NHS
Whittington Health
NHS Trust

Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board held in public on **Friday, 22 July 2022** from **9.30am to 11.00am** via video conference.

Item	Time	Title	Presenter	Action
		Standing agenda items		
1.	*930*	Welcome, apologies, declarations of interest	Trust Chair	Note
2.	*931*	Patient experience story	Acting Chief Nurse & Director of Allied Health Professionals	Discuss
3.	*950*	27 May 2022 public Board meeting minutes, action log, matters arising	Trust Chair	Approve
4.	*955*	Chair's report	Trust Chair	Note
5.	*1000*	Chief Executive's report	Chief Executive	Note
		Board Committee reports		
6.	*1005*	Quality Assurance Committee Chair's report	Committee Chair	Note
7.	*1010*	Workforce Assurance Committee Chair's report	Committee Chair	Note
8.	*1015*	Innovation, Digital and Transformation Committee Chair's report	Committee Chair	Note
		Performance		
9.	*1020*	Integrated performance report	Deputy Chief Operating Officer	Discuss
10.	*1030*	Finance, capital expenditure and cost improvement report	Chief Finance Officer	Discuss
		Governance		
11.	*1040*	2022/23 Q1 Delivery of corporate objectives and Q2 Board Assurance Framework	Director of Strategy & Corporate Governance	Note
12.	*1050*	Strategy update	Director of Strategy & Corporate Governance	Note
13.	*1055*	Questions to the Board on agenda items	Trust Chair	Note
14.	*1100*	Any other urgent business	Trust Chair	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 27 May 2022

Present:	
Baroness Julia Neuberger	Non-Executive Director and Chair
Carol Gillen	Acting Chief Executive
Dr Clare Dollery	Medical Director
Professor Naomi Fulop	Non-Executive Director
Baroness Glenys Thornton	Non-Executive Director
Tony Rice	Non-Executive Director
Dr Junaid Bajwa	Non-Executive Director
Rob Vincent CBE	Non-Executive Director
In attendance:	
Mr A	Patient (item 2)
Helen Brown	Chief Executive-designate
Nicola Surman-Wells	Associate Director of Nursing, Surgery & Cancer Integrated Clinical Service Unit (ICSU) (item 2)
Raegelle Brenley-Sy	Matron, Surgical Wards (item 2)
Chetan Bhan	Clinical Director, Surgery & Cancer ICSU (item 2)
Jerry Francine	Operational Director of Finance
Jonathan Gardner	Director of Strategy & Corporate Affairs
Tina Jegede	Joint Director, Race, Equality, Diversity & Inclusion and Nurse Lead, Islington Care Homes
Marcia Marrast-Lewis	Assistant Trust Secretary
Dale-Charlotte Moore	Acting Chief Operating Officer
Deborah Clatworthy	Deputy Chief Nurse
Swarnjit Singh	Joint Director, Race, Equality, Diversity & Inclusion and Trust Secretary
Jerry Francine	Operational Director of Finance

No.	Item
1.	**Welcome, apologies and declarations of interest**
1.1	The Chair gave a warm welcome to everyone present at the meeting, particularly to Carol Gillen, Dale-Charlotte Moore, and Helen Brown.
1.2	Apologies for absence were received from Amanda Gibbon, Non-Executive Director, Michelle Johnson, Chief Nurse and Director of Allied Health Professionals, Kevin Curnow, Chief Finance Officer, and Sarah Humphery, Medical Director for Integrated Care.
1.3	A new declaration of interest was received from Baroness Glenys Thornton who confirmed her appointment as the Shadow Minister for

	Women and Equalities. The Board noted the declaration, which would be added to the register.
2.	**Patient Story**
2.1	Clare Dollery introduced Mr A, a retired gentleman and, until the pandemic, a regular volunteer at the Whittington Hospital. He was also a contributor to an organisation called "Lived Through This", a charitable organisation which provided cancer support and advocacy for the LGBTQ+ community and had commenced work on personalised cancer care with the North Central London Cancer Alliance.
2.2	Mr A explained that, following treatment for anal cancer at St Bartholomew's Hospital, he developed a severe haematuria. He was admitted to the Whittington Hospital when attempts to control the bleeding failed in the accident and emergency (A&E) department. Mr A expressed his gratitude and admiration for the staff in the A&E where he felt they did their utmost to treat the condition in a very busy and pressured environment. He was admitted on to a ward within 90 minutes of presenting at the A&E. Mr A's condition was complicated by compromised immunity and sleep apnoea, and he was moved very quickly to a side room where he continued to receive treatment, which included a triple catheter, which meant that he was immobile and could not get out of bed for four days. During this time, he was not washed or shaved and had to resort to the goodwill of a friend to bring wet wipes into the hospital, so that he could cleanse himself. By the time the catheter was removed, Mr A was covered in his own dried blood.
2.3	Mr A said that his overriding feeling during this time had been of isolation, because he was in a room on his own and had no visitors, due to visiting protocols in place during the COVID-19 pandemic. He stated that medical staff had had difficulty in determining the root cause of the bleeding, which, in his opinion, was worsened as access to medical records at St Bartholomew's hospital was not a straightforward process. So it was left to him to talk through his treatment received on a clinical trial for anal cancer. Prior to discharge, he was told that he would need to follow-up his treatment with a cystoscopy, which, for reasons unknown, did not take place. Mr A also discovered, at a routine appointment with his oncologist at Barts Hospitals, that they had no knowledge or information of his treatment for haematuria at the Whittington Hospital.
2.4	Mr A was subsequently referred to the Homerton Hospital by his clinical nurse specialist at St Bartholomew's, following a second episode of haematuria, which was a very different experience. The Homerton could easily access all of his medical records at both St Bartholomew's and the Whittington, which facilitated a quick diagnosis and treatment plan without the need for admission to a ward.
2.5	Despite the poor experience related to his personal care, Mr A felt that treatment received at all hospitals was very positive. He re-iterated that the level of care received at the A&E department at the Whittington was

	faultless, while the nurses on the ward were all working at full capacity. He was, however, disappointed with the lack of follow-up and some elements of care on the ward which had contributed to lasting anxiety and stress.
2.6	During discussion, the following points arose: • The Chair gave a wholehearted apology on behalf of the Trust for the negative elements of Mr A's treatment and the isolation experienced at the Whittington Hospital. She suggested that management should take a closer look at the time that Mr A was under the care of the hospital. Clare Dollery assured Mr A that recent changes in the level of critical incidents around COVID-19 across England meant that visiting at hospitals could be brought back to pre-covid arrangements. She sympathised with the feeling of isolation felt during his stay, which was commonly felt across medical wards and areas during the pandemic • Mr A felt that nurses did their best to ensure that all patients had some form of human contact each day but, unfortunately, he was unable to facetime, or have any form of video link with friends or family due to poor wifi connectivity at the hospital. • Glenys Thornton suggested that thought should be given to the provision of additional support when patients were alone and without support from friends or family. • Chetan Bhan offered an apology on behalf of the Surgery & Cancer ICSU for the stress and discomfort experienced during Mr A stay at the hospital. He acknowledged the stress, fear and feelings of isolation experienced by patients in hospital when coming to terms with a new diagnosis of cancer and treatment without the support of family and friends was particularly difficult. He added that the transfer of notes between hospitals and cancer networks was an issue which would need to be addressed by the NHS more widely. He gave an assurance that he would take steps to address the issue around outpatient follow-up diagnostics with colleagues. • Nicola Surman-Wells also offered her apologies for the less positive aspects of Mr A's care and gave her assurance that she would follow up with the teams in the areas that required improvement. She would also meet with Mr A to have a full and open discussion about the care received, which hopefully would help to relieve the anxiety that was still felt. Rob Vincent concurred that further conversation was needed to fully understand and learn from Mr A's experience. • Mr A added that one of the most profound aspects of his experience was the fact that none of the hospital trusts that contributed to his psychological distress was willing to pay for any mental health support, and that he had to pay for it himself.
2.7	**The Chair thanked Mr A for sharing his experience with the Board and assured him that lessons would be learnt, and improvements made going forward. The Chair also requested that the Board was updated as and when measures were put in place once an investigation was undertaken.**

3. 3.1	**Minutes of the meeting held on 30 March 2022** The draft minutes were approved as a correct record. The updated action log was noted.
4 4.1 4.2 4.3 4.4	**Chair's report** The Chair extended her thanks and appreciation to all hospital and community services' staff for their continued and diligent work, particularly to those staff in the emergency department and paediatric emergency department, where it was still very busy and pressured. The Chair updated the Board on recent executive and non-executive appointments: • Sarah Wilding would be joining the Trust as Chief Nurse and Director of Allied Health Professionals in the late summer • Rob Vincent, Non-Executive Director, had been appointed as the Chair of the Workforce Assurance Committee • Junaid Bajwa had become a substantive Non-Executive Director and would join the Workforce Assurance Committee • Amanda Gibbon had succeeded Anu Singh as Vice Chair of the Trust Board • She noted the list of Non-Executive Director champions in accordance with guidance received from NHS England • Short listing for the position of Chief Operating Officer had been completed and interviews would take place on 10 June 2022. The Chair paid tribute to Carol Gillen who would be Interim Chief Executive until Helen Brown started on 20 June 2022. **The Board noted the Chair's report**.
5. 5.1 5.2	**Chief Executive's report** Carol Gillen presented the report. She highlighted the following areas: • The Queen's speech, earlier this month, included details of plans to reform and publish the first women's health strategy and additional funding through the Health & Social Care Levy. • The Secretary of State's (for Health and Social Care) plans to tackle dementia, which would be accompanied by additional funding for research. • The persistence of operational challenges across the North Central London sector. • Annual Staff awards were held on 12 May at the Royal College of Physicians, in which there were 14 winners • Staff continued to work very hard with COVID-19 patients. On the date of the meeting, the Trust had three inpatients that had tested positive for Covid. Staff absence was at 3.9% and would continue to be monitored. Carol Gillen sought delegated approval for the Chief Executive and Chair to approve the final annual report version before submission to NHS

	England and NHS Improvement in June. She also asked for Board agreement for the annual NHS Provider Licence self-certifications for publication on the Trust website.
5.3	Carol Gillen congratulated Serena Wilshire, Senior Human Resources Business Partner, who was recognised at the internal human resources day as a rising star, for her outstanding work and contributions in human resources.
5.4	**The Board:** **i. agree delegated authority for the Acting Chief Executive and Trust Chair to approve the final annual report version prior to its submission to NHS England and Improvement by 22 June 2022; and** **ii. noted the assurance evidence in support of, and approve, the statements for compliance with NHS provider licence conditions prior to the publication on the Trust's website.**
6.	**Quality Assurance Committee**
6.1	Naomi Fulop presented the report for the meeting of the Committee held on 11 May. She. confirmed that the Committee was able to receive significant and reasonable assurance on several items listed in the report, and drew specific attention to the sickle cell disease inpatient improvement plan. The Committee received significant assurance that good progress had been made in raising awareness around the issues surrounding the care of patients presenting in sickle cell disease crisis and that a robust improvement plan had been developed with improvements seen and documented.
6.2	Naomi Fulop also drew the Board's attention to the top three risks: • ongoing clinical staffing challenges in various departments across the Trust, particularly in radiography and sonography services. An outcome of the deep dive into recruitment and retention would be reported to the Workforce Assurance Committee • demands on urgent and emergency care services. The need to move patients from ambulatory care in order to increase the turnaround time of ambulances had been escalated to divisional management teams for a formal risk assessment • staffing capacity and its impact in a backlog of serious incident reports requiring completion. The Committee received assurance that, going forward. the monthly reports on serious incidents would include the number of open investigation and mitigations in place, that immediate and essential learning would be implemented without delay and that there was full compliance with duty of candour arrangements
6.3	Naomi Fulop sought approval for the Committee's refreshed terms of reference. Clare Dollery noted that the normal timescales for serious incident reporting was intentionally suspended by NHS England during the pandemic, so that clinicians could focus on COVID-19 pressures. She provided assurance that a more business-as-usual approach would

	be taken going forward, so that learning could be facilitated as quickly as possible without additional pressures on staff.
6.4	**The Board noted the Chair's assurance report for the Committee meeting held on 11 May 2022 and approved the Committee's revised terms of reference.**
7.	**Midwifery Continuity of Carer**
7.1	Clare Dollery summarised the report, which described the Trust's current position on activity, staffing, redeployment of staff with time scales and a recruitment plan to ensure the development and implementation of the Midwifery Continuity of Carer model. To this end, the Trust was proposing to maintain the provision of the Midwifery Continuity of Carer model for all pregnant women in the Islington area in the first instance. The Trust would also continue the recruitment to full establishment of midwives, of which 13 out of the 16 additional midwives required to comply with safe staffing had already been recruited.
7.2	Rob Vincent queried whether the increased need for additional midwives would be considered at North Central London level. The Chair confirmed that this was the case. Norma French added that the Trust had been moderately successful with the recruitment of overseas nurses and that four overseas midwives were due to join Whittington Health as part of recruitment activity in the sector. The chair welcomed the additional staff joining the Trust and advised on the need to also attract and help develop local people into these roles.
7.3	**The Board** **i. noted the report;** **ii. agreed to continued support for maternity services in the delivery of a transformed model of care;** **iii. agreed that a quarterly update be provided to the Board for review, in line with the national guidance; and** **iv. agreed to provide an increase in staffing/equipment or estate requirements.**
8.	**Modification of Maternity Training**
8.1	Clare Dollery presented the report on the Trust's approach to midwifery and maternity training, in accordance with the recommendations made by the Clinical Negligence Scheme for Trusts and Maternity Incentive Scheme published in May 2022, which encouraged the reinstatement of face-to-face training where practicable. The report's recommendation acknowledged that there may be some circumstances where face-to-face training was not possible, and that therefore remote or digital training (which covered the requirements within the safety actions) would be accepted to count towards the training compliance of the Trust.
8.2	Clare Dollery confirmed that, during the preceding 18 months, the Trust had maintained 90% training compliance, which was achieved through a hybrid of remote/online learning and face-to-face learning. In the

	circumstances, the Board was requested to approve the continuation of a hybrid model of training until the Whittington Education Centre was completed and accessible, whereupon the Trust would resume delivery of face-to-face training.
8.3	**The Trust Board noted the report and endorsed the continuation of a hybrid model of maternity training.**
9.	**Annual Safeguarding Children and Adults Declaration**
9.1	Deborah Clatworthy highlighted the annual Joint Safeguarding Adults and Children declaration which provided assurance that the Trust was meeting its statutory requirements in relation to safeguarding children, young people, and adults in its care, and that internal processes were in place to deliver the Trust's safeguarding obligations.
9.2	**The Board noted the report and endorsed the publication of the declaration of assurance on the Trust website**
10.	**Eliminating Mixed Gender Hospital Accommodation**
10.1	Deborah Clatworthy presented the report, which provided an annual statement of assurance that patients who required inpatient/day case care were cared for in single gender accommodation, except for patients who required intensive/critical care, emergency care and some high dependency observation bays.
10.2	**The Board noted the report and endorsed the publication of the statement of assurance on the Trust website.**
11.	**Draft 2021/22 Quality Account**
11.1	Clare Dollery presented the final draft of the Quality Account for 2021/22 and the agreed quality priorities for 2022/23, which were approved by the Quality Assurance Committee at its meeting on 11 May 2022. She reminded Board members that it was a statutory requirement to publish the account each year. The deadline for the current year was 30 June 2022.
11.2	Clare Dollery talked through the quality priorities which were planned over a three period, which facilitated a strategic approach to the development of the Trust's quality interventions. She explained that one of the key themes incorporated into the priorities related to the reduction of health inequalities. Other themes included: • the reduction of harm from hospital acquired deconditioning incorporating the reduction of length of stay and improved communication between consultants and patients • the development of a patient safety syllabus, particularly around blood transfusion safety. • ensuring that 100% of sickle cell patients received their first dose of pain relief within 30 minutes of presentation in the emergency department. • holding several prostate cancer events in pop-up barber shops.

11.3	**The Board:** **i. noted the draft 2021/22 Quality Account;** **ii. agreed that any drafting amendments be sent to Kat Nolan-Cullen, Quality and Compliance Manager, by 10 June; and** **iii. approved delegated authority for the Medical Director and Chief Nurse to agree the final version of the 2021/22 Quality Account for publication by 30 June 2022.**
12. 12.1	**Integrated Performance Report** Dale-Charlotte Moore summarised the report, which covered the period in March and April 2022 when the Trust was still managing winter pressures and utilising an extended bed base and surge beds. She highlighted the following areas: • Performance against the Emergency Department (ED) four hours' wait target was positive and in line with North Central London • The Trust had implemented "fit to sit" criteria for ambulance handovers and this had had a positive effect • Directions from ambulances to same day emergency care which would bypass the ED front door., • Performance against cancer targets was particularly challenging due to workforce issues • The Trust was participating in a national discharge pilot which was also having a positive impact. A new clinically ready discharge pilot would commence on 6 June 2022 • On referral to treatment, the Trust was ahead of its 52 week trajectory. • On elective recovery, theatre utilisation had shown improvement • Community audiology waiting times had not reduced over the previous month, mainly due to staffing challenges. The backlog of follow up appointments had increased to 1,053 patients. A revised trajectory against compliance was expected in May 2022
12.2	Junaid Bajwa asked if the Trust was more challenged than similar-sized NHS providers across London during the month of April. He noted his concern in relation to 13 cancellations of elective procedures, which was a significant worsening of the situation compared to the previous month. Dale-Charlotte Moore confirmed that the Trust was not an outlier compared to North Central London pressures. She reported that the Trust was also seeing higher numbers, for the time of year, of Respiratory Syncytial Virus acuity in children. In terms of emergency department attendances, the Trust was in line with North Central London. She confirmed that high numbers of mental health patients had impacted on capacity.
12.3	Rob Vincent observed that the response rates for the friends and family test responses had fallen and no progress had been made on appraisal rates. Dale-Charlotte Moore explained that a targeted approach had been implemented in terms of appraisal rates, which had been impacted by workforce challenges, including sickness absence. Norma French

	advised that a slow increase in statutory and mandatory training had been made and that appraisals had been migrated to the Elev8 System, which would give a better focus on compliance with appraisals and statutory and mandatory training. She provided assurance that each ICSU had been asked to manage a month-by-month performance trajectory. On the friends and family test, Clare Dollery stated that it could be linked in part to midwifery staffing, and a number of measures had been implemented that were expected to improve response rates over the coming months.
12.4	Tony Rice sought clarification on demand and capacity issues that could impact performance, and their link to productivity and costs. He also commented that theatre utilisation was 73% and should be higher. Dale-Charlotte Moore explained that the greater use of statistical process control would help to identify trends and give a clearer picture of activity. She provided assurance that there were now system solutions in place with local partners, through mutual aid arrangements, when there was a significant impact on services from staffing capacity. She also concurred that more detail was needed across service lines to fully understand the extent of the issues. Jonathan Gardner reported that there were significant recruitment challenges in theatre staffing.
12.5	**The Board noted the report, taking good assurance that the Trust was managing performance and compliance effectively given the constraints around services.**
13.	**Month 1 Finance, capital expenditure and cost improvement report.**
13.1	Jerry Francine took the report as read and highlighted the following: • The Trust had submitted a draft financial plan with a £17.75m deficit which included £10m in cost improvement savings. Discussions were ongoing with the Integrated Care System to explore reducing the deficit. • The Trust achieved a deficit of £1.7m at end of April, which was £0.03m better than plan • Overspends related to pay pressures and the under-delivery of savings was being offset by slippage on planned investments • There was no significant movement in the cash position, which at the end of April was £80.99m. The Trust was forecasting that cash balances would reduce to £50m by the end of this financial year • The Trust had a capital expenditure plan in place of £30.4m, and, while expenditure in month 1 had been insignificant, it was expected to increase later in the year
13.2	Tony Rice suggested that savings could be made if vacant posts were not backfilled with agency or bank staff. Norma French explained that discussions were ongoing with financial colleagues to determine the precise number of vacant posts and the proportion of vacant posts that were backfilled by bank and agency staff or fixed-term contracts. Clare Dollery supported filling posts substantively where they were required and advised that other options were available to help with staffing challenges, through developing allied health professionals' roles and activities. Carol

	Gillen added that the hotspot areas which needed staff were well known, so that recruitment should continue at pace. She commented that more steps should also be taken to retain staff.
13.3	Jerry Francine supported a review of non-recurrent investments and reported that approval for agency expenditure for non-clinical roles would be needed from the North Central London system.
13.4	**The Board thanked Jerry Francine for his attendance at the meeting and noted the report.**
14.	**Charitable Funds Committee Chair's Assurance report.**
14.1	Tony Rice summarised the report, in which he highlighted the continued decrease in charitable donations as the Covid-19 pandemic reduced. He drew attention to significant work carried out to consolidate the Charity's restricted and unrestricted funds and to prepare the charity for targeted fundraising work to support maternity transformation, oncology and the estates programme. Tony Rice reported that the Committee carried out its annual review of its terms of reference and agreed that the membership was amended to include two independent appointees.
14.2	**The Trust Board noted the Committee Chair's assurance report for the meeting held on 19 May 2022 and approved the revised terms of reference.**
15.	**Audit Committee Chair's Assurance report**
15.1	Rob Vincent reported that the Committee received significant assurance from the three successful outcomes from internal auditors' reviews for financial systems and processes, projects, programmes and change, and governance of the recovery and backlog He confirmed that the minor recommendations for implementation following each review would be included on a tracker to monitor progress. The Committee also considered and approved an updated set of standing orders and standing financial instructions following their annual review.
15.2	**The Trust Board noted the Committee Chair's assurance report for the meeting held on 31 March 2022 and endorsed the approval of the revised standing orders and standing financial instructions.**
16.	**Questions to the Board on agenda items**
16.1	There were none received.
17.	**Any other business**
17.1	The Chair acknowledged that, although she was absent, Michelle Johnson Chief Nurse would leave the Trust by the end June. On behalf of the Trust Board, the Chair recorded her sincere thanks for Michelle's contribution to Trust and wished her well.

Action log, 27 May 2022 Public Board meeting

Agenda item	Action	Lead(s)	Progress
Patient story	Provide an update on the outcome of investigations and actions taken of the experience of Mr A during his time as an inpatient with hematuria.	Clare Dollery / Deborah Clatworthy	A report with input from the multidisciplinary team was considered at the Serious Incident Executive Assurance Group meeting on 15 July. A number of areas of learning have been identified and these will be taken forward by the ICSU. One aspect of the action plan is nursing care study day for Coyle ward staff led by the practice development team. Mr A is being kept updated with developments
2021/22 Quality Account	Send any drafting amendments by 10 June to the Quality and Compliance Manager	All	Completed
Maternity Continuity of Carer	Provide quarterly updates to the Board	Deborah Clatworthy	Included on Board forward plan

Meeting title	**Trust Board – public meeting**	**Date: 22 July 2022**
Report title	**Chair's report**	**Agenda item: 4**
Non-Executive Director	Julia Neuberger, Trust Chair	
Executive director lead	Jonathan Gardner, Director of Strategy and Corporate Affairs	
Report authors	Swarnjit Singh, Joint Director of Race, Equality, Diversity and Inclusion and Trust Secretary and Julia Neuberger	
Executive summary	This report provides a summary of activity since the last Board meeting held in public in May 2022	
Purpose	Noting	
Recommendation(s)	Board members are asked to note the report.	
Board Assurance Framework	All BAF entries	
Report history	Report to each Board meeting held in public	
Appendices	None	

Chair's report

This report gives an update to Board members on recent activities.

Covid-19

In the face of increasing COVID-19 infection rates and increased hospital admissions, we have very sadly had to revert to holding this Board meeting virtually.

I would like to thank all our amazing staff and volunteers for their continued resilience and dedication in delivering high quality and safe services to all our patients, when we have had a heat wave and rising COVID rates. Our staff are remarkable.

Recruitment to executive director roles

I was delighted to welcome Helen Brown as our new Chief Executive at Whittington Health on 20 June. Following a full and open recruitment and selection process, I am happy to confirm that Chinyama Okunuga has been appointed as our new Chief Operating Officer. She will join us in September from East and North Hertfordshire NHS Trust, where she is currently Managing Director for Unplanned Care.

30 June Board meeting and seminar

A private meeting of the Trust Board was held on 30 June in the new Whittington Education Centre, which provides excellent facilities. The meeting discussed and approved the Articles of Association and 2022/23 business plan for the University College London Health Alliance. Other key items covered at the meeting included an update on progress with our 2019-24 strategy, and Chairs' assurance reports from the Audit and Risk and Finance and Business Development Committees. At the Board seminar held afterwards, there was a review of the activity, workforce, and financial assumptions in our 2022/23 plan submitted to the North Central London sector and an anti-bribery training session, delivered by our local counter fraud specialist.

