and processes to enable the successful delivery of our strategic and corporate objectives. The risk management strategy provides a framework for the identification, management and escalation of risk within the organisation. Sound risk management is an imperative not only to provide a safe environment and high quality of care for service users and staff, it is also critical in the business planning process where a more competitive edge and greater public accountability in delivering healthcare services is required. It is also an active component in improving our governance and, ultimately our performance.

1.2 Whittington Health's vision as an integrated care organisation 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 Purpose

3. Purpose

3.1 Strategic aims for the Risk management strategy include:

- Compliance with relevant statutory, mandatory and professional requirements and maintenance of the Trust's registration with the Care Quality Commission
- The embedment of consistent and effective risk management processes at all organisational levels
- Promoting an open culture where people feel encouraged to take responsibility for reporting and managing risks
- The integration of risk management into business processes, for example ensuring service developments do not adversely impact on safety
- Set out the Trust Board's annual appetite for risk
- Highlight the integration between the Board Assurance Framework and the Corporate Risk Register

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. The Board is supported in its oversight of risk management arrangements by its key Board Committees who have a responsibility in monitoring risk and providing assurance to the Trust Board that there are both effective systems in place to effectively identify, manage and escalate risks, where necessary and that risks are being effectively mitigated.

4.2 Supported by the Trust's Management Group, each Committee has responsibility for specific risks to ensure there is clear accountability and oversight, and that information and any concerns, in particular, are escalated to the Board. The Committees can also 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 scoring matrix: (http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools- and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/) and an 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. Risks that cannot be reduced or represent a risk to the delivery of the Trust's strategic and corporate objectives must be escalated appropriately to the relevant executive and Trust Board 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, with executive leads and relevant governance committee shown where such risks are reviewed:

Risk category	Executive lead(s)	Committee
Patient safety and quality	Chief Nurse & Director of Allied Health Professionals /	Quality Assurance
Financial	Chief Finance Officer	Finance & Business Development
Workforce	Director of Workforce	Workforce Assurance
Health and safety	Director of Environment	Quality Assurance
Estate or infrastructure	Director of Environment	Finance & Business Development
Information Technology	Chief Information Officer	Finance & Business Development
Digital/Information Governance	Chief Operating Officer	Innovation and Digital Assurance
Security	Director of Environment	Trust Management Group

- In light of the Covid-19 pandemic, an additional section was added to the risk assessment form to highlight if the risk relates to the Covid-19 pandemic
- There will be a process of challenge at quarterly Integrated Clinical Service Unit (ICSU) and corporate services' Performance Review meetings by the Executive Team will assess the effective mitigation of key risks
- 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

5.3 Risk assessments, including quality impact assessments, will be undertaken for all cost improvement programmes The Chief Nurse & Director of Allied Health Professionals is responsible for ensuring the risk register is maintained according to the risk management strategy.

5.4 ICSU directors and corporate department directors are responsible for developing and maintaining their respective local risk registers.

5.5 While individual risk leads 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 departmental 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 rated ≥15 will be escalated to the Trust Management Group and relevant Board Committee for review and agreement.

5.9 To help embed good risk management practice, each meeting forum will have the relevant Board Assurance Framework and Trust Risk Register entries taken as items early in their meeting agendas. They will also have a penultimate agenda item which for which the aim is to confirm the top three risks for the forum and to identify whether during the course of the meeting's deliberations, there were any new risks which need to be included on the risk register. Each forum will be expected to review whether appropriate attention was being given to the key risks and their effective mitigation.

5.10 The Capital Monitoring Group considers ≥15 risks in prioritisation for capital spending each year.

6. Risk register

6.1 The Trust has set a threshold of ≥15 risk grading for review at Board Committees. This is to ensure that there is Non-Executive Director and Executive Director oversight of these risks and a clear escalation process through the Trist's committee governance structure 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 There will be a monthly review of the ≥15 Risk Register by the Trust Management Group

and the Executive Team.

6.6 Trust Board Committees have delegated responsibility for reviewing risk management and provide assurance to the Trust Board that both risks are being effectively reviewed and managed on the ≥15 Risk Register. Concerns are escalated for Board consideration as required and included in Chair's assurance reports to the Board following each Committee's meeting.

7. Reporting process for ≥15 risk register and the BAF

7.1 The Trust Board delegates responsibility for reviewing the ≥15 risk register to the relevant Board Committees through the executive director leads for the committee. Board Committees also review relevant BAF risks to the delivery of Whittington Health's strategic and corporate objectives. These arrangements are shown below:

	Board Assurance Framework	**Risk Register**
Trust Board	Quarterly	Quarterly - ≥ 15 risk register
Audit & Risk Committee	Quarterly	Each meeting - ≥ 15 risk register
Finance & Business Development Committee	Sustainability risks (1 and 2) at each meeting	Each meeting - Finance, Information Management & Technology and Information Governance risks ≥15
Innovation and Digital Assurance Committee	Sustainability risk 3 at each meeting	All ≥ 15 risks
Quality Assurance Committee	Quality risks at each meeting	All ≥ 15 risks
Workforce Assurance Committee	People risks at each meeting	All workforce risks ≥15
Trust Management Group	Quarterly	Quarterly ≥ 15 risk register