Induction

I was pleased to meet new staff recruits at Whittington Health at the monthly corporate induction held in June. In addition, I held an induction meeting with Phil Wells, the new Chief Finance Officer for the North Central London Integrated Care System.

Consultant recruitment

I am grateful to Amanda Gibbon, Non-Executive Director, for participating in the recruitment and selection panels held on 7 July for a Consultant post in acute and general medicine and on 13 July for two Consultant anaesthetic posts.

Non-Executive Director appraisals
In line with guidance from NHS England, my annual appraisal was completed by the Senior Independent Director. Arrangements are in place to complete the annual appraisals of other Non-Executive Director colleagues by 30 September.

External meetings
I attended meetings with partners in the North Central London Integrated Care System and in the University College London Health Alliance.

Meeting title	**Trust Board – public meeting**	**Date: 22 July 2022**
Report title	**Chief Executive's report**	**Agenda item: 5**
Executive director lead	Helen Brown, Chief Executive	
Report authors	Swarnjit Singh, Joint Director of Inclusion and Trust Secretary, and Helen Brown	
Executive summary	This report provides Board members with updates on developments nationally and locally since the last meeting held in public on 27 May 2022.	
Purpose	Noting	
Recommendation	Board members are invited to note the report.	
Board Assurance Framework	All Board Assurance Framework entries	
Report history	Report to each Board meeting held in public	
Appendices	None	

Chief Executive's report

COVID-19

This is my initial report to the Trust Board as Chief Executive of Whittington Health. I am delighted to have joined this integrated care organisation with such a good reputation in North Central London. During my first few weeks, I have been meeting staff and visiting as many service areas as possible in both the hospital and community sites and will continue to do so.

I would like to thank all our staff, in the hospital and at our community services' sites, for their continued hard work and perseverance in delivering high quality safe services. During June and July, there has been a marked increase in COVID-19 infections nationally, with the NHS seeing a rise in patients admitted with the coronavirus. As of 15 July, there were 58 inpatients with the virus and 32 inpatients who were post-infection. The increase in coronavirus transmission has also impacted on staffing capacity. The daily monitoring of all forms of absence continues and, as of 14 July, the overall absence rate was 4.93%. Whittington Health continues to invest in the health and wellbeing of all its staff during the pandemic through the provision of a comprehensive range of assistance for our staff to access.

Following the rise in COVID-19 cases, Whittington Health has reintroduced the requirement for masks to be worn on our sites. In line with local infection prevention and control advice, we are recommending that social distancing is in place with a people staying one metre apart and most meetings have reverted to virtual settings. This applies to staff, patients, and visitors in clinical, non-clinical, public and administrative spaces. While there is currently a surge in cases, it is hoped that these measures will be temporary and can be reduced again, in due course.

NHS birthday and George Cross

On 5 July, the Trust marked the 74th birthday of the National Health Service and said a big thank you to all our staff for all that they continue to do. The last couple of years have been especially challenging. The NHS could not have made the significant progress in looking after the nation's health without the skill and dedication of our people. On 12 July, Amanda Pritchard, NHS Chief Executive, along with May Parsons, the nurse who delivered the world's first COVID-19 vaccination outside a clinical trial, received the George Cross from Her Majesty the Queen on

behalf of our incredible 1.5 million NHS colleagues in the United Kingdom. The George Cross, the highest civilian award for gallantry, recognises the incredible dedication, courage, compassion, and skill shown by all NHS staff – from nurses and doctors to porters, cleaners, therapists, and countless other roles – over more than seven decades, and particularly in the face of the pandemic. Since its introduction in 1940, this is only the third time the George Cross has been given to a collective body, and it is granted in recognition of “acts of the greatest heroism or of the most courage in circumstances of extreme danger”.

Secretary of State
Following the resignation of the Rt Hon Sajid Javid, the Rt Hon Steve Barclay was welcomed as the Health and Social Care Secretary.

Henrietta Hughes, national patients Safety commissioner
On 6 July, Dr Henrietta Hughes OBE was appointed as the new, independent patient safety commissioner for England. She will act as a champion for patients and lead a drive to improve the safety of medicines and medical devices. Dr Hughes was formerly the National Guardian for the NHS and brings wealth of experience in fostering an open and learning culture.

Single Oversight Framework segmentation
NHS England published its 2022/23 System Oversight Framework on 28 June, ahead of the official launch of integrated care systems (ICSs), as part of the new statutory framework. The refreshed Oversight Framework seeks to ensure the alignment of priorities across the NHS and between partners in local systems and sets out the approach to be used for oversight of Integrated Care Boards and individual provider trusts. Each provider is assessed and given a segmentation rating decision which indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). I am pleased to say that Whittington Health has been assessed as being in segment two.

North Central London system
On 1 July, the North Central London Integrated Care System and Integrated Care Board were formed on a statutory footing following the passing of the Heath and Care Act (2022) and are wished every success. This legislation formalises how trusts, local authorities, primary care, and voluntary and community services will work together to tackle local health inequalities and to plan and deliver joined up services and care to around 1.6 million people in the North Central London area. It is noticeable that there is a real shared commitment to collaborating positively in North Central London.

Start Well Case for Change
On 23 June, the NHS and partners in North Central London published a case for change for maternity, neonatal, and children’s and young people’s services, as part of the Start Well programme. The case for change describes current services in North Central London, the areas that work well, and identified where there are best practice standards and how our services compare against them. It also identified areas where there are potential opportunities for improvement. The aim is to make sure we are delivering the best care to meet the needs of local babies, children,

young people, and pregnant women and people. The key findings from the case for change have been shared at a series of staff briefings over the past few weeks. There will be an engagement period from 4 July to 9 September, where staff and patients and the public will be invited to give their views on the ideas and opportunities in the case for change and to identify if there are any additional areas that need to be considered.

2021/22 Annual Report and Quality Account
During June, Whittington Health submitted its audited 2021/22 annual accounts and annual report to NHS England. We also published our 2021/22 Quality Account and submitted our 2022/23 activity, workforce and financial plan to the North Central London system.

Regional Ockenden assurance visit
On 27 June, Whittington Health's maternity services underwent an assurance visit NHS London's regional team. The purpose of the visit was to provide assurance against the seven immediate and essential actions from the interim Ockenden report (December 2020). The feedback from the assurance team was positive and the Trust's full compliance, since March 2022, across all of the seven immediate and essential actions outlined in the Ockenden interim report was recognised. The assurance team's draft report has been received and is being reviewed for factual accuracy and to take forward the recommendations for areas for improvement.

Electronic prescribing upgrade
In the final week of June, the upgraded electronic prescribing and medicines administration system was successfully implemented. I thank the team and the floorwalkers who were on hand to support staff as this great new digital solution was rolled out.

Industrial action
On 21 and 23 June, there was industrial action which disrupted train and tube services. I would like to thank everyone for their efforts to get to work and ensure that we could continue to provide excellent patient care. I am pleased to report that we successfully avoided cancelling patient activity during this time.

Project Wingman
June was also the last week that the Project Wingman staff were on our hospital site to help provide support for staff health and wellbeing. The support they provided to everyone through some of the hardest times many of us have worked through was amazing. We were proud to have been the pilot site for the Project Wingman initiative which was adopted across many NHS organisations during the pandemic.

Workforce equality submissions
The outcomes from our annual workforce disability and race equality standard have been produced and will be submitted to NHS England by 31 August. Both reports were discussed by the Workforce Assurance Committee and are appended to its Committee Chair's report which features later on today's agenda. While the outcomes continue to show improvement against most indicators, there remain areas for focused work such as better workforce diversity coverage, particularly in

relation to staff disability, improved coverage of all training and development activity, and a review of our formal employee relations cases.

People Pulse
The People Pulse survey was issued in July and provides an opportunity for our staff to make their views heard to senior leadership, who will use this as part of reflecting and planning for the future.

South Asian Heritage Month
The 2022 South Asian Heritage Month is taking place from 18 July-17 August. The theme for this year is 'Journey of Empire'. I would encourage staff to join in some of the events taking place via this link: South Asian Heritage Month

Meeting title	**Trust Board – public meeting**	**Date: 22 July 2022**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 6**
Committee Chair	Naomi Fulop, Non-Executive Director	
Executive director leads	Clare Dollery, Medical Director, Carol Gillen, Chief Operating Officer, and Deborah Clatworthy, Interim Chief Nurse and Director of Allied Health Professionals	
Report authors	Naomi Fulop and Swarnjit Singh, Joint Director of Inclusion and Trust Secretary	
Executive summary	The Quality Assurance Committee Chair will deliver a verbal report to Board members of meeting held on 13 July 2022.	
Purpose	Noting	
Recommendations	Board members are asked to note the Quality Assurance Committee Chair's the verbal report from for the meeting held on 13 July 2022, together with the two appendices showing the bi-annual safeguarding report for adults and children and the 2021/22 annual report for complaints, compliments and patient advice and liaison service activity	
BAF	Quality strategic objective entries	
Appendices	1: Bi-annual adult and children safeguarding report 2: 2021/22 complaints, compliments and patient advice and liaison service annual report	

Meeting title	**Quality Assurance Committee**	**Date: 13th July 2022**
Report title	Adult and Children's Safeguarding six monthly report (September 2021 to April 2022)	**Agenda item: 4.2**
Executive director lead	Deborah Clatworthy, interim Chief Nurse & Director of Director of Allied Health Professionals	
Report author	Head of Safeguarding (Children) Karen Miller Head of Safeguarding (Adults) Theresa Renwick	
Executive summary	**Executive summary** This report provides a summary of the work undertaken across adult and children's safeguarding and covers the period between September 2021 to April 2022. The Trust's safeguarding teams continue to provide a range of services to support key areas of safeguarding work, respond to emerging themes and strive to ensure all safeguarding processes are robust and effective and meet statutory and regulatory obligations. **Adult** • The relentless increase in both numbers and complexity of safeguarding adult concerns continued in the period of this report. • The lead Tissue Viability Nurse for the Trust delivered raining to over 100 social care, care agency and care home staff during this period as numbers of pressure ulcers reported as safeguarding adult concerns had increased in the previous two quarters (Q1&Q2 2021-2022). • WRAP 3 compliance is 83%, with basic awareness of PREVENT at 89% at end of March 2022. • Training compliance for level 1 safeguarding adults remains at 88% at end of March 2022. • For Level 2 safeguarding adults, the compliance rate has increased to 80% at end of March 2022. • Preparations for the implementation of the new Liberty Protection safeguards (LPS) to replace DoLS continue. • The Safeguarding Adult Lead sits on the national and London LPS Clinical Review Groups and as such is able to influence both regional and national responses to the LPS consultation which finishes on 14th July. • Internal preparation for LPS includes analysing data held for the numbers of urgent DoLS authorisations and length of stay in hospital.	

	• This will impact on resources required to ensure the Trust is legally compliant with the new legal requirements of being a Responsible Body. • Numbers of DoLS assessments being completed for standard authorisations organised by local social services has decreased significantly since the first Covid surge. • A part-time safeguarding adult advisor began work in September 2021. **Children & Young People** • Safeguarding training compliance has vastly improved since introduction of Elev8. Level 1 is currently 89%, level 2 86% and level 3 is 80%. The introduction of Elev8 online learning platform will help improve training compliance recording. • The complexity of cases being seen within the safeguarding arena has increased. Higher incidences of mental health and domestic abuse feature in the referrals. • Adolescent mental health remains a key issue within safeguarding. The lack of specialist provision nationally combined with a landscape of more complex mental health emerging at a younger age has presented the safeguarding team with consistent challenges. • Domestic abuse cases have stabilised across the boroughs, but domestic abuse remains the primary reason for referrals to social care. • Changes to domestic abuse legislation were announced in 2021 with the recognition in law that children who live with domestic abuse are victims in their own right. This is a significant factor for professionals working within safeguarding. • Local Safeguarding Practice Review (LSPR) as they are now known under new legislation (previously known as Serious Case Reviews SCR) activity at this time indicates nine active reviews in progress. Whittington Health has a robust action plan in place to address the learning from SCR's, with most actions already completed before publication of the SCR/SPR. • Staff supervision compliance has remained high. Ad hoc supervision sessions to discuss complex cases are very helpful to staff. • Formalised supervision and restorative supervision has been extended to allied health professionals including Haringey improving Access to

	Psychological Therapies (IAPT) and the community children and young people therapies teams.
Purpose:	Review and approve
Recommendation(s)	The Trust Board is asked to: - (i) To receive assurance that there are systems in place to protect children and vulnerable adults from abuse and neglect whilst in our care. (ii) To be assured that partners have confidence that Whittington Health is fulfilling its role as a statutory partner in safeguarding children and adults at risk in the wider community and health and care economy.
Risk Register or Board Assurance Framework	Board Assurance Framework risk entry 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation
Report history	Trust Integrated Safeguarding Committee April 2021
Appendices	1 - Biannual Integrated safeguarding report to Trust Board (September 2021 to March 2022)

Appendix One

BIANNUAL INTEGRATED SAFEGUARDING REPORT
September 2021 to March 2022

1. INTRODUCTION

1.1 This bi-annual report for safeguarding children and adults informs the Trust Board of activity and progress in improving and strengthening the safeguarding arrangements for adults and children across Whittington Health NHS Trust. The report has been recommended by the Trust Quality Committee for approval by the Trust Board on recommendation from the Quality Committee. It covers the period from September 2021 to March 2022. The report provides assurance around the following:

- Adoption of national policy changes
- Responding to and learning from safeguarding concerns raised from internal incidents and serious incidents; Safeguarding Practice Reviews, Safeguarding Adult and Domestic Homicide Reviews and regulatory inspections
- Work plan and objectives for the coming period of review
- Impact of Covid 19 on safeguarding practice.

2.0 SAFEGUARDING CHILDREN

2.1 The Serious Case Review process has been replaced with National Child Safeguarding Practice Review Panel. This is hoped to streamline the process and implement a system of national learning in a more timely way. Seven cases are currently open to Whittington Health. The only significant point of learning for Whittington Health raised within these SCR's/SPR's is multi agency discharge planning from acute hospitals for children admitted with suspected non-accidental injuries.

2.2 Safeguarding supervision continues to be provided within statutory guidelines with compliance consistently maintained. Safeguarding supervision has also been widened to include supervision of allied health professionals. This is in recognition that they also work frontline with vulnerable children and often identify safeguarding concerns.

2.3 Safeguarding referral rates are back to pre-Covid levels with a marked increase in the complexity of cases presenting. Excellent engagement with our multi agency partners has helped in the response to this issue.

2.4 Currently attendances to Emergency Departments for paediatrics are very high as a result of increased adolescent mental illness, Covid anxiety ('the worried well') and difficulties for families in accessing GP face to face contacts.

2.5 Domestic abuse remains as the most common reason for referrals into social care. An increased incidence of men/fathers and same sex relationships presenting as the victims. This is encouraging to see that men feel confident in reporting their experiences, but it highlights the need for staff to be vigilant to wider factors prevalent in domestic abuse. Domestic abuse support services have always prioritised their work with female victims and support for male victims has always been limited.

2.6 Increased incidences of midwifery referrals to social care have been noted. The primary increase in referrals is as a result of mental health. This has resulted in the provision of a dedicated midwifery role to support both clients and professionals in managing the risks presented by maternal mental health.

3.0 SAFEGUARDING ADULTS

3.1. These two quarters continued to be a very busy one for safeguarding adults, DoLS and the Mental Capacity Act

3.2 The severity of abuse identified has been increasing throughout the Pandemic.

3.3 Demographic data of patients who have a safeguarding adult concern raised for them is shared with the local SABs, to consider if any response is required by the partnership. An example of this has been a deep dive in Haringey which looked into numbers of safeguarding adult concerns raised for Black Caribbean residents.

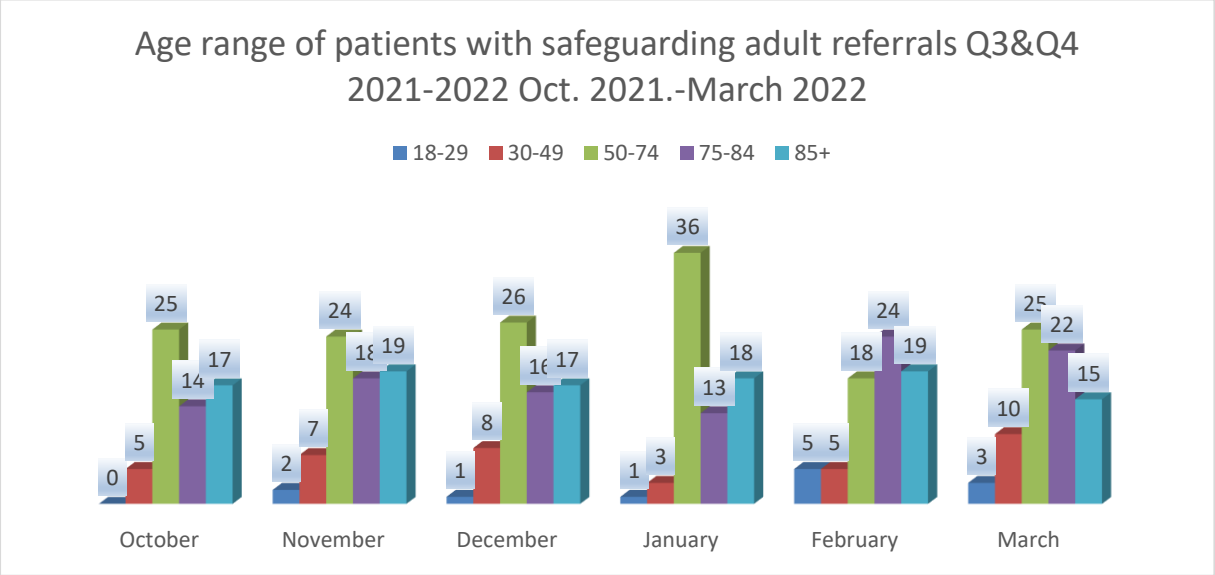
3.4 Urgent and Emergency Medicine ICSU continues to raise the most safeguarding adult concerns for the period covered in this report.

3.5 Training compliance continues to be monitored, and compliance has increased during this reporting period, with level 2 safeguarding adults at 80% on 31st March 2022.

3.6. Graphs 1-9 below show the demographics, nature of allegations, person alleged to have caused harm and location of alleged abuse for safeguarding adults.

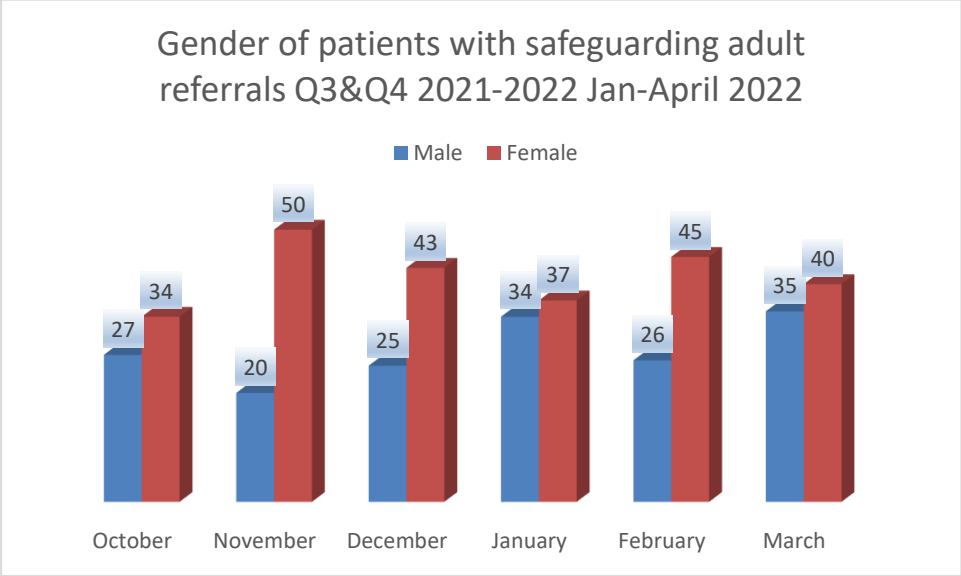
Graph 1

3.7 Graph 2 below shows significant numbers of safeguarding adult concerns are raised for those aged 50 and above, consistent with national data[1].



Graph 2

3.8. Graph 3 shows a distinct difference between the genders, women more likely to be identified as experiencing abuse.



Graph 3

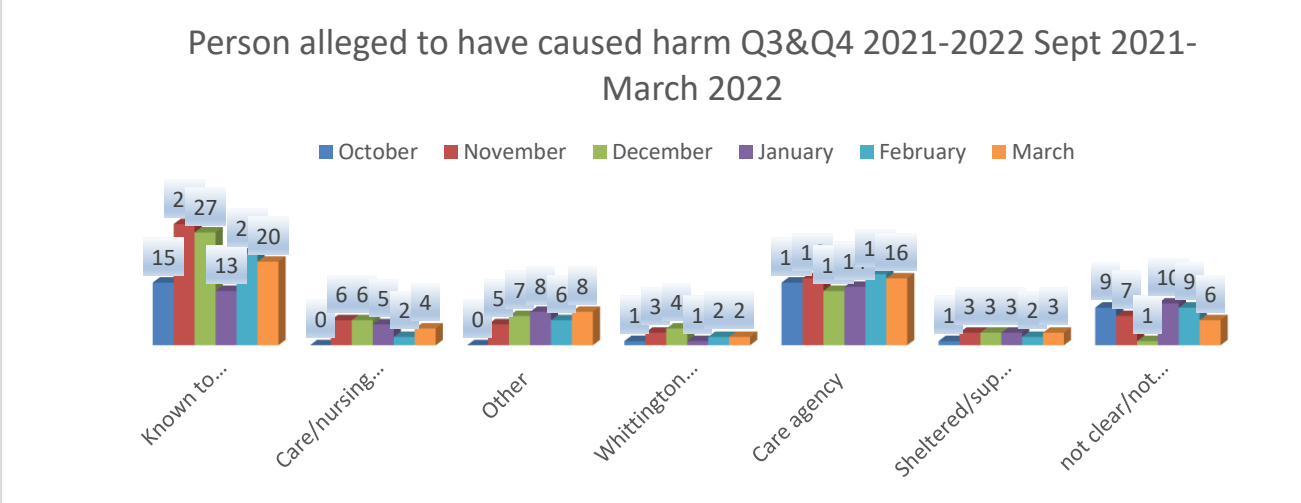
3.9 Graph 4 below shows neglect as the category with the most alleged abuse, with organisational abuse being a close second. Coupled with the significant numbers of persons alleged to have caused harm being care agencies (graph

[1] https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2020-21

5 below), this requires continued monitoring.

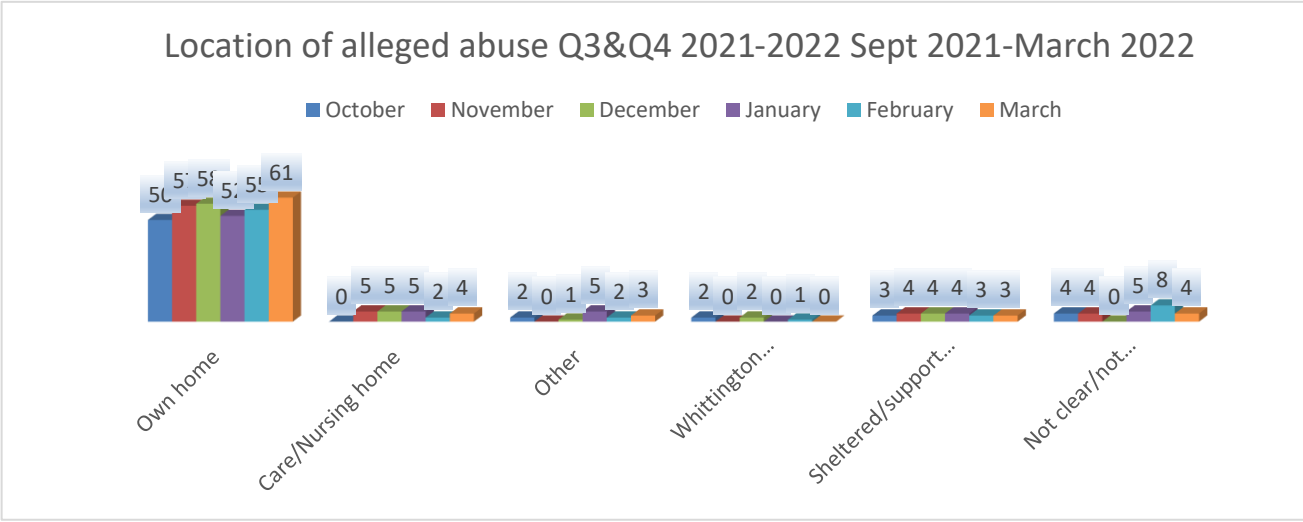
Graph 4

3.10 Table 5 below shows patient are likely to know the person alleged to have caused harm.



Graph 5

3.11 'Own home' was the most frequently identified location of abuse as graph 6 below shows.

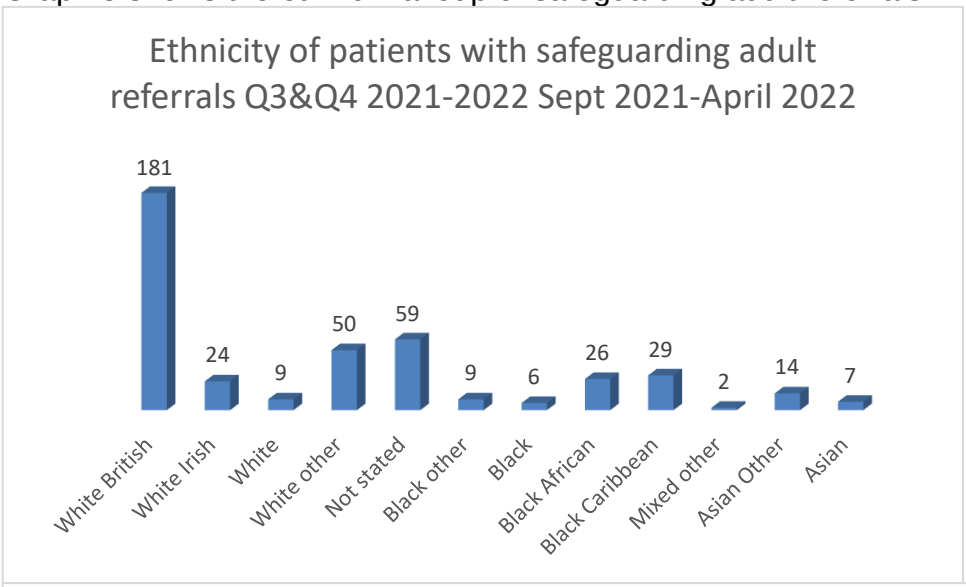


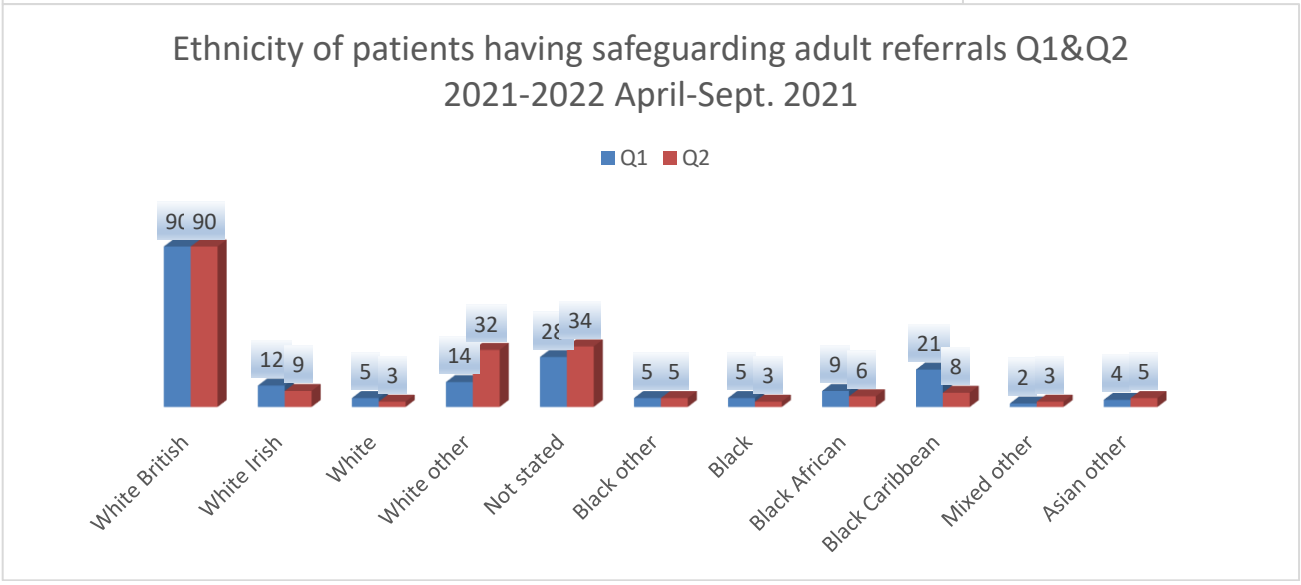
Graph 6

3.12. Graph 7 below shows the distribution of safeguarding adult concerns across local authorities.

Graph 7

3.13 Graph 8 shows the ethnic makeup of safeguarding adult referrals.





Graph 8

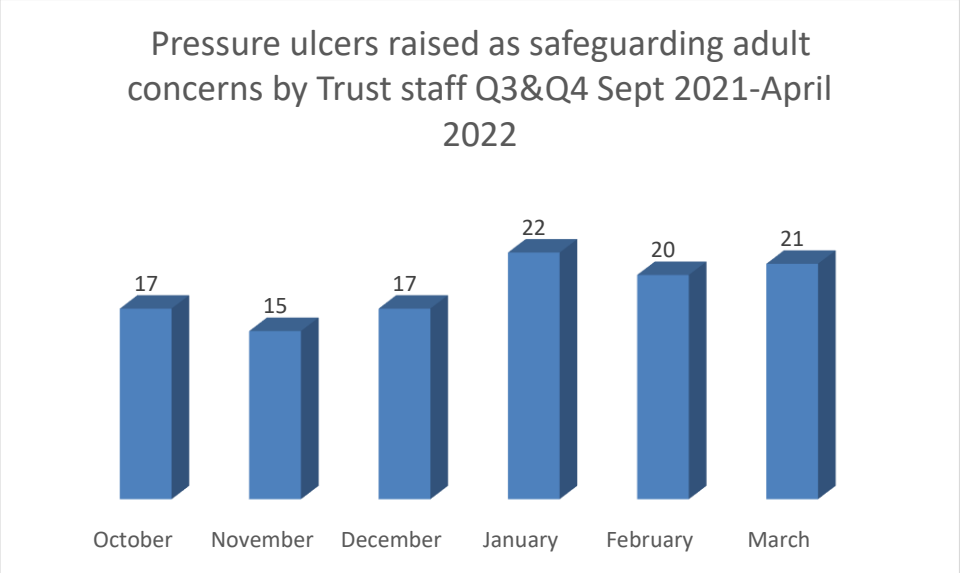
3.14 The case example below is an example of a safeguarding adult concern.

CASE EXAMPLE

Clive is a 63 year old wheelchair user, following a leg amputation. Homeless and a user of both drugs and alcohol, Clive has been a frequent attender to the hospital. Concerns have been raised about his self-neglect, and physical health. Following four presentations to ED in a matter of days, Clive always taking his own discharge to buy illicit drugs, a robust plan was put in place to ensure his need for both nicotine and methadone were assessed rapidly upon next presentation, to reduce his compulsion to take his own discharge before his significant physical health needs could be assessed, and treatment commenced. This involved support from partner agencies visiting Clive daily and working on a suitable discharge destination.

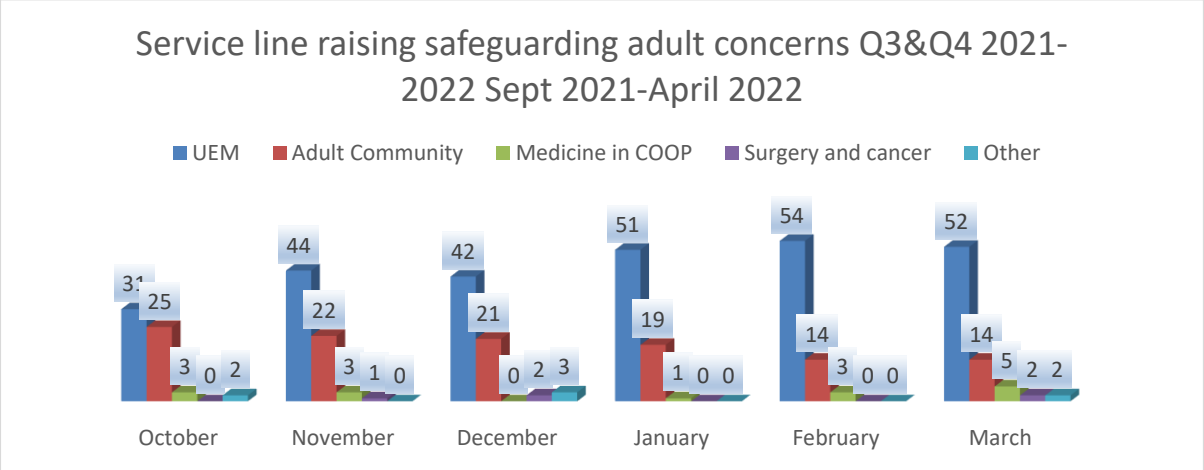
3.15 Training has been provided by the Trust lead TVN during this reporting period to social care, care agency staff, and care home staff.

3.16 Graph 9 below shows numbers of pressure ulcers being identified as safeguarding adult concerns by Trust staff over this period.



Graph 9

3.17 Graph 10 below shows service lines raising safeguarding adult concerns.



Graph 10

4. ALLEGATIONS MADE AGAINST STAFF

4.1. In this reporting period there have been no cases of a member staff employed by the Trust being referred to the LADO (Local Authority Designated Officer). The Allegations against Staff Policy remains in place.

4.2. The number of cases referred to the LADO from health settings is low, but this is in line with other health partners and is linked to the nature and level of contact health workers spend with children comparative to colleagues in education and social care settings.

5.0 TRAINING
Children

5.1 It had been recognised that there were issues with the ESR system's ability to record compliance across the levels. ESR reported compliance with statutory training is improving as a result of the introduction of a new reporting system Elev8. We know that we are training staff, but due to issues with previous reporting systems, accurate and timely recording was an issue.

Training compliance: **Level 1 89%**
Level 2 86%
Level 3 80%

5.2 Safeguarding Partnership Arrangements provide multi agency training and this will provide an additional area in which staff can access training outside of Whittington Health. Whittington Health staff faciltate sessions within this training to maintain the multi agency approach.

Adults

5.3 Training compliance for level 1 safeguarding adults stands at 88% as of end of March 2022.
5.4 Level 2 compliance has increased to 80%.
5.5 WRAP 3 compliance reached 83%.
5.6 Basic Awareness of PREVENT is recorded as 89% compliance.
5.7 These figures are an increase in compliance from the previous two quarters.

6.0 LEARNING FROM SERIOUS INCIDENTS (SI), SERIOUS CASE REVIEWS (SCR CHILD), SAFEGUARDING PRACTICE REVIEWS (SPR's), SAFEGUARDING ADULT (SAR) AND DOMESTIC HOMICIDE REVIEWS (DHR)

Learning and action plans from the SCRs and relevant SIs are presented to the Integrated Safeguarding Committee and through sub groups of the relevant Safeguarding Partnerships and Safeguarding Adult Partnership Board (SAPB).

Safeguarding Children

6.1 Trauma Informed Practice (TIP) remains a key focus across practice and TIPS training has been rolled out across the workforce. Supervision models also focus on trauma and the impact this will have on behaviour and emotional wellbeing in both adults and children.

6.3. Whittington Health has a Serious Case Review/Serious Incident (SCR/SPR/SI) Action Plan that is monitored through the quarterly Integrated

Safeguarding Committee to ensure relevant learning from the SCR/SPR/SI's is implemented. Actions are also monitored through the Safeguarding Partnerships and their respective sub groups.

6.4. In April 2020 external funding from Islington CCG and Public Health to fund a dedicated MASH health worker. This is recognition of the crucial role health plays in the safeguarding partnership. A member of staff was recruited in November 2020 and negotiations are in place to make this a substantive role from September 2022.

Haringey borough has had a long standing commitment to health representation in MASH. In September 2021 an additional substantive member of staff joined the existing permanent member of staff who has been in post since 2018.

6.5. Within children's safeguarding the Trust does not count the number of referrals made to children's social care as this would require central reporting from many different services across the Trust and could delay direct referrals to Children's Social Care (the importance of timely referrals is key therefore appropriate for staff to make direct referrals rather than through centralised place). It would be difficult to generate this data for Whittington Health, however, Children's Social Services departments quality check referrals, and those of poor quality are re-directed back to Whittington Health via the safeguarding team for support and training purposes.

. **Safeguarding Adults**

6.6 Whittington Health inputs into Safeguarding Adult Reviews when asked.

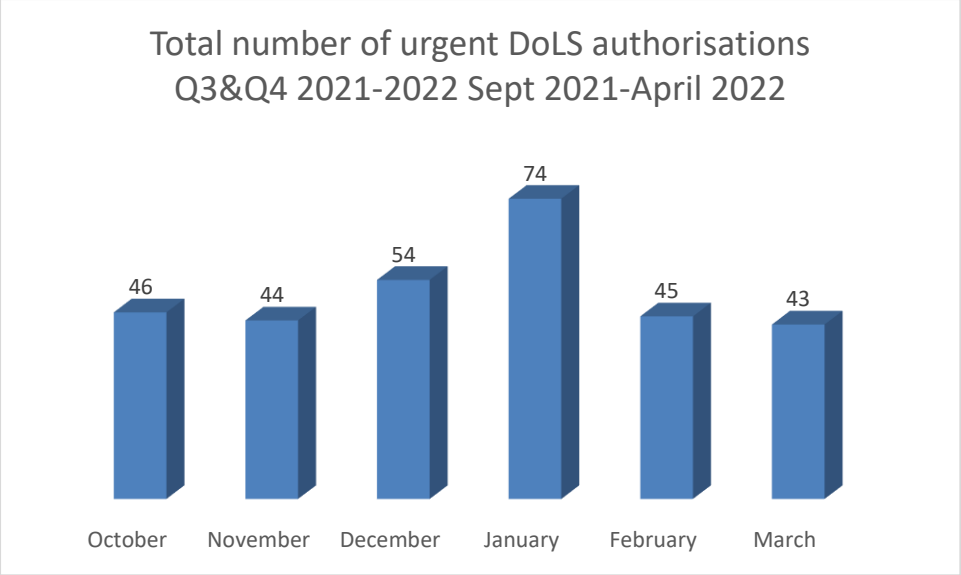
6.7 Currently, we are awaiting two reports, for which Whittington Health had minimal input.

6.8 The Trust continues to be very involved in the Learning Disability death Mortality Review (LeDeR) process, contributing to the dissemination of lessons to be learned, and improving the experience of people with learning disabilities.

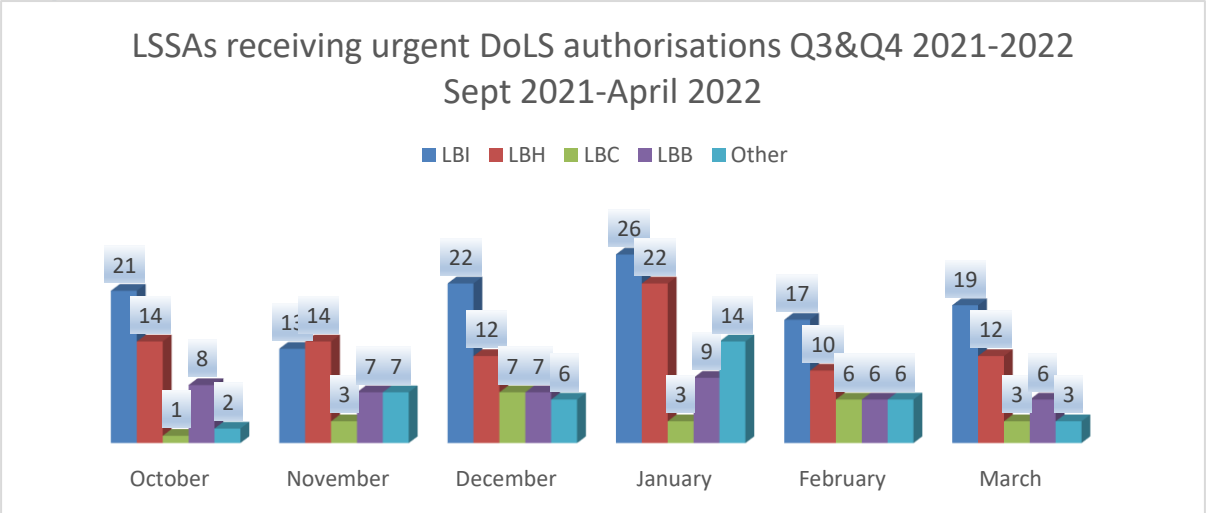
7. DEPRIVATIONS OF LIBERTY SAFEGUARDS

7.1. Graphs 11 and 12 below show numbers of Deprivation of Liberty urgent authorisations applied for within Whittington Health, and which local authority received these.

7.2 These figures will assist when considering resources for the new Liberty Protection Safeguards.



Graph11



Graph 12

8. PRIORITIES 2022/23

8.1. Children

- To continue to support the introduction of Domestic Abuse advocates (IDVA's) across the Trust particularly in the Emergency Department
- To support the introduction of a Trauma Informed Practice (TIPS) approach to practice across the Trust
- To continue to provide high level safeguarding training with the introduction of internally organised safeguarding conferences every quarter
- To contribute and develop practice across the organisation with regards to emerging themes around contextual safeguarding e.g. sexual exploitation and safeguarding risks in the wider community.
- To further develop partnership working between acute hospitals and community services to communicate health and safeguarding needs.

- To strengthen partnership working between midwifery and health visiting in respect of increased perinatal mental health.
- To positively evaluate the impact of the externally funded MASH health worker in Islington to ensure this becomes a permanently funded role.

8.2. **Adults**

- Continue to address develop training around use of the Mental Capacity Act within the Trust for staff
- Ensure a review of the current provision within the Trust for safeguarding adults is undertaken.
- Look to develop appropriate and relevant training for safeguarding adults to reduce the reliance on face-to-face training.
- Undertake a scoping exercise in relation to DoLS activity within the organisation, to assist in planning for the new LPS framework.

9. RECOMMENDATIONS

The Trust Board is asked to: -

(i) To receive assurance that there are systems in place to protect children and vulnerable adults from abuse and neglect whilst in our care.

(ii) To be assured that partners have confidence that Whittington Health is fulfilling its role as a statutory partner in safeguarding children and adults at risk in the wider community and health and care economy.

Meeting title	**Quality Assurance Committee**	**Date:** 19.5.2022
Report title	Annual Compliments, Complaints & PALS Report 2021-2022	**Agenda item:** 14
Executive Director Lead	Michelle Johnson, Chief Nurse and Director of Patient Experience	
Report author	Paul Macpherson, PALS & Complaints Manager	
Executive summary	This report provides an annual overview of compliments, complaints, PALS and quality alerts received during the period 1st April 2021 – 31st March 2022. **Complaints** • 308 complaints requiring a response in 2021-22, 77 in Quarter 1, 95 in Quarter 2, 69 in Quarter 3 and 67 in Quarter 4. This is an increase of 56% in the volume compared to 2020-21 (198), but in line with the figures the years from 2016-2017 through to 2019-2020. • 97% of complaints were acknowledged within the stipulated 3 working days (against the 90% target). • During December 2021 & January 2022, Trust staff were under considerable pressure due to the impact of the Omicron variant and the availability of staff was reduced due to the number of colleagues being unwell themselves or having to isolate. As a result, it was agreed not to report the performance of complaint responses against the 80% target for those two months. The average performance for the remaining months in the year was 64%. (This compares to 81% in 2018-2019, 83% in 2019-2020 & 80% in 2020-21). • There were 8 requests from the Parliamentary & Health Service Ombudsman for information – (9 in 2020-21). **Compliments** • During 2021-22, the Trust received 442 compliments compared to 345 compliments during 2020-21. **PALS & GP concerns** • During 2021-2022, a total of 3165 PALS contacts were received (including those received from GP practices about individual patients) compared to the 2617 contacts during 2020-2021. • 76% of PALS issues related to concerns and 24% related to requests for information, in line with the figures for 2020-21.	

	Quality Alerts • During 2021-2022 the Trust received 5 Quality Alerts from GP Practices, compared to 2 in 2020-21. • These are related to wider issues as opposed to concerns about an individual patient that are logged as 'GP concerns' rather than a 'Quality Alert'. Each of these were immediately shared with the ICSU involved and have been resolved.
Purpose:	The Committee is asked to review and approve the attached Annual Report. This report provides a high-level overview of compliments, complaints, PALS and quality alerts for 2021-22. Please note this report is being presented for the Committee to approve the report's content; document design to be finalised for wider publication by September 2022.
Recommendation(s)	The Committee is asked to review and approve this report for circulation to other relevant meetings and boards.
Risk Register or Board Assurance Framework	This links to BAF Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.
Report history	This report will be available as a public document by September 2022.

Introduction
This is the Complaints & PALS annual report for Whittington Health NHS Trust for 2021 – 2022. The Trust provides services for a population of 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney.

The report provides a summary of patient complaints due to be closed in 2021-2022. It includes details of numbers of complaints received during the year, performance in responding to complaints, Parliamentary and Health Service Ombudsman investigations, and action taken by the Trust in response to complaints.

The report also includes details of the PALS concerns and enquiries and compliments received during 2021-2022, including concerns from GP Practices about individual patients. Of note is that the Trust continues to receive more compliments centrally through the PALS & Complaints team than complaints. There are also a significant number of compliments that are received at ICSU level which are not formally captured.

It should be noted that due to the pandemic, every effort was made to address complaints effectively and positively without the need for a full investigation and written response – there has been an increase in complaint volume as the effect of the pandemic eases somewhat.

Delivering a quality service to our patients and being accountable is one of the Trust's core ICARE values. Key national programmes to drive improvement in patient experience include the annual Quality Account and the Care Quality Commission national patient survey programme.

The Whittington has a strong focus on improving patient experience and this continues to develop and evolve. There are both well established, and some newer mechanisms to capture the experience of patients and drive ongoing improvement. These include the Friends & Family survey and use of information gathered through complaints and PALS, listening to patients, our excellent volunteering programme and in addition each Trust Board meeting starts with a patient story.

A tracker of 'live' complaints is kept and shared with the ICSU's on a weekly basis and discussed at regular meetings with ICSU lead investigators to ensure complaint investigations are on track and any barriers to timely completion identified.

Patient complaints are reported to the Board on a monthly basis in the integrated board performance report, which in addition forms part of the Patient Experience report, which integrates complaints data with patient feedback from the Patient Advice and Liaison Service (PALS), the inpatient survey and patient comments.

In summary during 2021-2022 there were:

- 308 complaints requiring a response 77 in Quarter 1, 95 in Quarter 2, 69 in Quarter 3 and 67 in Quarter 4. This is an increase of 56% in the volume compared to 2020-21 (198), but in line with the figure for 2019-20 (309).
- 97% of complaints were acknowledged within the stipulated 3 working days (against the 90% target).
- 442 compliments received compared with 308 complaints.
- 64% of complaints were responded to within the stipulated target number of working days; the target is 80%. (This compares to 81% in 2018-2019, 83% in 2019-2020 & 80% in 2020-21). However, this does not include the performance against target for December 2021 & January 2022 due to the effect on staff availability of the Omicron variant due to sickness and the need to self-isolate.
- A total of 3,165 PALS & GP concerns were received, compared to 2,617 in 2020-2021.
- There were 6 requests for information received from the Parliamentary & Health Service Ombudsman (PHSO) – one case remains under investigation with the Ombudsman Service.

To put these figures into context, during 2021-2022 there were 46,013 inpatient admissions, 374,883 patients were seen in Outpatient appointments, 107,713 patients attended the Emergency Department, 163,164 patients attended the Imaging Department, & 7,477 theatre procedures were undertaken.

1.0 COMPLAINTS

1.1 Complaints across Directorates and Integrated Clinical Service Units (ICSUs) within the Trust

During 2021-22 a total of 308 complaints requiring a response were dealt with, which is an increase of 56% on the previous year 2020-21 when 198 complaints were dealt with. However, this is in line with the figures since 2016-2017 shown in the chart below. This is largely due to the effects of the pandemic and complainants who are likely to have held complaints back at the height of the pandemic.