7.2 The detailed process for managing the risk register on DATIX is outlined in the Risk Management policy.

8. Board Assurance Framework

8.1 The Board Assurance Framework (BAF) provides a structure and process that enables the Trust to focus on risks to the delivery of its 2019/24 strategy and its annual corporate 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 The following changes to the BAF are incorporated into this strategy following a review by Grant Thornton in 2020 which rated arrangements at Whittington Health as significant assurance with some improvements needed:

- Linking the BAF to the most relevant annual corporate objective as well as a long term, strategic objective
- Evidence of the metrics applicable for a control and linking the control to an assurance
- Directly linking all controls on the BAF template to at least one assurance where there is evidence the control is operating as described
- Clarifying operational responsibility for the implementation of mitigating actions which should follow "SMART" principles
- Demonstrating that the effectiveness of controls or assurances or the need for additional mitigating actions has been reassessed when a BAF risk score is changed
- Strengthening the responsibility of Committees to review relevant BAF entries within their terms of reference
- Clarifying the time period for controls which are not on-going information
- For level 1 assurances, highlight the report, performance indicator used to give that level of comfort
- Reviewing risk target scores to ensure they are consistent and appropriate and are aligned with the lowest risk the Trust is prepared to tolerate
- Incorporating risk appetite scoring guidance in the BAF report
- Assessing awareness of risk appetite guidance and reviewing the target scores for all risks scored higher than 15 when these are inconsistent with the risk appetite statement

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 (dynamic risk register).

Example

Strategic objective	Corporate objective	BAF entry	Link to operational in year risk register entries scored ≥15
People	Promote inclusive, compassionate leadership, accountability and team working where bullying and harassment is not tolerated	Failure to recruit and retain staff, deteriorating NHS staff survey engagement scores	Inadequate consultant cover High district nursing vacancy rates

8.5 The Head of Quality Governance is responsible for presenting the key changes to the ≥15

Risk Register to the Trust Management Group (TMG). The TMG, along with other Board Committees mentioned in section 6.6 are responsible for recommending changes to the BAF that must be approved by the Trust Board.

8.6 In partnership with respective risk leads, the Director of Strategy Development & Corporate Affairs and Trust Corporate Secretary are responsible for maintaining and reporting on the BAF, including updating the framework with assurance and mitigating actions as required, providing reports to the Trust Board as required, highlighting significant changes to the BAF.

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 or trust 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,

Risk Appetite Statement

9.4 The Trust recognises that its long term sustainability depends upon the delivery of its strategic and corporate objectives and its relationships with its service users, carers, staff, public and partners. It will not tolerate risks that materially provide a negative impact on quality or safety of 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.

Risk tolerance and management options

9.5 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 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 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 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 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 (**Error! Hyperlink reference not valid.** 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 the risk management 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 risk management 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, Quality Account and ICSU performance dashboards
- Receiving assurance from internal and external audit reports that the Trust's risk management and governance processes are being implemented
- External reporting is undertaken in accordance with reporting requirements and timescales
- Risk register reports to the Trust Management Group and Board Committees and minutes from meetings
- Audit and Risk Committee review of compliance with agreed risk tolerance

11.3 The Head of Quality Governance is responsible for ensuring systems and processes are in place to monitor the effectiveness of the risk management strategy. – Key Linked Trust policies

Strategy / Policy	
Risk Register Guidance (including risk scoring matrix)	https://whittnet.whittington.nhs.uk/document.ashx?id=13269
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=2 518
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

Appendix 2: 2021/22 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 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,

2021/22 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 Board of Directors has developed and agreed the principles of risk that the Trust is prepared to accept, deal and tolerate whilst in pursuit of its objectives.

The Board of Directors has a broadly cautious to open approach to risk but actively encourages well-managed and defined risk management, in alignment with its risk strategy, acknowledging that service development, innovation and improvements in quality require a level of risk taking.

Our lowest risk appetite relates to regulatory compliance but we have greater risk appetite for innovation, commercial and partnership strategies. This means that we will ensure we prioritise the minimisation of risks relating to our legal obligations whilst seeking opportunities to develop and enhance the quality and efficiency of our service delivery."

The following principles outline the Board's appetite for risk further

Risk category	Specific risk appetite statement	Risk Appetite level based on GGI matrix	Indicative risk rating range for the risk appetite
Quality (patient safety, experience & clinical outcomes)	The Board is committed to outstanding and consistent care, delivering the right care, at the right time, in the right place and compliance with all legislative and CQC requirements and will adopt a cautious approach to risks that threaten this aim, ensuring benefits are justifiable and the potential for mitigating actions are strong.	Cautious	3 - 8
Finance	The Board has a cautious risk appetite for risk that may affect our aim to be financially sustainable and governed to the highest possible standards. However, we have an open risk appetite to investing or allocating resources that may capitalise on opportunities for generating longer term return.	Cautious / Open	3 - 10
Operational performance	The Board is committed to maintaining and improving performance against core standards and will adopt a cautious approach to risks that may adversely affect this aim.	Cautious	3 - 8
Strategic change &	The Board has a high risk appetite for strategic change, innovation, partnerships	Open / Seeking	6 - 15