Table 1: Overall complaint volumes from 2016-2017 to 2021-2022

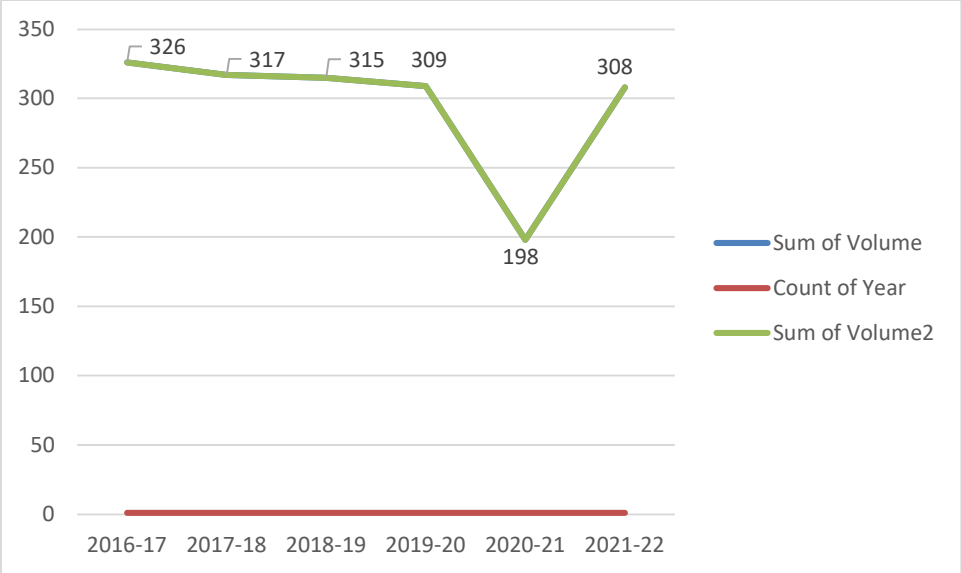
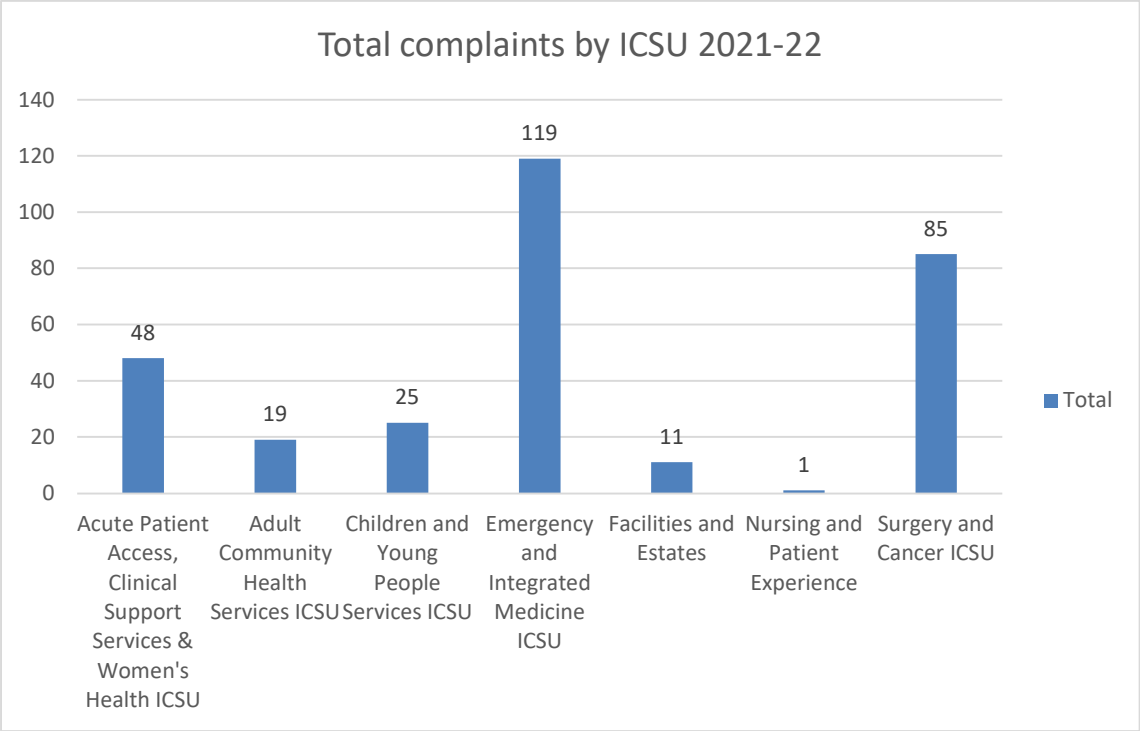


Table 2: Complaints by number April 2021 to March 2022



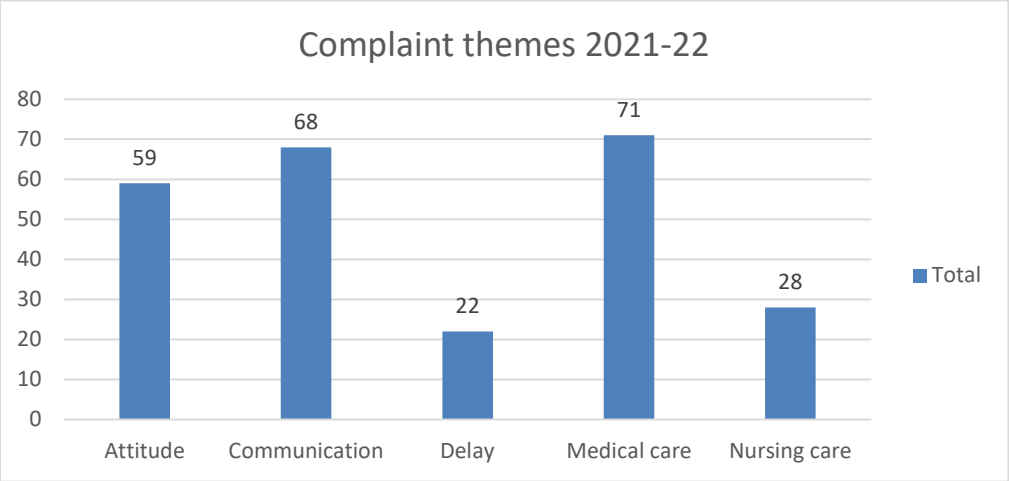
1.2 Complaints across the Trust by subject area (theme)

Table 3 below shows the top 5 subject areas cited in the complaints received during 2021-2022. Themes and trends from complaints are incorporated into the Quality Account priority setting, to ensure we focus on what matters most to our patients.

Communication between clinicians and patients and their families, remains an ongoing priority for the Trust. Building on information directly taken from complaints analysis, the Trust has identified a new quality improvement project relating to improving timely contact with patient's Next of Kin on

admission, as well as rolling out the Zesty app, which gives patients more power to make and amend bookings, which is a key topic in complaints and PALS concerns.

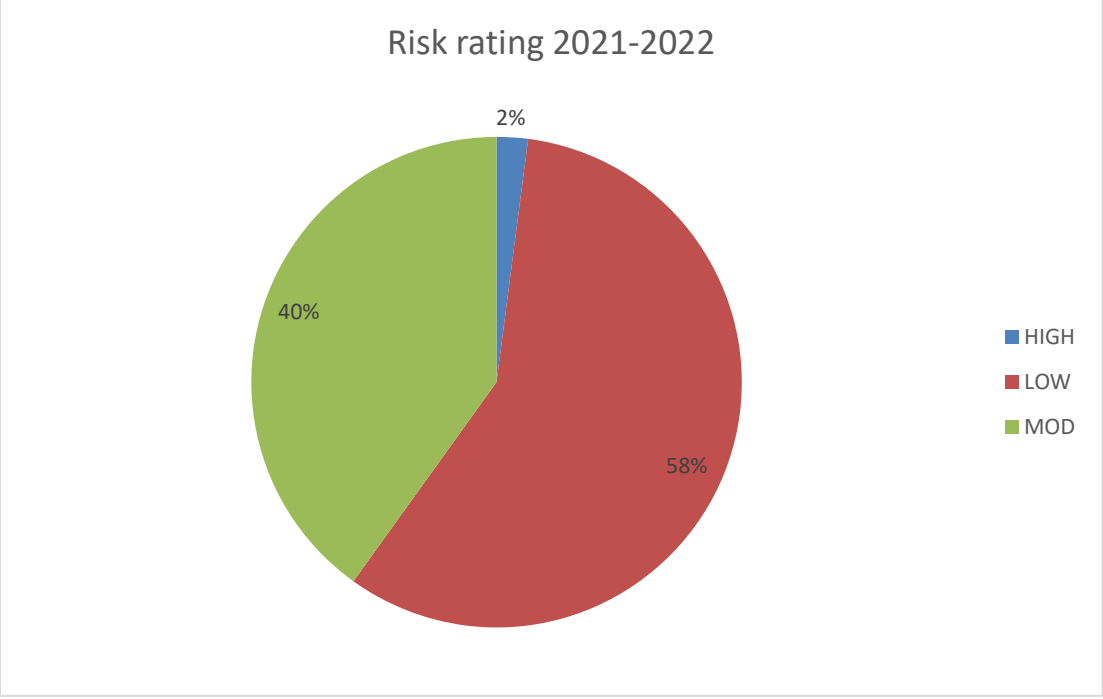
Table 3: Top 5 complaint themes 2021-2022



1.3 Complaints across the Trust by risk rating

During 2021-2022 7 (2%) of complaints were designated as 'high' risk compared to 2 (1%) complaints in 2020-21; most complaints 177 (58%) were designated 'low' risk. 124 complaints (40%) were designated 'moderate' risk. All complaints are risk assessed by the PALS & Complaints team upon receipt and are required to be risk-assessed again by the lead investigator following completion of the investigation.

Table 4: Trust Complaints by risk rating 2021-2022



1.4 Complaints across the Trust by Upheld Status

Of the complaints that were closed on 2021-22, 64 (27%) were fully upheld and 102 (43%) were partially upheld meaning that 166 (70%) of complaints were upheld in one form or another, compared to 2020-2021 when 153 (79%) complaints were upheld in one form or another.

Table 5: Complaints by Upheld Status 2021-2022

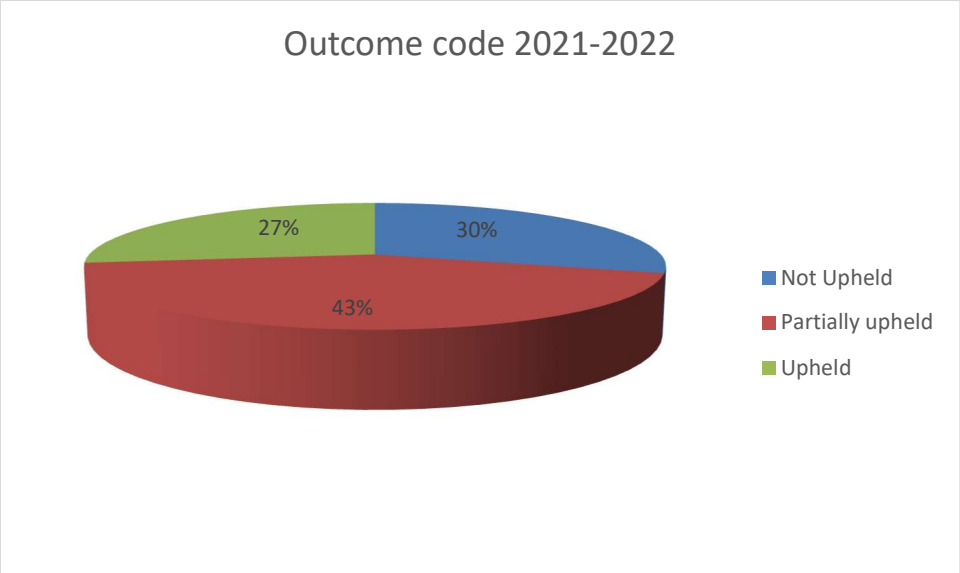
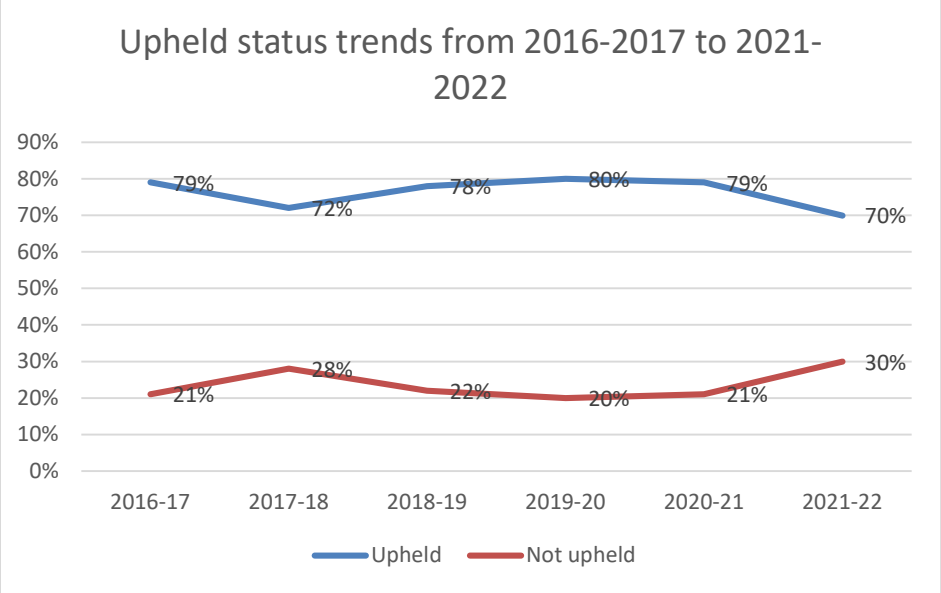


Table 6:



1.5 Response Timescales

The Trust target is for 80% of complaints to have a response sent within the expected timeframe (either 25 or 40 working days) and some 'bespoke (bsk)' where the complaint is linked to a Serious Incident (SI) investigation.

During 2021-2022 64% of complaints were responded to within the stipulated target number of working days, which compares to 81% in 2018-2019, 83% in 2019-2020 & 80% in 2020-21).

However, this does not include the performance against target for December 2021 & January 2022 due to the effect on staff availability of the Omicron variant due to sickness and the need to self-isolate.

Table 7:

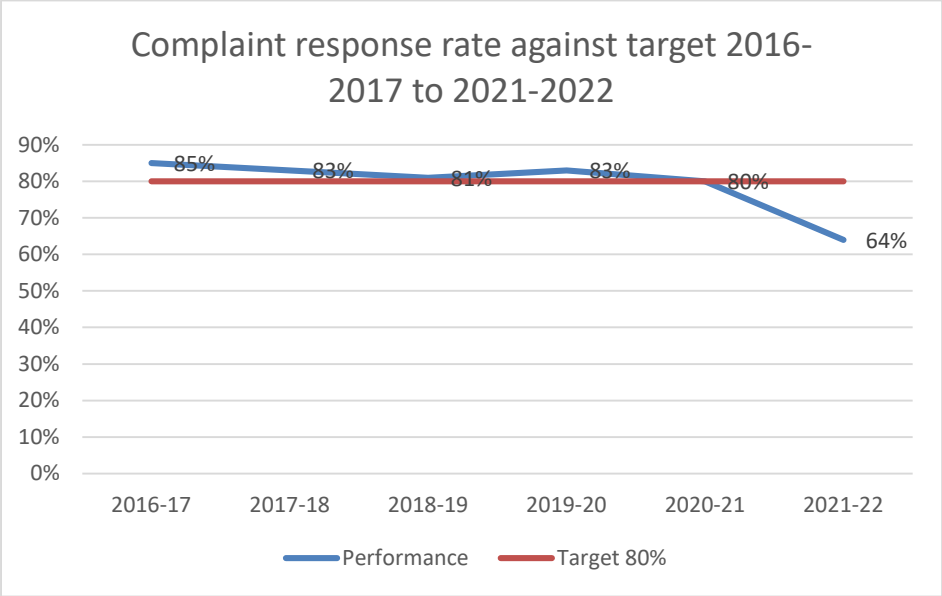
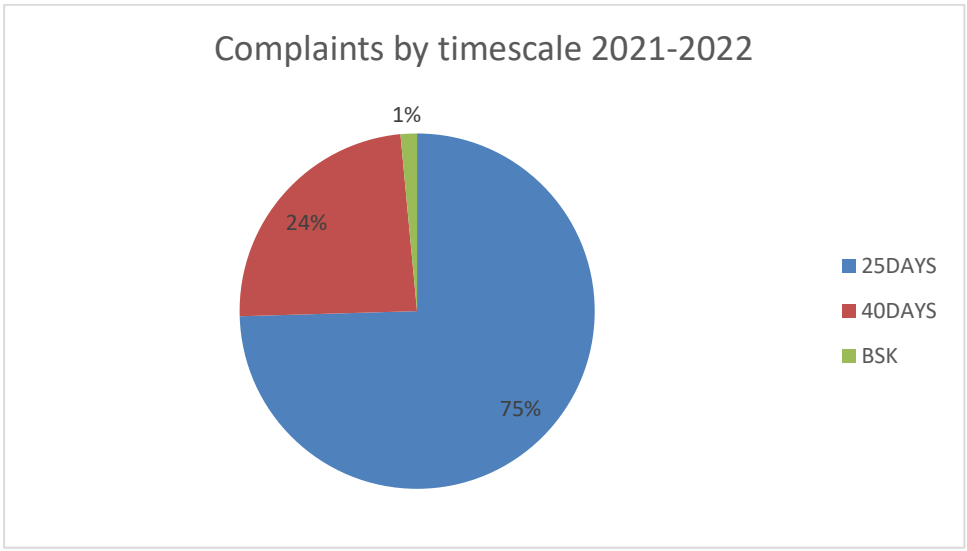


Table 8: Complaints by Timescale 2021-2022



1.6 Quality Alerts

During 2021-2022 the Trust received 5 Quality Alerts, compared to 2 in 2020-2021 – three of these related to delays in ICSUs responding to GP's request for guidance and two related to GP's being asked to refer to other services where that referral should have been done by the clinicians in the Trust. All of these have been responded to and actions taken by the ICSUs, including a review of resources to ensure generic mailboxes are monitored regularly and responses sent.

Table 9:

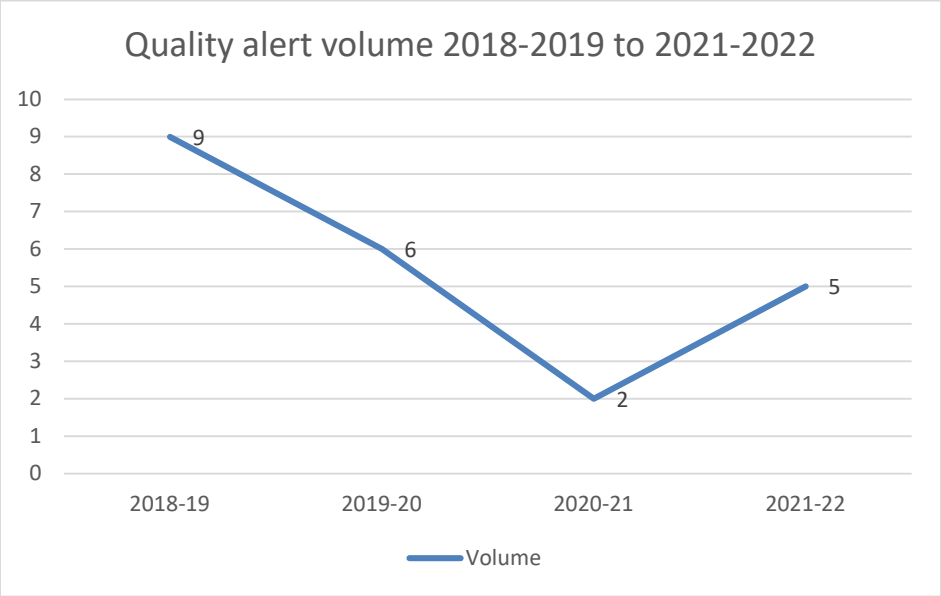


Table 10: Quality Alerts by ICSU 2021-2022

ICSU	2021-2022
ACW	0
ACS	0
EIM	1
S&C	4
Trust	**5**

1.7 Dissatisfied complaints

Table 11 below shows the number of complainants returning dissatisfied or requiring further clarification (by ICSU). During 2021-2022, 48 complainants returned as dissatisfied (or asking for clarification) compared to 31 during 2020-2021. The figure for 2021-2022 is in line with pre-pandemic levels.

Table 11: Dissatisfied Complaints by ICSU 2021-2022

ICSU	Total
Surgery and Cancer ICSU	14
Community Health Services for Adults ICSU	5
Emergency and Integrated Medicine ICSU	19
Acute Patient Access, Clinical Support Services & Women's Health ICSU	7
Children and Young People Services ICSU	3
Trust	**48**

1.8 Parliamentary Health Service Ombudsman (PHSO) Cases

The Ombudsman Service makes final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other UK public organisations. It investigates complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or has given a poor service and not put things right.

During 2021-2022 the Trust received six requests from the PHSO to provide our complaint file and associated records in order that the PHSO could review and consider whether to undertake an independent review compared to eight in 2020-2021.

Case Number	ICSU	PHSO Investigation Yes/No	Complaint Upheld
42528	E&IM	No full investigation	Settlement agreed with complainant
35134	E&IM	Pending – awaiting PHSO update	TBC
38978	E&IM	Pending – awaiting PHSO update	TBC
45733	E&IM	Pending – awaiting PHSO update	TBC
41874	E&IM	No full investigation	Settlement agreed with complainant
39315	E&IM	Pending – awaiting PHSO update	TBC

2.0 COMPLIMENTS

During 2021-2022 the Trust received 442 compliments (for 948 individuals or services) compared to 345 compliments during 2020-2021. These are compliments received via the PALS service or through the Chief Executive's Office. Many more are received directly by services across the Trust. As in previous years, the Trust received more compliments than formal complaints during 2021-2022.

A few examples of the comments received are shown below.

Table 12: Compliment volumes 2016-2017 to 2021-2022

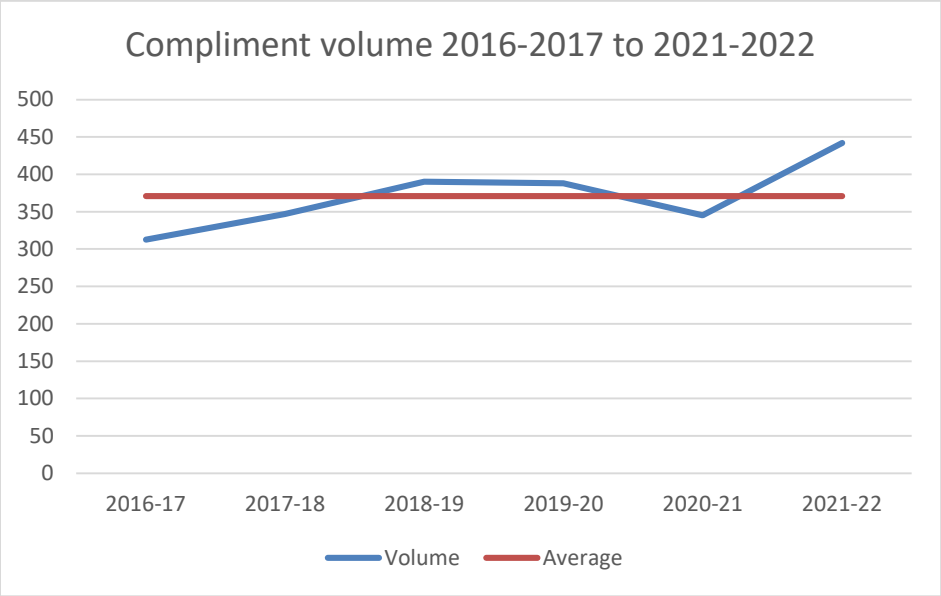


Table 13: Compliments by ICSU 2021-2022

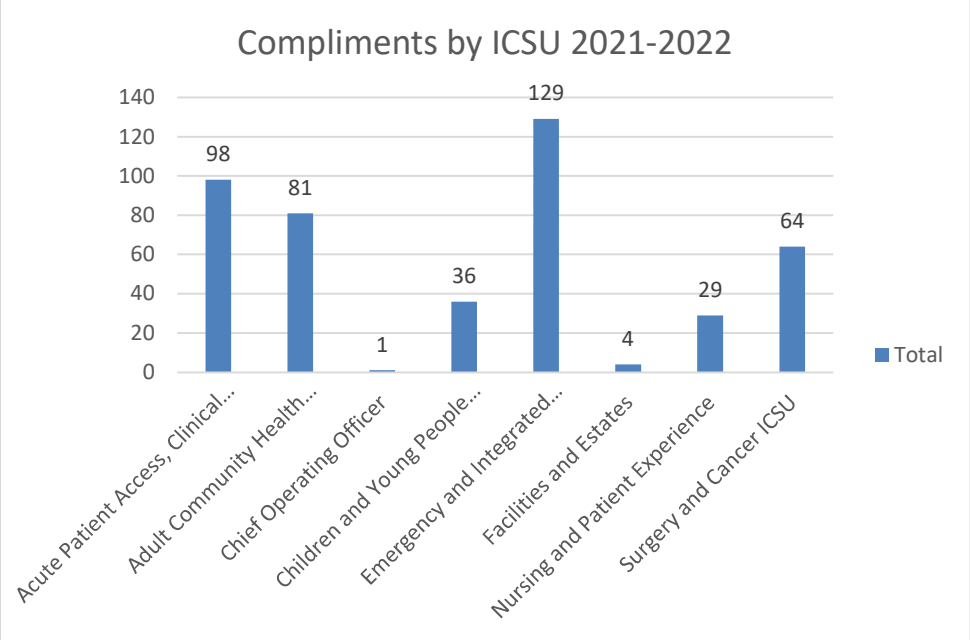
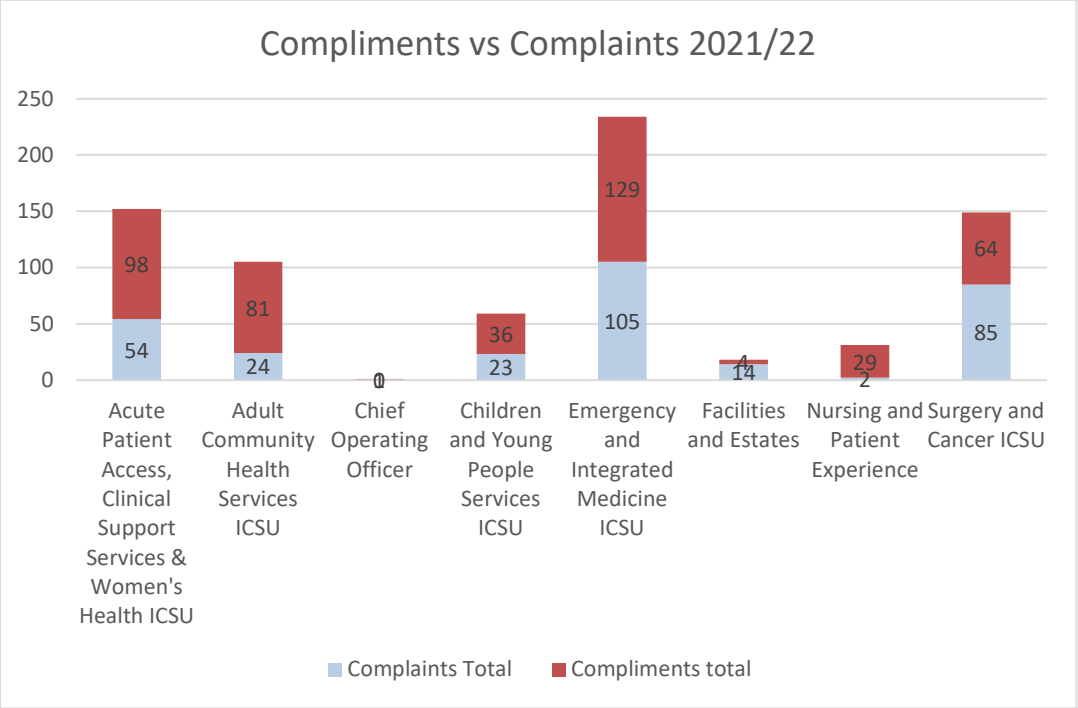


Table 14: Compliments v Complaints by ICSU 2021-2022



3.0 PALS

During 2021-2022 a total of 2,853 PALS contacts were received compared to 2,312 contacts during 2020-2021. 2,103 (74%) related to concerns and 750 (24%) related to requests for information.

Table 15.

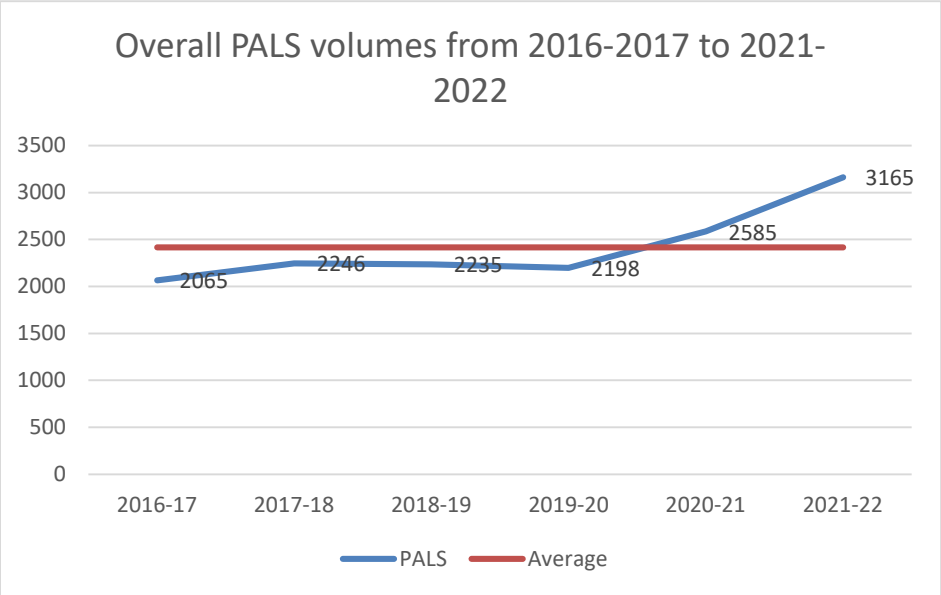
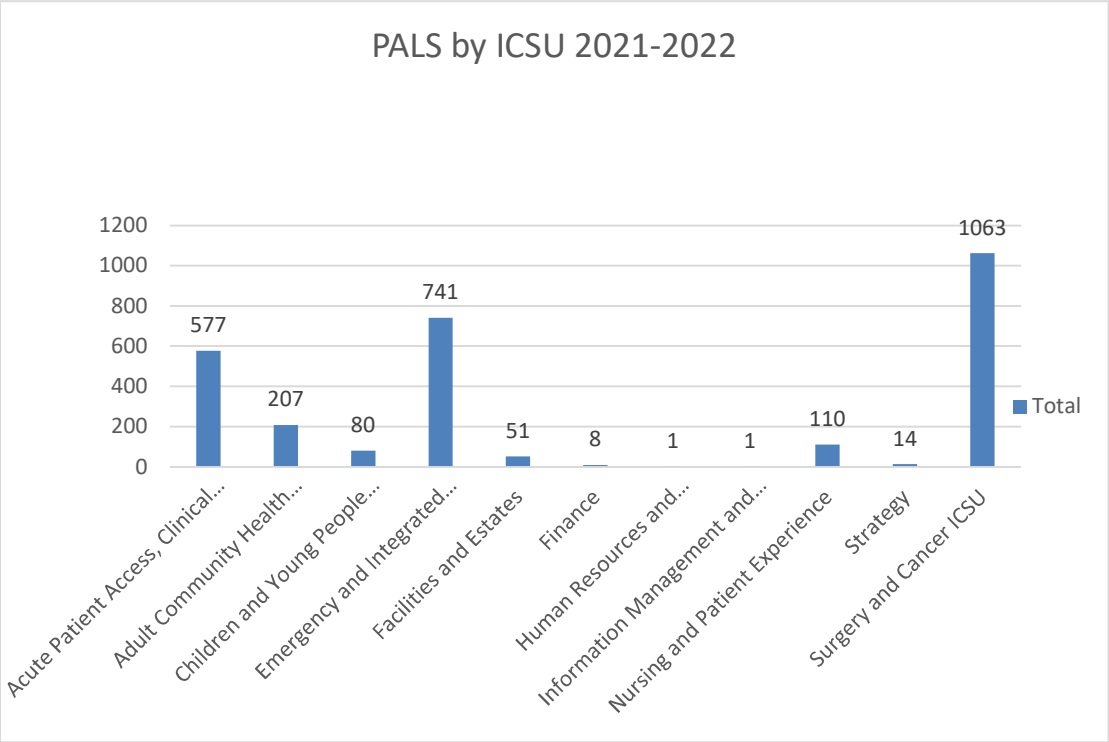


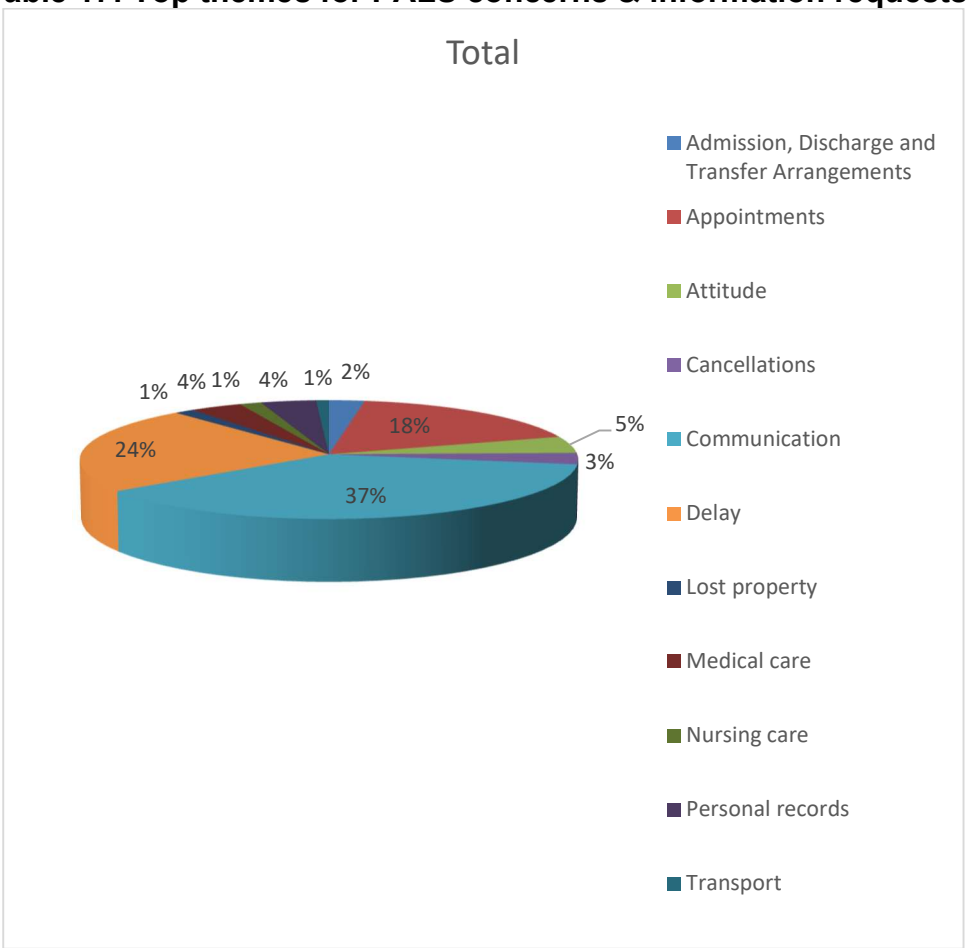
Table 16: PALS Contacts 2021-2022



3.1 Trust PALS Contacts by subject area

The chart below shows the top subject areas cited in PALS contacts received during 2021-2022.

Table 17: Top themes for PALS concerns & information requests 2021-2022



3.2 Diversity Data

The PALS & Complaints team continues to cross-check this information through Medway although the information is also requested through the PALS & Complaints leaflet. The PALS & Complaints team have access to the community electronic patient record system (RiO) enabling the team to cross-check information from 2021-2022. All data collected from Datix is shared with the Department of Health through the KO41 quarterly reports.

Charts 18 and 19 below show the demographic data for Ethnicity & Gender for 2021-2022. The data for age and disability figures had too many unknowns to provide a meaningful breakdown.

Chart 18: Ethnicity

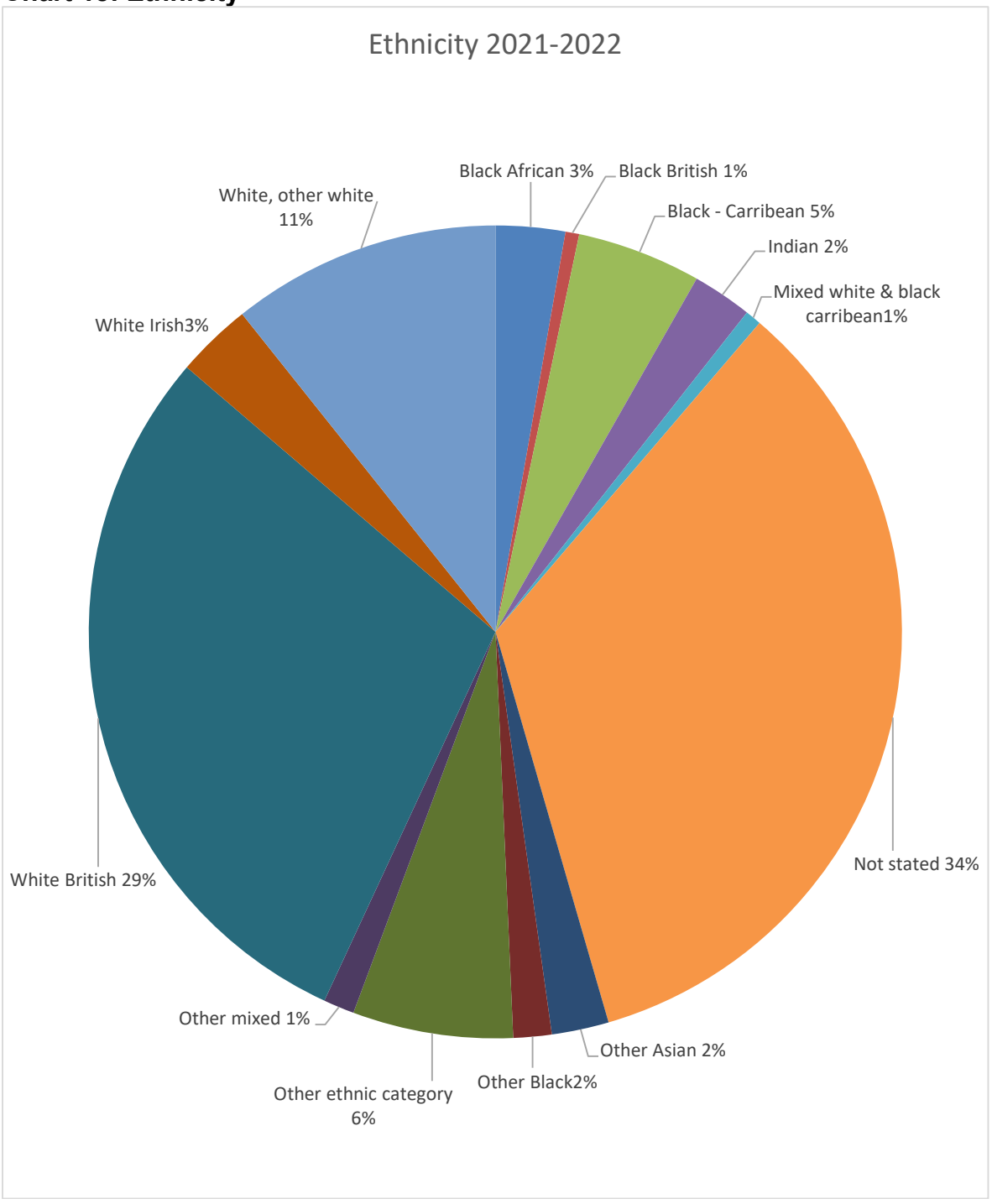
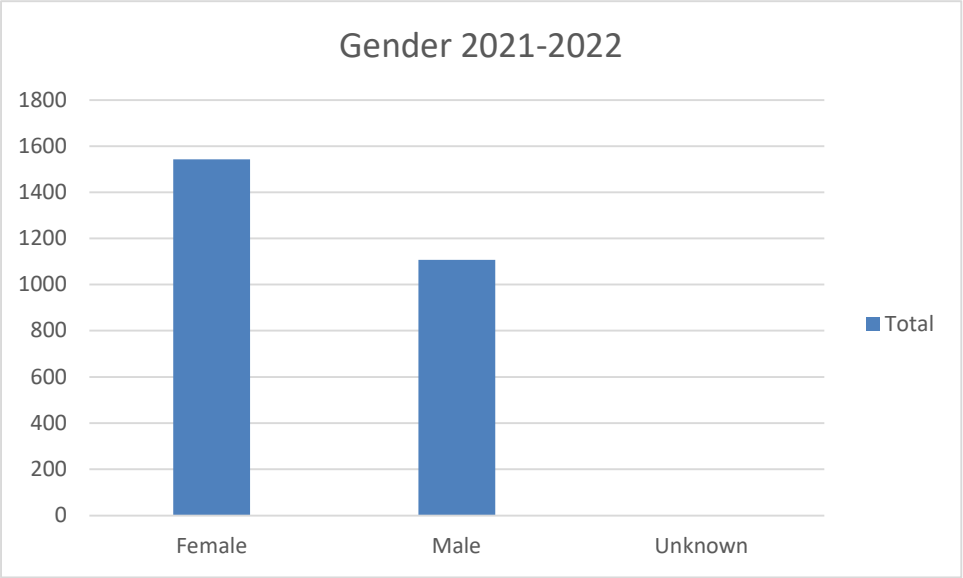


Chart 19: Gender



3.3 GP Concerns

During 2021-2022 the Trust received 312 concerns from GP Practices. This compares to 273 received in 2020-2021. The split between the ICSUs & the main themes are shown in the graphs below.

Table 20: GP concerns by ICSU 2021-2022

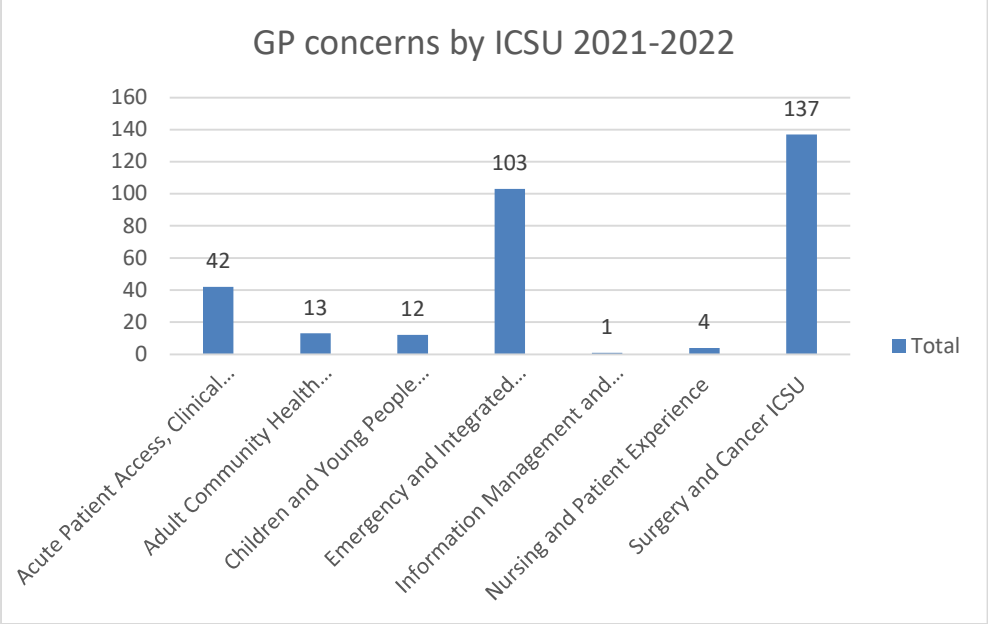
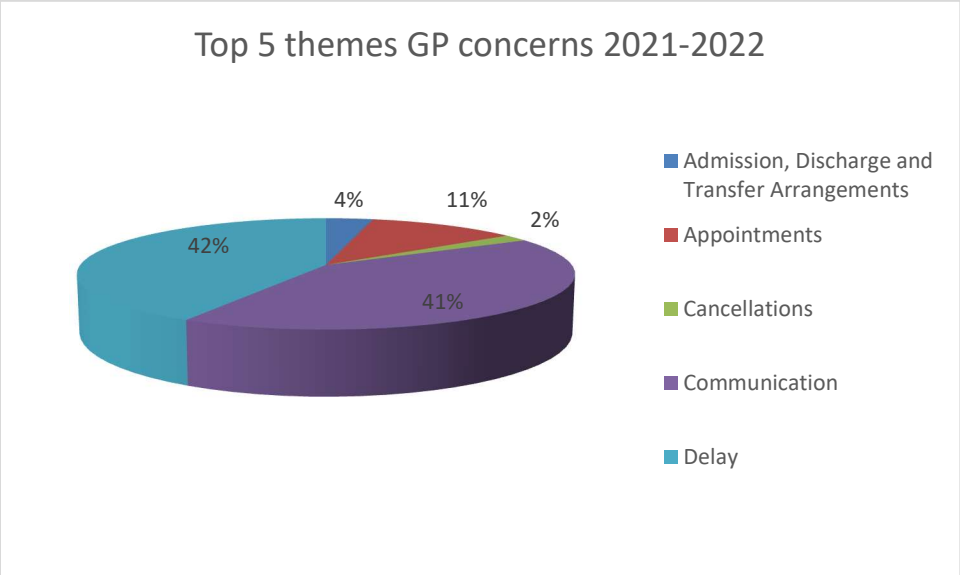


Table 21: GP concerns top 5 by Theme 2021-2022



In all cases the GP requests for help were shared with the appropriate service who were asked to resolve and contact the GP Practice. A significant number related to the lack of discharge summaries (or the lack of detail in discharge summaries) following patients attending the Emergency Department. This has been escalated to senior staff including the Director of Operations and Associate Director of Nursing for E&IM together with the Trust's Chief Operating Officer.

3.4 NHS Choices

The Trust continued to receive anonymous feedback via NHS Choices, which are included in the Compliments and PALS figures shown above. All of these were acknowledged and responded to and shared with the relevant ICSU. Where concerns were raised our acknowledgement included an invitation to contact the PALS team with details for further investigation.

4.0 Support & Training

The PALS & Complaints team provides ongoing support to the ICSUs by ensuring the availability of a regular programme of training sessions, delivered across several sites. The team also provided a complaints introductory session as part of Trust Induction and ad hoc complaints management training for relevant new employees. Induction sessions have recently recommenced.

The team will continue to work closely with the ICSUs to identify further ways in which it can be supportive and facilitate continuous learning and improvement.

During 2021-2022 most training was curtailed due to the pandemic. However bespoke training via TEAMS was delivered to several ICSUs on request.

5.0 PLANS FOR 2022-2023

5.1 Learning from incidents, complaints and claims

A collaborative project is to be undertaken by the Complaints and Legal Services Team to improve safety and learning through the triangulation of data by investigating and monitoring the percentage of complaints that become claims. A data set has been identified and collated which will be reviewed to identify whether any common themes exist with the aim to reduce claims, legal costs and improve patient experience.

5.2 Evaluating the learning from complaints

All complaints that are either upheld in any way require an Action Plan to be described in the response to demonstrate any learning that has been identified. Those actions are recorded on Datix and followed up by the ICSUs to ensure learning is embedded.

5.3 Examples of learning to improve the patient experience

5.3.1 A complaint about a missed hip fracture was responded to in Q4. The patient, who had suffered a fall, declined to attend the Emergency Department due to waiting times and COVID. Her Rheumatology consultant referred the patient for an x-ray, which was then discussed in a Rheumatology Radiology meeting, where (with the patient's known history in mind) a Radiologist reported there was no fracture seen, which was reported back to the patient, though the patient was advised to attend the ED if their pain persisted. A review three days later showed there was a subtle hip fracture, which was then confirmed by a CT scan and the patient referred to Orthopaedics.

As a result of the complaint, all patients to be discussed at the Rheumatology meeting are now listed so there are no ad hoc discussions/requests. This will allow the Radiologist involved the time prior to the meeting to review any imaging without distraction.

The x-ray has also been referred to the Radiology discrepancy group where all missed/discrepancies are discussed and used a learning tool.