Risk category	Specific risk appetite statement	Risk Appetite level based on GGI matrix	Indicative risk rating range for the risk appetite
innovation	and commercial ventures that will develop our clinical & operational service delivery.		
Regulation & Compliance	The Board has a minimal to cautious risk appetite when it comes to compliance and regulatory issues (including financial obligations). The Board will make every effort to meet statutory regulations and standards, unless there is compelling evidence or argument to challenge them.	Cautious	3- 8
Workforce	The Board has a cautious approach to risks that may affect our commitment to value, develop, involve and empower our staff.	Cautious	3 - 8
Reputational	The Board has a cautious to open approach for risks that may affect the Trust's reputation. On occasions we may be accept risks where there are potential benefits to delivering our quality priorities.	Cautious / Open	3 - 10

Meeting title	**Trust Board – public meeting**	**Date: 27 January 2022**
Report title	**Charitable Funds Committee Chair's Assurance report**	**Agenda item: 13**
Committee Chair	Tony Rice, Non-Executive Director	
Executive director leads	Kevin Curnow, Chief Finance Officer	
Report author	Marcia Marrast-Lewis – Assistant Trust Secretary	
Executive summary	In line with governance arrangements, this Committee Chair's report reports on areas of assurance on the items considered at the 16 December 2021 Charitable Funds Committee meeting which included: • Month 8 Finance Report including fund balances. • Charity re-brand update • 2020/21 Annual report • Fundraising activities • Applications for funding There were no items covered at these meetings for which where the Committee is reporting limited assurance to the Trust Board.	
Purpose:	Noting	
Recommendation(s)	Board members are invited to note the Chair's assurance report for the Charitable Funds Committee meeting held on 16 December 2021 and the applications for funding agreed.	
Risk Register or Board Assurance Framework	Sustainability 1	
Report history	Public Board meetings following each committee meeting	
Appendices	None	

Committee name	Charitable Funds Committee
Date of meeting	16 December 2021

Summary of assurance:

1. The committee can report significant assurance to the Trust Board in the following areas:

Month 8 Finance Report

- Income for 2021/22 continued to be lower than the previous year as Covid-19 donations had tailed off as the crisis reduced.
- Expenditure to month 8 was £690k which was split between charitable activities in the amount of £580k, equipment in the amount of £38k and £72k on staff and governance costs.
- The total fund balance as at 31 November 2021 was £2.375m.
- There was a £61k increase in the value of investment funds, the full Investec Report is provided in appendix A of this report.

The Committee were apprised of the work undertaken in respect of the fund consolidation exercise where approval of the consolidation of funds into 8 target funds, one for each of the Integrated Clinical Support Units, plus Staff and Wellbeing, Research and Education and a General Fund had been granted, the exercise would be completed by 1 April 2022. The Committee noted that £558k would be moved to the general fund to satisfy a number of bids received.

2020/21 Annual Report

The Committee received the draft Annual Report for the year ending 31 March 2021 noting that accounts were ready for sign off save for a minor amendment related to the deferral of income arising from misclassified grants that had not been fully utilised by 31 March 2021.

Charity report

The Committee received a report outlining the following activity:

- Fundraising - The Committee was updated on work taking place on the winter fundraising appeal which went live on 30 November 2021 via an email to 800 constituents and a social media appeal.

- The Committee was also apprised of progress of a new case management system noting that migration from Donor Strategy to Donorfy which would vastly improve fundraising operations and user experience.

2. The Committee is reporting moderate assurance to the Board on the following matters:

Charity rebrand update.

The Committee were updated on the progress of the charity re-branding exercise noting that a testing and consultation phase had been completed. The Committee discussed funding required for the relaunch of the Charity noting that an application for £30k would

	be made to NHS Charities to take this forward. The Committee approved £3,000 expenditure on initial brand rollout. **Applications for funding** The Committee reviewed and approved bids received, including the following: ▪ New furniture for DTC room - £7,200 ▪ Classical music bid - £24,280 ▪ Organ Donation Committee - £12,000 ▪ Christmas tree hire - £4,135
4.	**Other key issues** Approval was granted by Chair's action for a bid for £7.5k to support digital inclusion work which would help patients access digital appointments and advice.
5.	**Attendance:** Tony Rice, Non-Executive Director (Committee Chair) Julia Neuberger, Chair Amanda Gibbon – Non-Executive Director Kevin Curnow, Chief Finance Officer Alex Ogilvie, Deputy Head of Financial Services Jonathan Gardner, Director of Strategy, Development & Corporate Affairs Siobhan Harrington, Chief Executive Clare Dollrey – Medical Director Allison Ballsamo – Trust & Foundation and Charity Projects Manager Fundraising Sam Lister – Head of Charity Martin Linton – Assistant Director Financial Services Robert Smith – GSM Accountants Michelle Johnson, Chief Nurse & Director of Allied Health Professionals Vivien Bucke, Business Support Manager