5.3.2 A complaint relating to Trauma & Orthopaedics (T&O) where a patient was diagnosed with a right achilles rupture when attending the Emergency Department. The initial decision was to operate, but then the decision changed to conservative management. Apologies were given for the confusion and discomfort the patient has experienced.

The T&O service is working to introduce an electronic trauma system that will improve the management of referrals and improve communication with patients including via text updates on their pathway. The service is also working on a physio-led quality improvement project to review how the service manages the achilles tendon pathway and how they communicate with patients regarding condition management.

Finally, the service is working with the reception teams to improve communication via a series of customer service training over the next few months and the introduction of a looped answer phone message system to ensure faster response times to calls.

5.3.3 A complaint relating to Pharmacy where a patient was directed back to the prescribing doctor (a GP working in the Emergency Department) when asking for their insulin due to a discrepancy on the request. Unfortunately, the doctor was not immediately available. Eventually the GP returned to Pharmacy with the patient who was given their insulin.

As a result of the complaint, Pharmacy staff have been advised not to send patients back to departments and to escalate to senior Pharmacy staff to seek a resolution.

5.3.4 A complaint relating to a delay in District Nursing liaising with a GP Practice for a repeat prescription for medication that needed to be administered regularly to a patient. Although the request for a repeat prescription was made there was a delay. As a result of the complaint, the District Nursing teams have been asked to follow-up any email request to GP Practices with a telephone call to ensure prescriptions are dealt with as quickly as possible.

Meeting title	**Trust Board – public meeting**	**Date: 22 July 2022**
Report title	**Workforce Assurance Committee Chair's report**	**Agenda item: 7**
Committee Chair	Rob Vincent, Non-Executive Director	
Executive director lead	Norma French, Director of Workforce	
Report authors	Swarnjit Singh, Joint Director of Inclusion and Trust Secretary	
Executive summary	Trust Board members are presented with the Workforce Assurance Committee Chair's report for the meeting held on 13 July 2022. **Areas of assurance:** • 2021/22 Quarter four workforce report • Staff survey results – pay levels • Guardian of Safe Working Hours report • Workforce disability and race equality standard submissions • Board Assurance Framework – People entries • Trust Risk Register – People entries The Committee thanked contributors for the quality of the reports discussed at the meeting. It also received a verbal update on the launch of the Just Culture work which was due to be launched at Whittington Health and noted a report would be considered at its next meeting in October. A short update was given on the development programme for bands 2 -7 from a black, minority ethnic background Although the Committee was assured by the level of attention, and the appropriateness of action plans, that were associated with each of the reports it considered, a recurrent theme was the continuing impact on the wellbeing of staff caused by extended periods of extended working hours The Committee also agreed that more time was needed at future meetings to allow for fuller consideration and discussion of the reports presented.	
Purpose	Note	
Recommendation(s)	Board members are invited to note the Committee Chair's report, particularly areas of significant assurance, and the outcomes from the Guardian of Safe Working report and the annual workforce disability and race equality standard outcomes for submission to NHS England.	
BAF	People entries	
Appendices	1: Guardian of safe working report 2: Workforce race equality standard submission 3: Workforce disability equality standard submission	

Committee Chair's assurance report

Committee name	Workforce Assurance Committee
Date of meeting	13 July 2022
Summary of assurance:	

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

2021/22 Quarter four workforce report

The Committee was apprised that the 2022/23, quarter one report was not yet available. It noted the following key headlines from the final quarter of the last financial year, which showed an increase in vacancy, sickness absence, and turnover rates.

Assurance was provided by the Associate Director of Workforce that the increase in sickness absence was largely short term absences and was being managed, along with the low numbers of cases involving long term staff sickness. Committee members were informed that pressures on management and Staff Side colleagues were the cause of some delays in formal employee relations cases and that staff involved were kept fully informed. They were also assured that one benefit from introducing the Just Culture initiative would be a reduction in formal employee relations cases.

During discussion of turnover rates, Committee members received assurance that the Trust continued to attract good quality candidates for advertised vacancies, apart from areas that were already identified as hard to recruit to, such as the emergency department, anaesthetists and physiotherapists.

The Committee also received an update on the comprehensive activity taking place both in North Central London and at Whittington Health to support staff with cost of living pressures. Areas under consideration for active support included an increase in mileage rate allowances, salary sacrifice initiatives such as cycle to work and cars, and partnership work with local food banks. It was noted that Whittington Health was already a London Living Wage employer.

Glenys Thornton commented that staffing remained the biggest single risk across the NHS. It was accepted that human resources work could be strengthened as part of anchor institution activity which the Trust was involved in with local health and social care partners to reduce health inequalities for local people. This would include Bank Partners providing opportunities to more young people in Camden and Islington and through better engagement with local schools to replicate arrangements in place with colleges.

Assurance was also provided that leaders across Whittington Health remained focussed on the need to improve compliance with annual staff appraisals and mandatory training. They were reviewed as part of quarterly reviews of performance by integrated clinical service units, with trajectories in place to achieve better compliance against target.

Staff survey results – pay levels
Committee members welcomed a report on the satisfaction of Whittington Health staff's satisfaction with current levels of remuneration. They noted the following points:

- Staff at the trust had experienced a steep decrease and the organisation has scored 1.5% above the worst in the acute and acute and community provider categories
- There are indications that registered nursing and midwifery staff, and medical staff were less satisfied with their level of pay, and that may be related to the fact that these staff groups also reported that they worked additional unpaid hours each week
- Dissatisfaction was also reported by some staff based in the community who received an outer London High Cost Area Supplement (HCAS) in comparison to the inner London HCAS for employees based in Camden and Islington

The Committee noted the report and that dissatisfaction with pay levels was part of a wider set of concerns by staff nationally at the cost of living currently and the constant pressures they had faced during the pandemic. Committee members also received assurance that Trust leaders were using every opportunity at a local and national level to draw attention to the concerns of staff.

2021/22 Quarter four Guardian of Safe Working Hours report
Committee members thanked the Guardian of Safe Working Hours for her all her work over the past years and noted that this would be her last attendance at the Committee before a new Guardian took up post. They noted that the reporting period covered was a time when many junior doctors were off sick with COVID-19 themselves or were working in areas adversely impacted by other staffing absences during a COVID-19 surge. They also noted the report's key conclusions:

- This quarter's report showed a steady, but variable levels of exception reporting.
- The majority of exception reporting continued to be seen in the Emergency and Integrated Medicine Clinical Service Unit. This was likely to reflect the ongoing impact of the pandemic on the work force both in terms of personal illness and fatigue but also persistent high clinical demands
- Primary events leading up to exceptions were issues due to workload and times when there was very minimal staffing on the wards due to rota gaps, on-call commitments and sickness. This had an increased impact, especially on the provision of emergency care and on-call rotas. The Trust was aware of the issues and is trying hard to mitigate risk to both patients and staff
- Very low levels of exception reporting was identified in certain specialities, e.g. anaesthetics, radiology and at higher grades. Attempts

	are being made to increase engagement and, while there had been some improvement, this was a well-recognised issue nationally The Committee thanked the Guardian of Safer Working Hours for the quarterly report. The Committee also noted the need to continue to promote exception reporting and the long term impact of the pandemic and from sustained operational pressures on junior doctors' working hours. **Workforce disability and race equality standard** Committee members thanked the Joint Directors of Inclusion for their report on the outcomes for the annual disability and race equality standard which would be submitted to NHS England by the deadline of 31 August. They noted the continued improvement in most indicators and supported the updated action plan to address findings. In particular, they noted the audit of employee relations cases to provide greater assurance and more details in relation to the disproportionate involvement of black and minority ethnic staff in formal disciplinary processes, the inclusion of all training and development activity, particularly for medical, nursing and midwifery and allied health professional staff, and the ongoing work to improve levels of diversity data held on staff, particularly in relation to disability status. **Board Assurance Framework and Trust Risk Register – People entries** The Committee noted the Board Assurance Framework and Trust Risk Register.
2.	**Present:** Rob Vincent, Non-Executive Director (Committee Chair) Junaid Bajwa, Non-Executive Director Kevin Curnow, Chief Finance Officer Clare Dollery, Medical Director Norma French, Director of Workforce Carol Gillen, Chief Operating Officer Glenys Thornton, Non-Executive Director **In attendance:** Simon Anjoyeb, Equality Lead Eliana Chrysostomou, Head of Organisational Development Jerry Francine, Operational Director of Finance Kate Green, Executive Assistant Tina Jegede, Joint Director, Race, Equality, Diversity & Inclusion and Lead Nurse, Islington Care Homes Helen Kent, Assistant Director of Learning & Organisational Development Beverleigh Senior, Director of Operations, Acute Clinical Services & Women's Health Mala Shaunak, Organisational Development Consultant Swarnjit Singh, Joint Director, Race, Equality, Diversity & Inclusion and Trust Secretary Rebecca Sullivan, Guardian of Safe Working Kate Wilson, Associate Director of Workforce

Meeting title	**Workforce Assurance Committee**	**Date: 13/07/22**
Report title	**Guardian of Safe Working Hours Report Q4 2021-22**	**Agenda item: 22/07**
Executive director lead	Dr Clare Dollery, Medical Director	
Report author	Dr Rebecca Sullivan, Guardian of Safe Working Hours (GoSWH)	
Executive summary	• This report also covers a time when lots of junior doctors were off sick with COVID-19 themselves and we saw critically low numbers of junior doctors in some teams. This led to low numbers of trainees on the wards during the end of this quarter. • This, coupled with high levels of acuity of patients has led to high levels of exception reporting this quarter. • Nationally there are lower than previous numbers of junior doctors available to fill bank and agency shifts also which leaves on-call teams very stretched. • We continue to be forced to move trainees within specialities at times to support safe working. • There continue to be high levels of fatigue and burnout amongst all staff across the NHS and this has affected our doctors and dentists in training also. • The GoSWH has continued to work with the postgraduate department, rota coordinators and the Junior Doctors Forum (JDF) during this period to support all the trainees to face the challenges before them whilst ensuring safe working throughout this period.	
Purpose:	• To provide assurance to the Board that Junior Doctors are working safe hours in accordance with the 2016 *Terms and Conditions of Service for NHS Doctors and Dentists in Training*.	
Recommendation(s)	The Board is asked to review this report.	
Risk Register or Board Assurance Framework	NA	
Report history	NA	
Appendices	NA	

Guardian of Safe Working Hours (GoSWH) Report Q4 2021-22

1. Introduction

1.1. This report is presented to the Board with the aim of providing context and assurance around safe working hours for Whittington Health junior doctors.

1.2. In August 2016 the new Terms and Conditions (TCS) were introduced for doctors in training. There are clear guidelines of safe working hours and adequate supervision. Trainees submit an 'exception report' (ER) if these conditions are breached. The 2016 TCS has more recently been amended in 2019.

1.3. ERs are raised by junior doctors where day to day work varies significantly and/or routinely from their agreed working schedule. Reports are raised electronically through the Allocate's E-Rota system. The educational/clinical Supervisor for the individual doctor and the GoSWH receives an alert which prompts a review of the ER and requires the supervisor to meet with the trainee to discuss the events leading to the ER and to take appropriate action to rectify. Such action may include time off in lieu or payment for additional hours worked. They are also asked to review the likelihood of a further exception recurring and address this with the trainee. Where issues are not resolved or a significant concern is raised, the GoSWH may request a review of the doctors' work schedule. The GoSWH, in conjunction with the Medical Workforce team, reviews all exception reports to identify whether a breach has occurred which incurs a financial penalty. The GoSWH will levy a fine to the department employing the doctor for those additional hours worked.

1.4. In line with the 2016 TCS a Junior Doctors Forum (JDF) has been jointly established with the GoSWH and the Director of Medical Education. It is chaired by the GoSWH. The Forum meets on an alternate monthly basis. We continue to have good attendance and engagement well above other local Trusts. Meetings are current a hybrid of a face to face and virtual meeting.

2. High level data

Number of doctors / dentists in training (total):	230
Number of doctors / dentists in training on 2016 TCS (total):	230
Job planned time for guardian:	1 PA
Admin support provided to the guardian (if any):	as required from MD office
Amount of job-planned time for educational supervision:	0.25 PAs per trainee

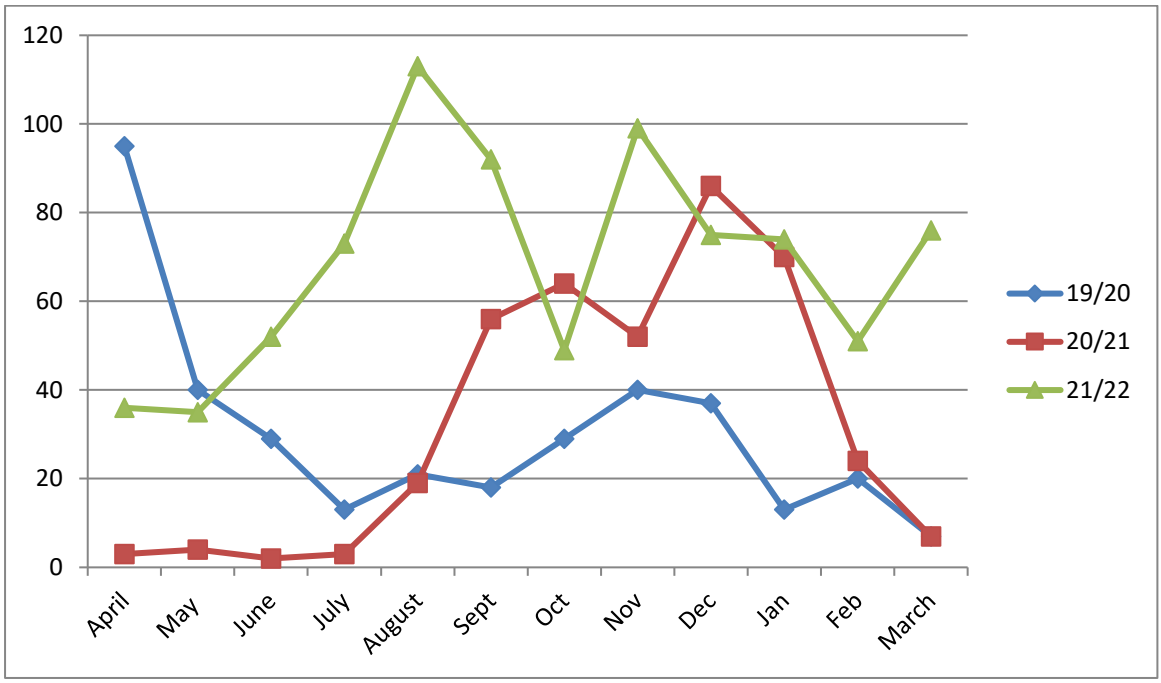
3. Exception reports (with regard to working hours)

3.1. Between the 1st January and the 31st March there have been a total of 201 ERs raised. The table below gives details on where exceptions have been raised and the responses to deal with the issue raised.

Table 1: Exception reports raised and responses

2022		Jan	Feb	Mar	Total
Reports	Grand Total	74	51	76	201
	Closed	74	51	76	201
	Open	0	0	0	0
Individual doctors / specialties reporting	Doctors	24	18	25	-
	Specialties	3	3	3	-
Immediate concern		1	2	2	5
Nature of exception	Hours/Rest/pattern	73	50	75	198
	Education/Training/service support	1	1	1	3
Additional hours	Total hours	100	79.25	115	294.25
Response	Agreed	74	51	76	201
	Not Agreed/Not yet actioned	0	0	0	0
Agreed Action *('No action required' is the only response available for 'education' exception reports)*	Time off in lieu (hrs)	19	11	7	37
	Payment for additional hours (hrs)	49	38	65	152
	No action required (ERs)	6	2	4	12
	Other/Pending (ERs)	0	0	0	0
Grade	Foundation year 1	63	39	52	-
	Foundation year 2	3	9	10	-
	IMT/ST1 or ST2	8	3	14	-
	GP Specialty Registrar	0	0	0	-
	Specialty Registrar	0	0	0	-
Exception type *(more than one type of exception can be submitted per exception report)*	Work Load	38	22	43	103
	Pt/Dr ratio too high	25	18	27	70
	Rota gaps	12	9	7	28
	Late running WR	3	3	5	11
	Deteriorating patient	15	8	9	32
	Educational	1	1	1	3
Specialty	General Medicine	49	48	63	160
	General Surgery	21	2	7	30
	T&O	0	0	0	0
	Paediatrics	0	0	0	0
	Anaesthetics/ITU	0	0	0	0
	Radiology	0	0	0	0
	Psychiatry	4	1	0	5
	Obstetrics and gynaecology	0	0	0	0
	Accident and emergency	0	0	6	6
	Histopathology and micro	0	0	0	0
	Ophthalmology	0	0	0	0

Graph 1: Exception reports over three years by Month



3.2. The number of ERs submitted per month is very variable throughout the year and year on year. The impact of the COVID-19 pandemic has exacerbated these variations as we have been hit by waves of infection. Over the last three months there has been an ongoing fluctuation in the level of ERs. The variation is in keeping with the unpredictable nature of the pandemic and exception reporting.

3.3. During this quarter we have had ongoing high levels of staff sickness and need for self-isolation. Despite the fall in the number of patients being admitted with COVID-19, and certainly a fall in the critically unwell patients with COVID-19, there is still an ongoing and extremely difficult impact on staffing because of the pandemic.

3.4. We have seen ongoing high numbers of non-COVID admissions with persistent use of escalation “winter pressures” beds during this quarter. This has led to high clinical workloads for junior doctors which is felt to be reflected in the ongoing higher level of ER during this quarter. The medical and emergency teams have been very stretched during this period.

3.5. As has been highlighted at a national level there is ongoing and increasing concern over the mental health and stamina of the NHS workforce across all professions and grades. It is likely that this will be reflected in the volume of ERs over the coming months and it will be very important to establish ongoing support of all trainees as this takes effect.

Immediate safety concerns

3.6. There were 5 reports that was flagged as an immediate safety concerns (ISC) over the three month period. Each has been reviewed in a timely fashion and appropriate action taken to ensure safe working.

Work Schedule reviews

3.7. No formal work schedule reviews have taken place during this quarter. Currently all rotas are compliant.

4. Establishment and Vacancy data

4.1. As has been highlighted in previous reports the accuracy of the data in this section is very hard to guarantee. Due to the working patterns during COVID-19 much of the available data is less reliable. Despite this the GoSWH has been working with the finance department and the workforce team to try to provide accurate data. For this report College tutors have been contacted directly to try to improve the accuracy of data presented.

4.2. Bank and Agency usage

4.2.1. Use of bank and agency staff is not fully reflective of current staff vacancies.

Table 2: Bank and agency usage Q4

Speciality	Bank		Agency		Total	
	Shifts	Hours	Shifts	Hours	Shifts	Hours
General medicine	173	1533	122	951	295	2484
ED	433	4100	111	1109	544	5209
General Surgery	49	480	114	1186	163	1666
Urology	43	675	63	729	106	1404
T&O	16	165	0	0	16	165
O&G	65	609	9	104	74	713
Anaesthetics	4	29	1	9	5	38
ITU	15	145	0	0	15	145
Paediatrics	57	590	52	386	109	976
Radiology	40	245	23	184	63	429
Total	895	8571	495	4658	1390	13229

4.3. Locum work carried out by trainees

4.3.1. This data is difficult to present reliably given the way in which the data is retrieved. This data is therefore only an estimate at shifts undertaken by trainees. This data may include trainees from other Trusts coming to cover shifts at the Whittington.

Table 3: Additional shifts worked by trainees

Due to the way that this information is currently collected it is not possible to currently give accurate data around additional shifts that are undertaken by trainees currently working within the trust.

4.4. Vacancies

4.4.1. Due to concerns about the accuracy of data provided by HEE the GOSWH has sought alternative methods of trying to ensure the data provided here is as accurate for the relevant quarter as possible. Presented below is the data that was available at the time of writing of this report.

Table 4: Vacancies per speciality Q4

Speciality	Current vacancies
General Medicine	3.9 WTE vacant ST3+ 0.6 WTE vacant FY2-IMT2
General Surgery inc urology and T&O	1 WTE vacant ST1-2
Obstetrics and Gynaecology	Data unavailable
Emergency medicine	5 WTE vacant ST3 + 5 WTE vacant FY2-ST2
Paediatrics (inc NICU)	1.5 WTE vacant ST3+ 3.2 WTE vacant SHO (Neonates) 1.2 WTE vacant SHO (Paeds)
Anaesthetics inc ITU	2.6 WTE vacant ST3+ 1 WTE vacant CT 1.2 WTE vacant middle grade
Radiology	No vacancies
Microbiology	Data unavailable
Psychiatry	Data unavailable

5. Fines and payment Exception Reports (with regard to working hours)

5.1. For this quarter a total of 309.25 hours are to be re-paid either in TOIL or, if this is not possible, as pay for additional hours worked. It would not be appropriate for TOIL accrued in one specialty to be rolled over to another specialty.

5.2. Currently, these hours equate to a total of approximately £4,428.18 of which £3,571.39 has so far been paid to the junior doctors directly.

5.3. £9,151.28 has been issued in fines to the Trust in accordance with the terms and conditions laid out in the contract. This is to be added to pre-existing fines that have been accrued and is to be kept in a separate fund for the junior doctors. There are currently still issues with ensuring that these fines have been paid and the money is ring-fenced for the JDF. Fines to the Guardian go into the JDF.

5.4. During this quarter the GOSWH has been working hard with the JDF to access the money accrued in fines. This has not been easy as there have been issues in relation to the ring-fencing of this money. The JDF have presented to the relevant senior members of the JDF including the GOSWH, DME and workforce team their proposals in how the fines money should be spent. We are working hard to ensure that the funds are accessible to be spent before the current junior doctors rotate in August. This is proving challenging but progress is being made.

Table 5: Breakdown of fines by ICSU

ICSU	Amount of Fine to Doctor	Amount of Fine to Guardian
Emergency and Integrated Medicine	£2,644.78	£4,409.01
Surgery and Cancer	£786.40	£1,311.09
Children and Young People	Nil	Nil

6. Next steps

6.1. GoSWH to continue to ensure all remaining open ERs are signed off in a timely fashion. Changes made to the contract in 2019 enables the GoSWH to action outstanding ERs at 30 days.

6.2. GoSWH and HR to work with the finance team to ensure the JDF is able to access the fines money to be able to spend it prior to August changeover date.

6.3. GoSWH to continue to work with ICSU leadership teams, rota coordinators and the bank office, to try to reduce the need for ERs by working to fill rota gaps whenever possible. There has been an increase in ER's and this is being monitored closely.

6.4. GoSWH to work with ICSU leads to try to ensure there is an accurate way of reporting bank and agency usage along with the fill rate, to ensure there is accurate and meaningful data for presentation to the Board. This is particularly challenging due to the way that the data is collected but alternative ways of collecting this data are proving more accurate.
6.5. GoSWH to continue to work with the relevant specialities to review working practices that are leading to long running ward rounds contributing to high levels of ERs in certain sub-specialities. The GOWSH has met with the surgical directorate to review barriers to reporting and to try to highlight the non-punitive function of ER's.

7. Conclusions

7.1. This quarter's report shows a steady but variable levels of ERs.
7.2. The majority of ER continues to be seen in the EIM ICSU. This is likely to reflect the ongoing impact of the pandemic on the work force both in terms of personal illness and fatigue but also persistent high clinical demands.
7.3. Primary events leading up to exceptions are issues due to workload and times when there is very minimal staffing on the wards due to rota gaps, on-call commitments and sickness. This is having an increasing impact especially on the provision of emergency care and on-call rotas. The trust is aware of the issues and is trying hard to mitigate risk to both patients and staff.
7.4. There are still very low levels of reporting in certain specialities, e.g. anaesthetics, radiology etc. and at higher grades. Attempts are being made to increase engagement and there has been some improvement. This is a well-recognised issue nationally. The GoSWH continues to promote ER in these areas.

8. Recommendations

8.1. Workforce Assurance Committee is asked to note this report and inform the board in line with national guidance for GoSWH reports.

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NHS
Whittington Health
NHS Trust

Workforce Race Equality Standard

2022 data analysis report for Whittington Health

June 2022

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Foreword

Our people are Whittington Health's greatest asset. Ensuring they have the best possible experience and opportunities links to better patient experience and care.

The NHS has one of the most culturally diverse workforces in the country, made up of over 200 nationalities. (NHS Staff from Overseas: Statistics, Carol Baker, House of Commons Library September 2021) Whittington Health, based in North London, has a higher proportion of Black, Asian and Minority Ethnic staff living and working in the area compared to national trends (circa 15%). This is one reason that good performance on the Workforce Race Equality Standard (WRES) is crucial to the organisation's success.

Our workforce helps deliver both acute and community services that are responsive and meet the needs of the diverse populations served by the Trust; in terms of outcomes and expectations.

The COVID-19 pandemic highlighted areas of inequity that Black, Asian and Minority Ethnic staff faced; and, in some respects, magnified them. The WRES acted as a vehicle to tell the stories of staff about what was going right and what needed improvement. These circumstances were not isolated to the NHS, and the inequity helped fuel movements such as Black Lives Matter in the UK.

This WRES report is the Trust's seventh since the standard was introduced. The report shows improvement in several WRES indicators, particularly regarding recruitment, accessing training and a reduction in reported experience of poor behaviours. However, areas such as the number of Black, Asian and Minority Ethnic senior managers and representation in formal disciplinary processes need further investigation and improvement.

This report acts as a lever for delivering targeted changes to help improve the experiences of our staff.

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Key findings

>Band 8a

From Band 8a onwards, the representation of BME staff drops dramatically. while the opposite is true for white staff.

Generally white staff are underrepresented in bands 2-5, but have overrepresentation in the majority of bands from 7 onwards.

24.1%

Nearly a quarter of Trust staff that have not declared their ethnicity on Electronic Staff Records.

This impacts on the quality of data relating to indicators 1, 3, 4 and 9.

x4.5

White staff are **4.5 times** more likely to progress from lower bands to higher bands than BME staff.

x1.42

White applicants were 1.42 times more likely to be appointed from shortlisting compared to BME applicants; this is an improvement since 2021.

x3.75

BME staff were 3.75 times more likely to enter the formal disciplinary process compared to white staff.

There has been a big increase since 2021, when it was 1.57 more likely.

x1.01

BME staff have equal chance of attending non-mandatory training and CPD as their white colleagues.

-2%

Since 2020, there has been an annual 2 percentage point drop of BME staff that have reported experiencing bullying, harassment and abuse from staff.

39.9%

39.9% BME staff feel that the trust offers equal opportunities for carer progression and progression.

White staff are **1.36 times** more likely to feel that this is the case regarding equal opportunities.

x2

BME staff are nearly twice more likely to have reported experiencing discrimination from their manager, team leader or other colleagues than their white colleagues.

17.6%

Of the board have identify as BME. However, comparing to the overall workforce there is an underrepresentation of **-20.6%** BME board members

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Key findings (2)

Table 1: WRES indicators for Whittington Health NHS Trust : 2017–2022

WRES indicator			Year					
			2017	2018	2019	2020	2021	2022
1	Percentage of BME staff	Overall	45.0%	43.0%	41.6%	40.2%	40%	38.2%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		2.17	2.14	1.65	1.55	1.64	1.42
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		2.41	0.75	1.44	0.85	1.57	3.75
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		-	-	0.94	0.91	1.26	1.01
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	28.6%	29.1%	35.9%	32.5%	30.3%	28.6%
		White	30.3%	28.4%	30.5%	30.6%	28.9%	27.9%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	31.9%	32.5%	36.2%	31.9%	29.7%	27.7%
		White	24.6%	26.7%	31.4%	29.9%	24.2%	25.7%
7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	BME	-	39.8%	35.8%	39.7%	39.7%	39.9%
		White	-	59.5%	56.2%	58.2%	56.4%	54.4%
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	16.6%	17.1%	20.3%	16.1%	16.9%	15.2%
		White	6.6%	8.2%	9.5%	7.8%	8.2%	8.3%
9	BME board membership		13.3%	20.0%	20.0%	16.7%	16.5%	17.6%

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Introduction

A place you want to come to, a place that's fruitful and abundant with joy and laughter. It's a safe and warm place that values and appreciates everyone's difference.

All staff, managers and leaders enable, empower and encourage colleagues, regardless of background to be their best and to give of their best. It's a place where we celebrate together the wonderful nature of our diversity and work together to deliver on our ambition of high quality patient care for the people in our locality and beyond.

Vision Statement
Whittington Health NHS Trust

The NHS is the largest employer in the UK with a workforce that has nearly 1.4 million people in it; of which 20% are from a Black, Asian or Minority Ethnic background. Staff from an minority ethnic background can be found in a number of roles and settings; however, this does not always translate in career progression and representation at senior levels.

The Workforce Race Equality Standard (WRES) is an annual process that is mandated by the NHS standard contract to measure and evaluate race equity within organisations. The WRES helps NHS Trusts to examine the employment journey and experiences of staff from a minority ethnic background and compare to their white colleagues.

What has become apparent over the years since the WRES started is that the experience of Black, Asian and Minority Ethnic staff is poorer compared to their white colleagues; and that any improvements in the data tends to be more of an incremental nature.

Improvement on the WRES indicators has been slow nationally. As a result Whittington Health is working with it's partners in the North Central London Integrated Care System (NCL ICS) to co-design and deliver work across the system.

Whittington Health is working hard and investing in the Equality, Diversity and Inclusion agenda to ensure that our vision statement becomes the everyday experience for all of our staff.

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Methodology

The WRES requires NHS trusts to self-assess against nine indicators of workplace experience and opportunity.

Four indicators relate specifically to workforce data, four are based on data from the national NHS staff survey questions, and one considers Black, Asian and Minority Ethnic representation on boards.

Detailed definitions for each indicator can be found in the WRES Technical Guidance (2022). The technical guidance explains the categories "white" and "black and minority ethnic", as used throughout this report and within the narrative for the WRES indicators. This report presents data for Whittington Health NHS Trust against all nine WRES indicators and, where possible, makes comparisons to the WRES data back to 2016.

Data sources

WRES data for 2021/22 was collected through a range of systems, including:

- Electronic Staff Records (ESR)
- Internal employee relations databases
- Internal employee training databases
- National Staff Survey Data – relevant data is taken from the 2021 results.
- TRAC (Recruitment System)

Data analyses

For indicators 2, 3 and 4, statistical analyses included the "four-fifths" rule.

The "four-fifths" ("4/5ths" or "80 percent") rule is used to highlight whether practices potentially have an adverse impact on an identified group. E.g. when comparing the outcome of BME to white staff.

For example, if the relative likelihood of an outcome for one group compared to another is less than 0.80 or higher than 1.25, then the process would be identified as having a statistical adverse impact.

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Data caveats

- The report contains information for Whittington Health covering 2021/22; historical data has also been included for comparative purposes.
- Indicator 2 – no data for 2022 for London and England at the time of writing.
- Indicator 3 – no data for 2022 for London and England at the time of writing.

  The calculation has been changed from using a two-year rolling average to using the year end figure. Both the numerator and denominator has changed for this calculations hence this is still comparable to historical figures.
- Indicator 4 – no data for 2022 for London and England at the time of writing.

  Local Trust data does not collect all training activity centrally, and therefore, not all activity is reported. This is being investigated, to further improve future reporting.
- Indicator 6 – data was not available for NCL ICS, and all trusts in London and England at the time of writing.
- Indicator 7 – Change in calculation, there is limited data to make a historical comparative overview that aligns to the change.
- Four of the WRES indicators (5 to 8) are drawn from questions in the national NHS staff survey. The reliability of the data drawn from those indicators is dependent upon the overall size of samples surveyed, the response rates to the survey questions, and whether the numbers of BME staff are large enough to not undermine confidence in the data.

  The 2021 Staff Survey results have been used in this report.

WRES indicator 1

Fig 1. Whittington Health breakdown of workforce by ethnicity 2022

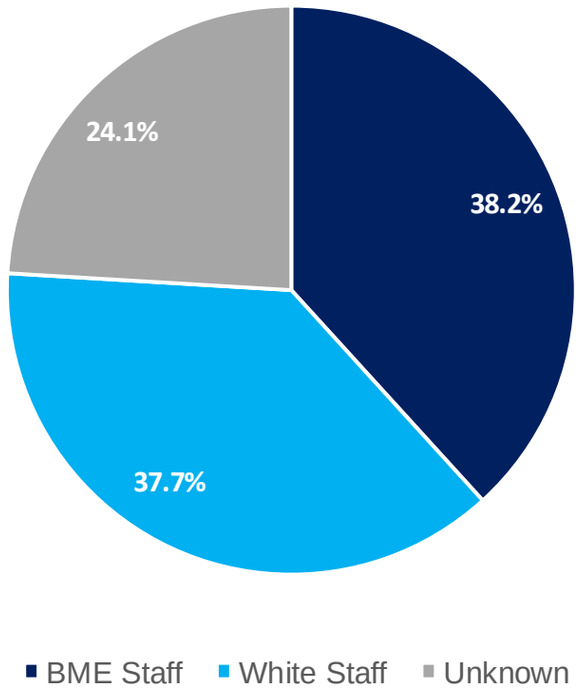
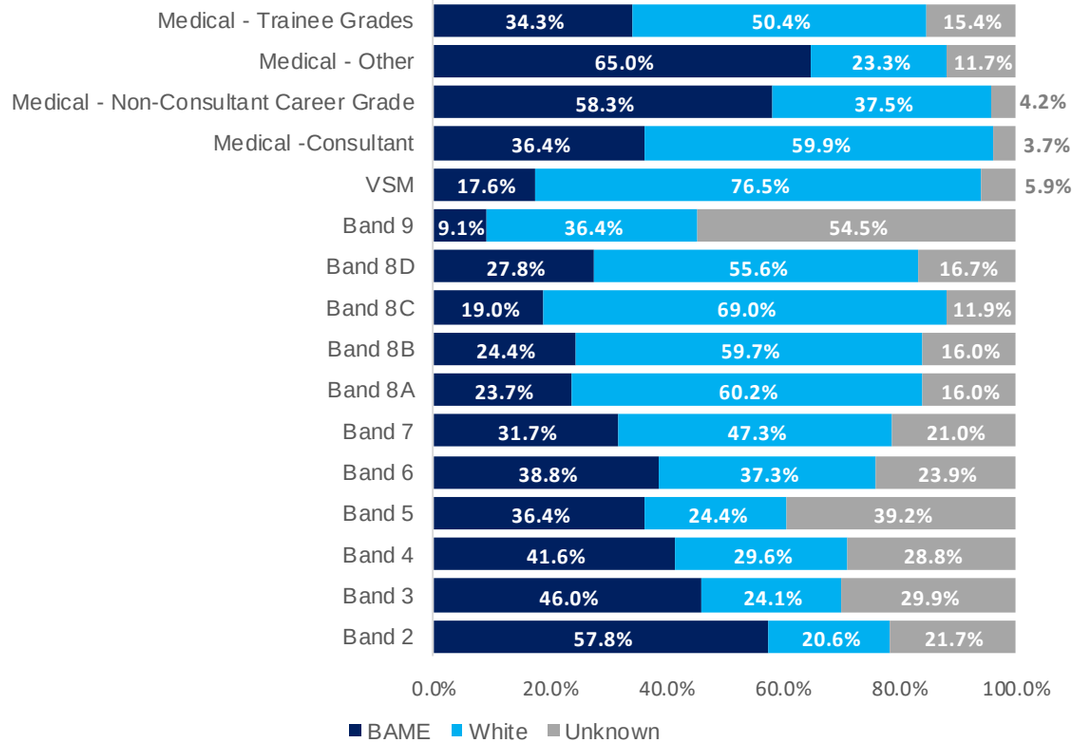


Fig 2. Breakdown of overall workforce by pay band and grade



- Overall we can see that nearly 25% of the workforce have not declared their ethnicity.
- The representation of BME staff decreased in more senior pay bands, but the opposite is true for white staff.
- In medical grades there is a lower than expected representation of BME staff in trainee and consultant grades.

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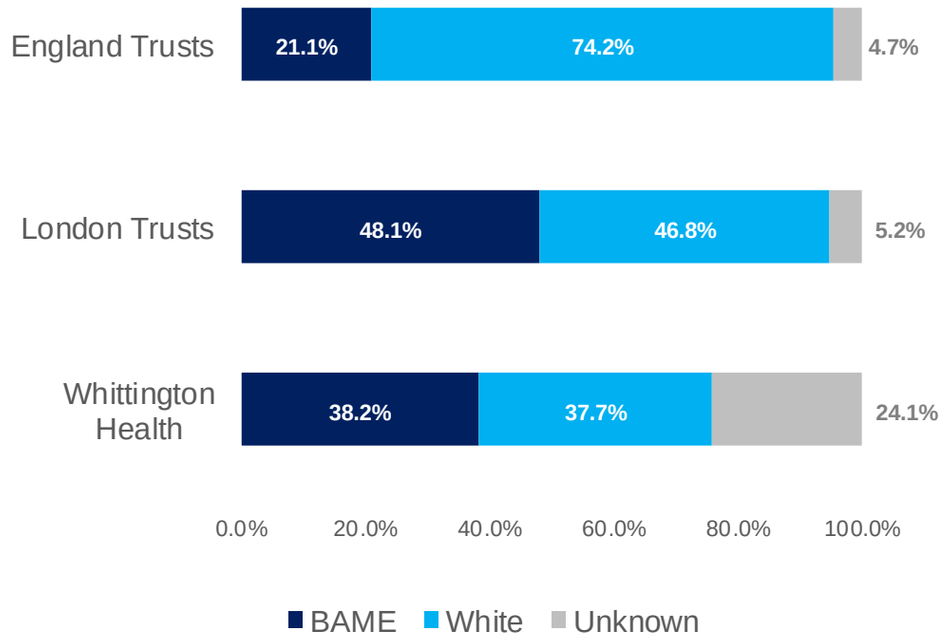
WRES indicator 1 (2)

Staff in NHS trusts by ethnicity

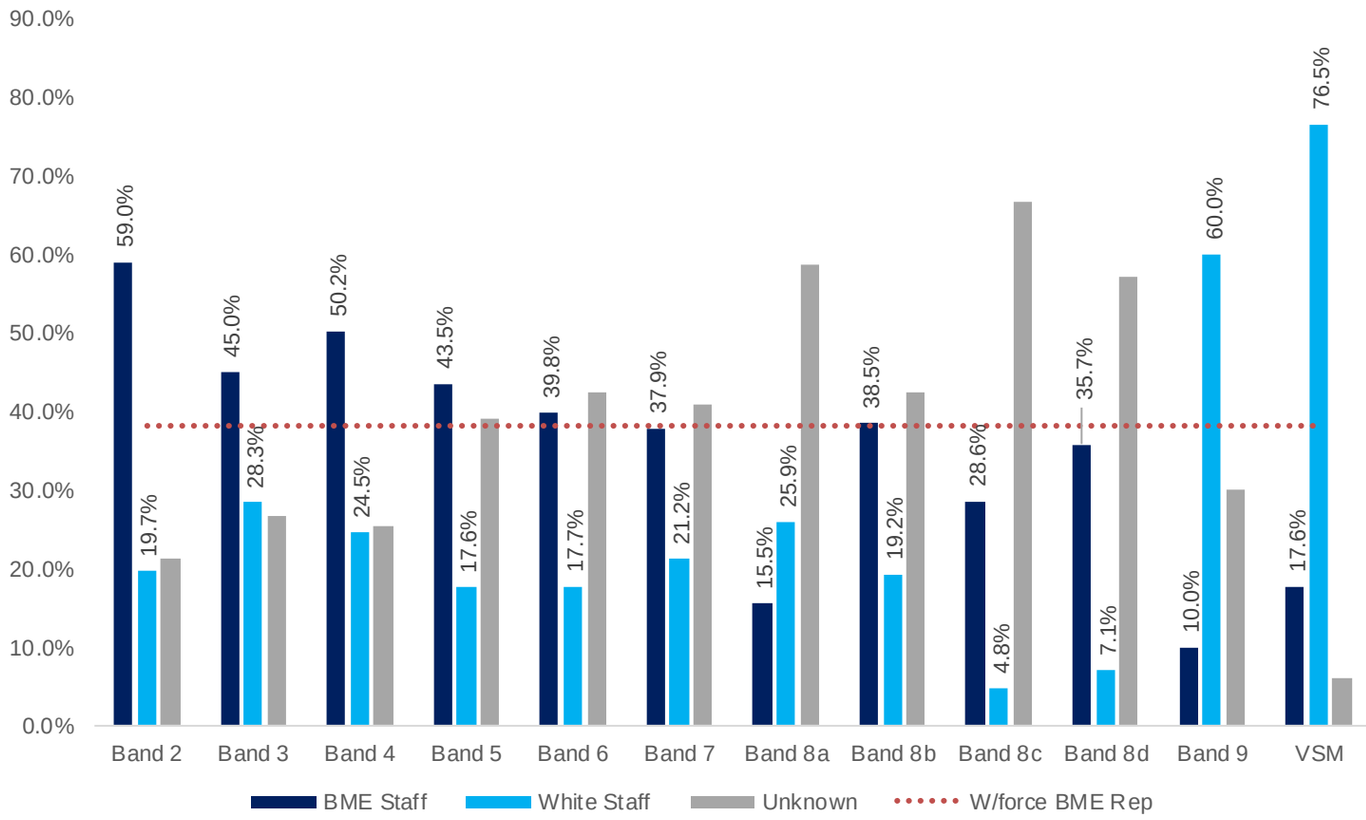
Fig 3. Comparing Whittington Health demographical breakdown compared to all trusts in London and England



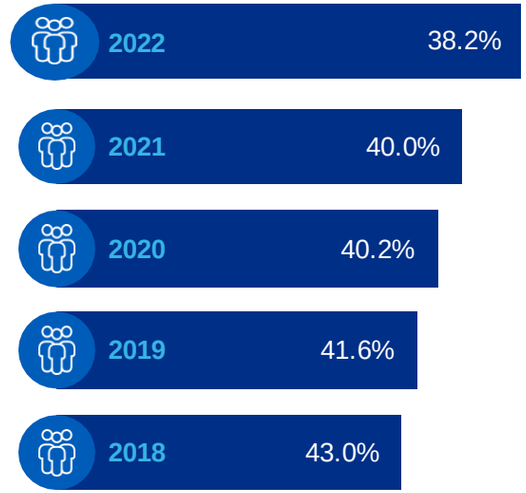
- The Trust has a greater representation of BME staff compared to the England average.
- The Trust has a lower representation of BME staff compared to the London Average.
- Nearly 25% of Trust staff have not disclosed their ethnicity which impacts the accuracy of reporting.

WRES indicator 1 (3)

Fig 4. Percentage of staff in non-clinical roles by ethnicity

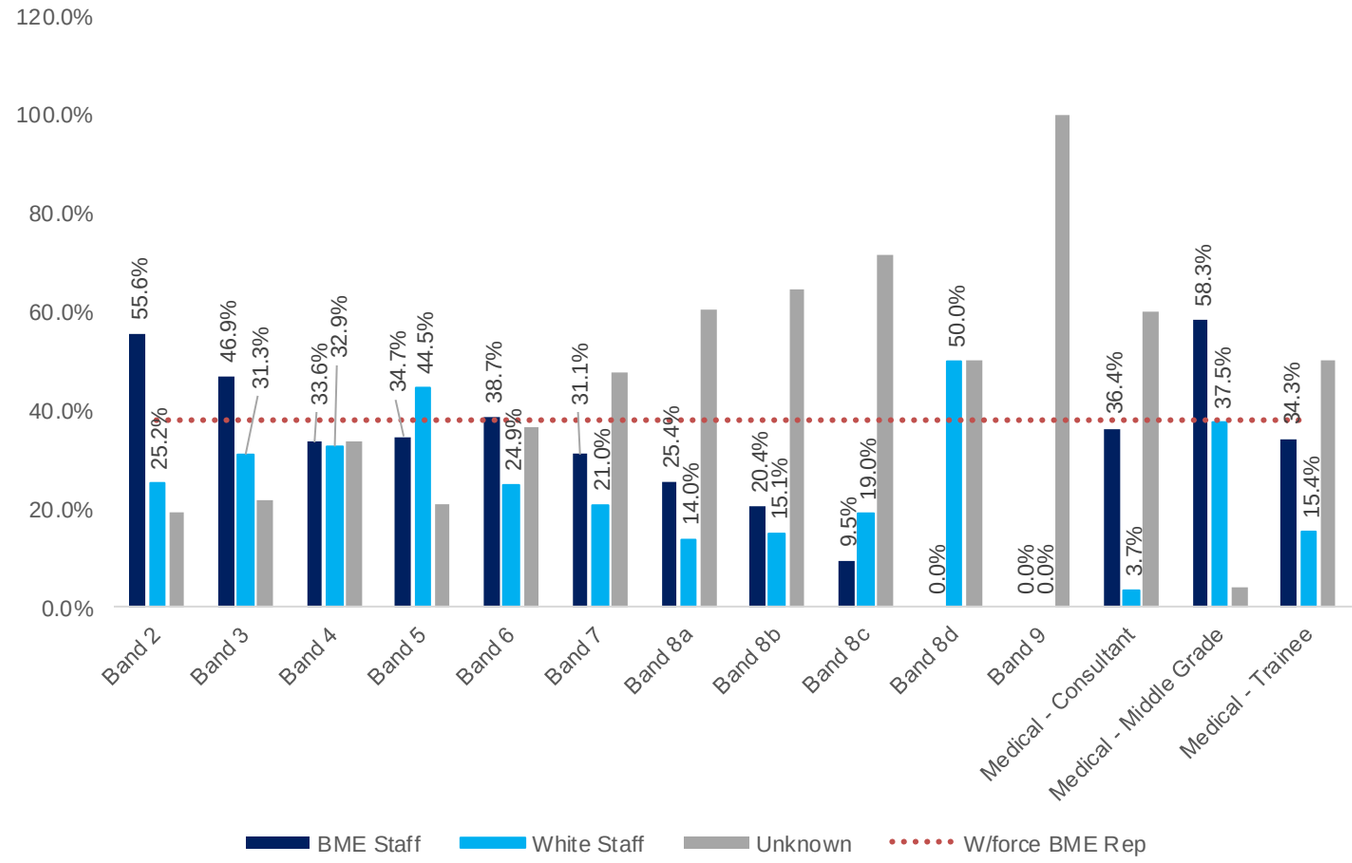


Overall %BME workforce

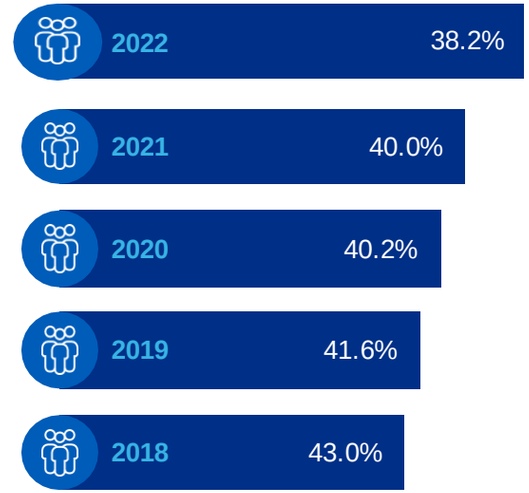


WRES indicator 1 (4)

Fig 5. Percentage of staff in clinical roles by ethnicity



Overall %BME workforce



WRES indicator 1 (5)

The disparity ratio is a reflection of staff progression in terms of representation through the pay bands. comparing BME with a ratio of 1 reflects parity of progression, and values higher than '1' reflect inequality, with a disadvantage for BME staff. Lower bands refers to band 5 and below, middle bands 6 and 7, higher bands 8a and above

The 2021/22 Trust data has been colour coded, green is odds ratio within the 'four-fifths rule' (i.e. between 0.8 - 1.25), amber is ratio 1.25 - 2.50 and red is greater than 2.51.

Table 2. Disparity ratio for non-clinical roles

	Lower to middle	Middle to higher	Lower to higher
Whittington Health 2021/22	2.02	2.28	4.60
Whittington Health 2020/21	2.24	2.50	5.60
London 2020/21	1.37	1.92	2.63
National 2020/21	0.91	1.39	1.27

Table 3. Disparity ratio for clinical roles (excluding medical and dental)

	Lower to middle	Middle to higher	Lower to higher
Whittington Health 2021/22	2.00	2.24	4.47
Whittington Health 2020/21	2.05	2.43	4.98
London 2020/21	2.03	2.10	4.25
National 2020/21	1.59	1.36	2.16

Key Findings

- For clinical and non-clinical roles, white staff are twice more likely to progress from lower to middle bands than BME staff.
- For clinical and non-clinical roles, white staff are 2¼ times more likely to progress from middle to higher bands than BME staff.
- For clinical and non-clinical roles, white staff are about 4½ times more likely to progress from lower to upper bands than BME staff.

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WRES indicator 1 (6)

Actions to take forward contained in:

- Recruitment Action Plan
- Development Action Plan
- Retention Action Plan
- Engagement Action Plan
- Infrastructure/Sustainability Action Plan
- Training Action Plan

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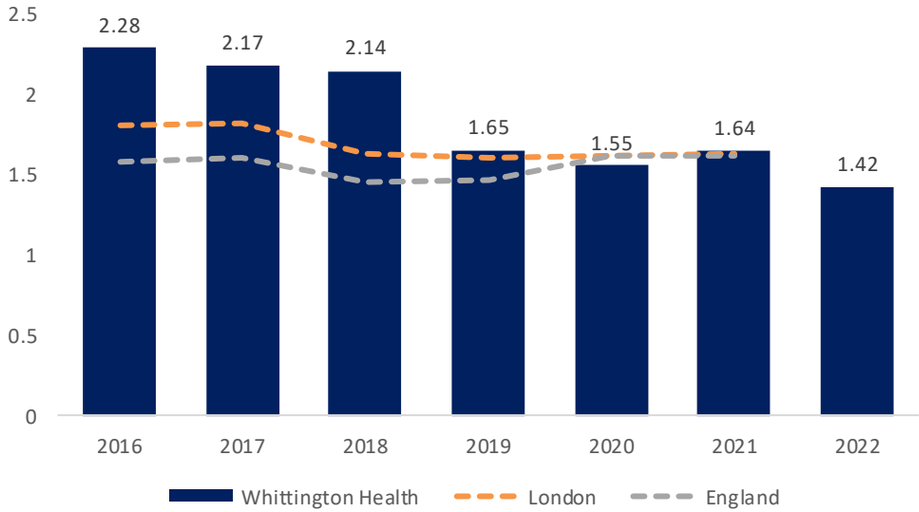
WRES indicator 2

Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants

Fig 6: White applicants being appointed from shortlisting compared to BME applicants: 2016-2022



Key Findings

- Compared to 2021, there has been a substantial decrease in the likelihood of white applicants being appointed from shortlisting compared to BAME applicants.
- From 2019-2021, the Trust's relative likelihood is broadly in line with the London average. Prior to 2019, there was a higher proportion of inequity than the average for London.
- The overall trend for the Trust has been decreasing year-on-year.
- The rule of four fifths suggests that there is a statistical adverse impact in recruitment for BAME applicants in 2022.

NB national and regional data was not available for 2022 at the time of writing this report.

Actions to take forward contained in:

- Recruitment Action Plan
- Retention Action Plan
- Infrastructure/Sustainability Action Plan
- Training Action Plan

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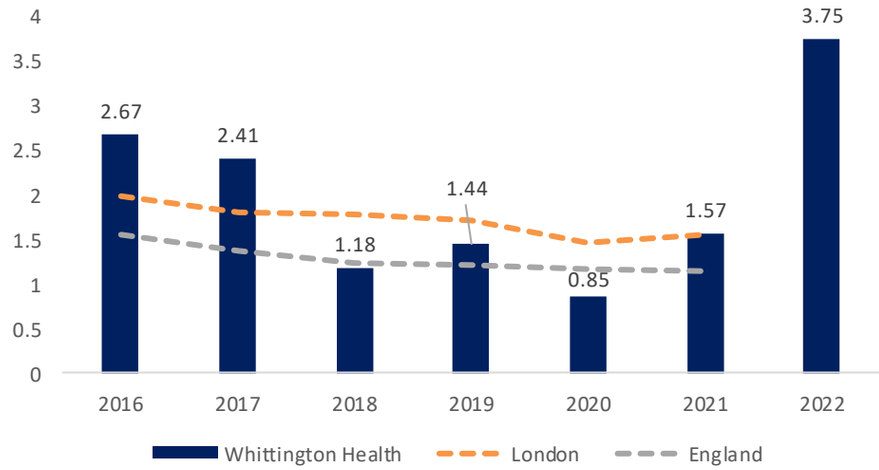
WRES indicator 3

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff

Fig 7: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff: 2016-2022



Key Findings

- Compared to 2021, significant increase in the number of BAME staff that have undergone a formal disciplinary process.
- Using the rule of four fifths, the 2022 data suggests that there is an adverse statistical impact on BAME staff.
- During 2018-2021, the Trust's score was either below or broadly in line with the London Average.

NB national and regional data was not available for 2022 at the time of writing this report.

Actions to take forward contained in:

- Retention Action Plan
- Infrastructure/Sustainability Action Plan
- Training Action Plan

- In year action: case review to ensure that equity and parity in the management of cases

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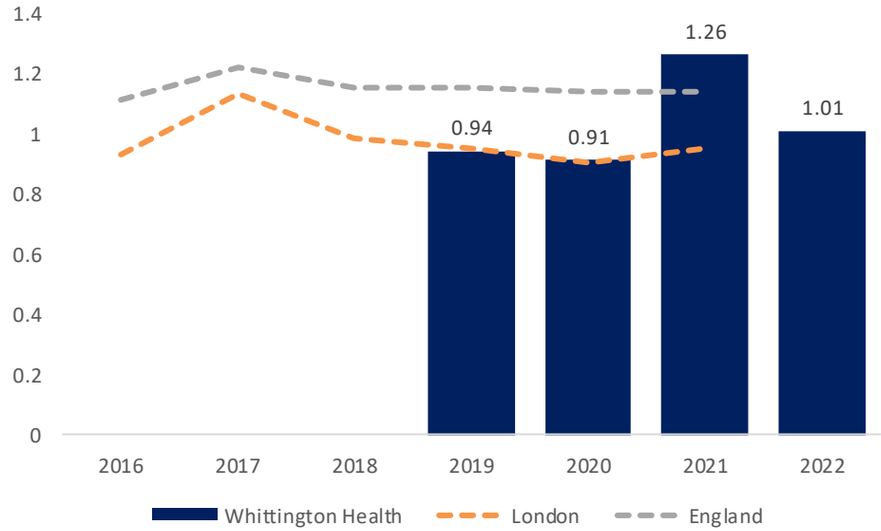
WRES indicator 4

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff

Fig 8: Relative Likelihood of white staff accessing non–mandatory training and continuing professional development (CPD) compared to BME staff: 2016 – 2022



Key Findings

- Compared to 2021, there has been a decrease in the likelihood of white staff accessing training compared to BAME staff. The data would suggest that that there is almost equal chance of both groups accessing training.
- From 2019-2020, the Trust's relative likelihood is broadly in line with the London average. In 2021 the Trust's score was much higher than the London average.
- The rule of four fifths suggests that there is not a statistical adverse impact for BME staff in 2022.

NB national and regional data was not available for 2022 at the time of writing this report. Due to a historical reporting issue it was not possible to provide information for this indicator prior to 2019.

Actions to take forward contained in:

- Development Action Plan
- Engagement Action Plan
- Infrastructure/Sustainability Action Plan
- Training Action Plan
- In year action: monitor and evaluate bands 2-7 talent management programme
- In year action: investigate ways to improve data capture/reporting for non-mandatory and CPD training across the Trust.

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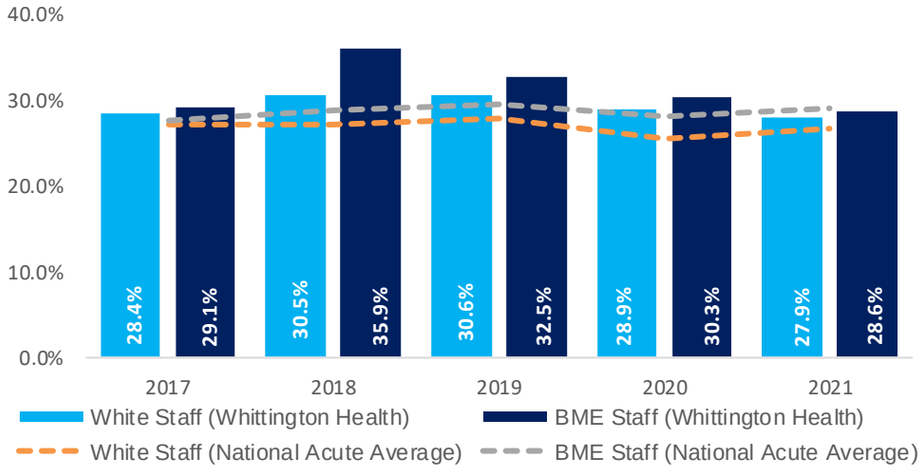
WRES indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients/service users, or the public in the last 12 months

Fig 9: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months: 2017-2021 (Whittington Health vs national acute average)

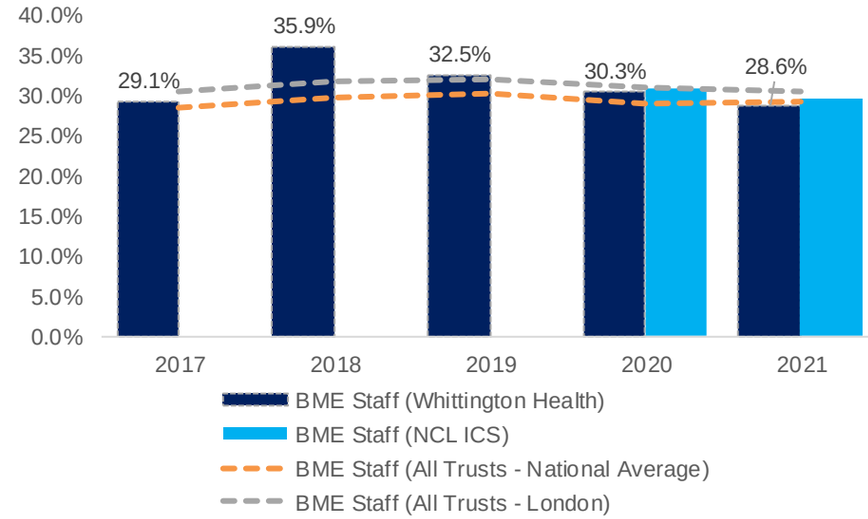


- From 2017-2020, more Trust staff reported experiencing harassment, bullying or abuse that the national acute average. In 2021, slightly less Trust staff reported experiencing these behaviours compared to the national average.
- Since 2018, there is a decreasing trend of Trust staff experiencing harassment, bullying or abuse from patients, services users or the public.

Key Findings

- Compared to 2020, there has been a decrease in the percentage of BME staff who have stated that they have experienced harassment, bullying and abuse from patients, services or the public.
- Since 2017, BME staff have consistently reported having experienced harassment, bullying and abuse from patients, services or the public than white staff.

Fig 10: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months: 2017-2021 (Whittington Health vs all trusts in NCL ICS/England/London)



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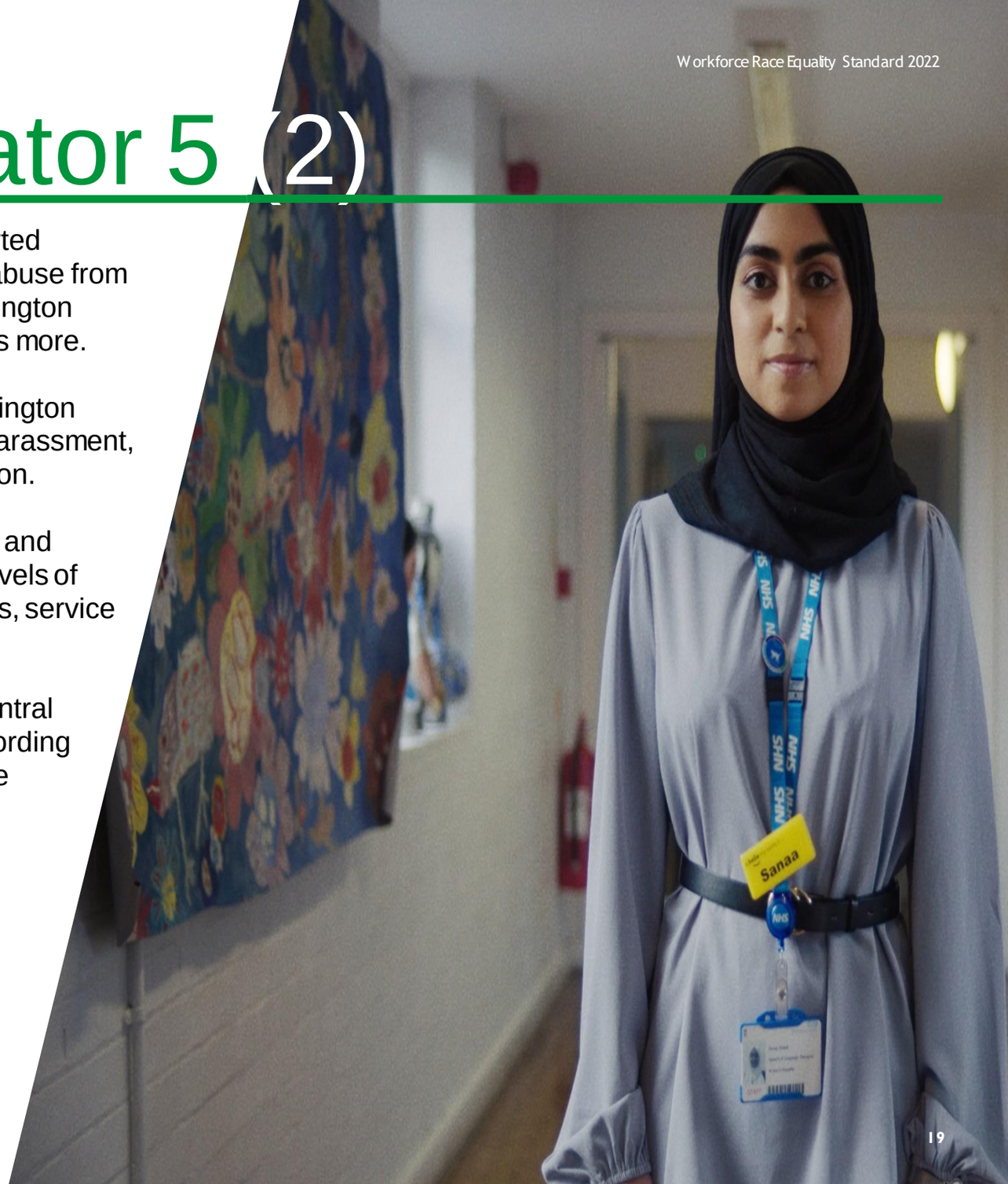
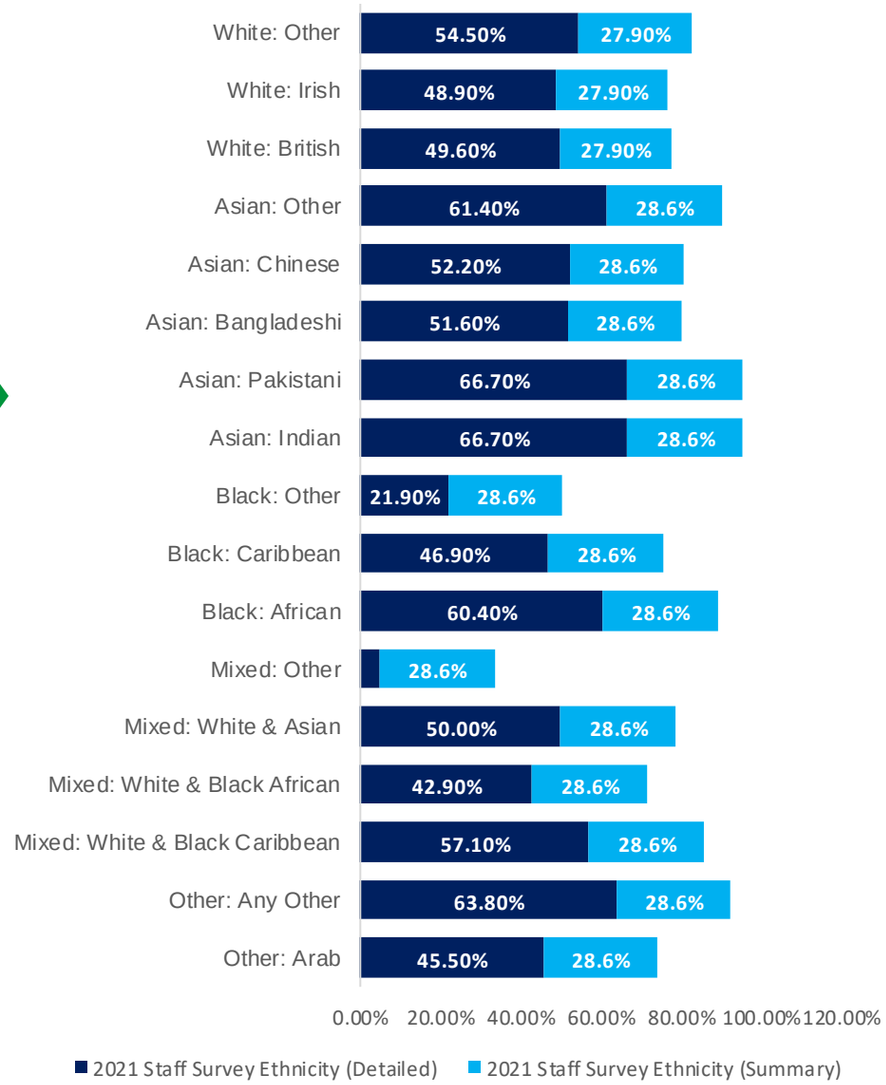
WRES indicator 5 (2)

- Compared to all trusts in England, staff reported experiencing less harassment, bullying and abuse from patients, service user and the public at Whittington Health in 2021 and 2017, in 2018-2020 it was more.
- Other than in 2018 (which was higher), Whittington Health is broadly in line with the amount of harassment, bullying and abuse as with all Trusts in London.
- Comparing the data from all trusts in London and England, BME staff in London report great levels of harassment, bullying and abuse form patients, service users and the public.
- The Trust is broadly in line with the North Central London (NCL) ICS data, in both years of recording Whittington Health was slightly lower than the average across the integrated care system.



WRES indicator 5 (3)

Fig 11: Detailed breakdown of indicator 5 by ethnicity vs. summary of ethnicity



The graph on this page looks experience of staff highlighted in fig. 11 , that has been further broken down by detailed ethnicity categories.

The dark blue part of the bar shows the experience of the detailed ethnicity categories, while the light part shows the summary e.g. white and BME staff.

For the majority of ethnicity categories, staff have reported more harassment, bullying and abuse compared to the summary i.e. white 27.9% and BME 28.6%.

Groups that have an experience much worse than the summary average include:

- **Mixed - White and Black Caribbean**
- **Asian – Indian**
- **Asian – Pakistani**
- **Asian – Any other**
- **Black – African**
- **Other – Any other**
- **White – Other**

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WRES indicator 5 (4)

Actions to take forward contained in:

- Retention Action Plan
- Infrastructure/Sustainability Action Plan
- Training Action Plan

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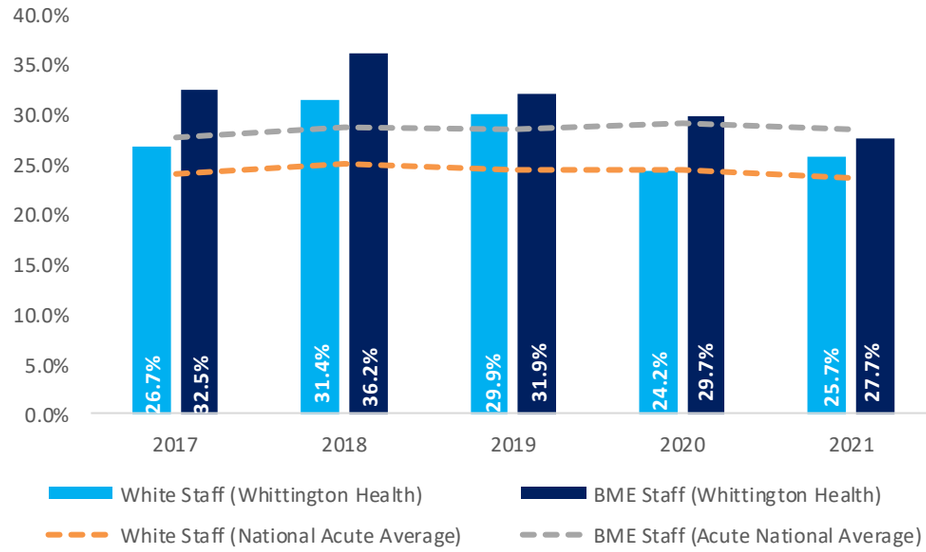
WRES indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

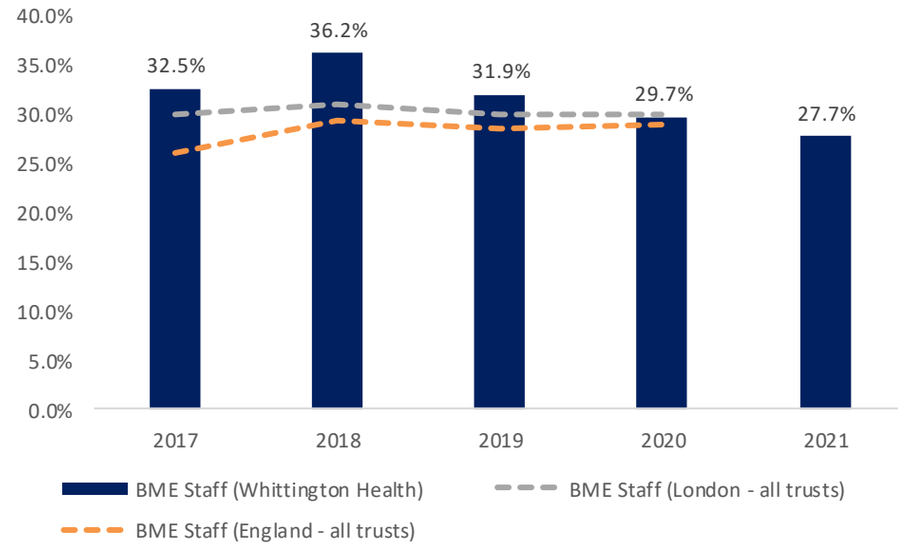
Fig 12: Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months: 2017 -2021



Key Findings

- Compared to 2020, there has been a 2% decrease in staff that have reported experiencing harassment, bullying and abuse from staff.
- Whittington Health's scores have been consistently higher than the national acute average for BME staff. However, in 2021 the Trust's score was nearly 1% lower than the national acute average.
- Since 2018, there is a decreasing trend of Trust staff experiencing harassment, bullying or abuse from staff.

Fig 13: Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months: 2017 -2021



- Whittington Health has consistently scored higher than the average for all trusts in England. This is also true during 2017-2019 for all trusts in London, but in 2020 Whittington Health was broadly in line.

NB data was not available for this indicator for NCL ICS, or 2021 data for all trusts in London and England.

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WRES indicator 6 (2)

Actions to take forward contained in:

- Retention Action Plan
- Infrastructure/Sustainability Action Plan
- Training Action Plan

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WRES indicator 7

Percentage of staff believing that there are equal opportunities for career progression/promotion

Fig 14: Percentage of staff believing that their trust provides equal opportunities for career progression or promotion: 2017 – 2021

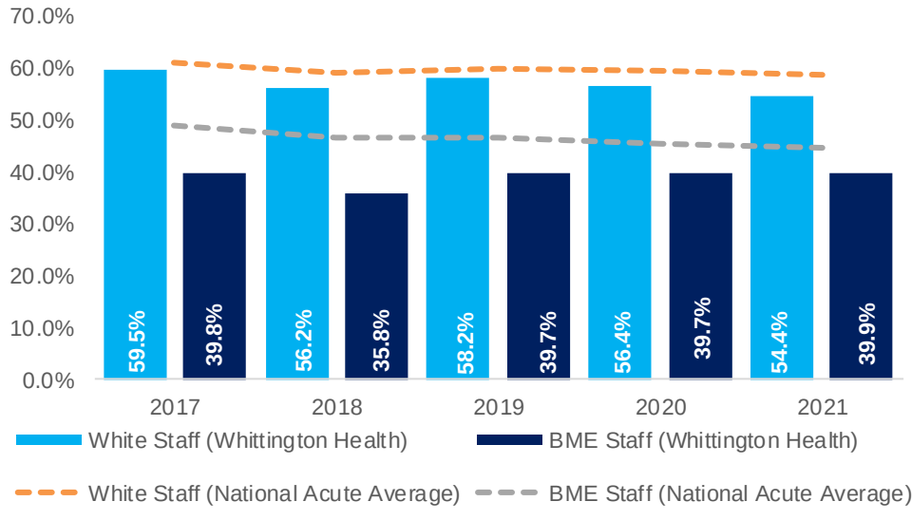
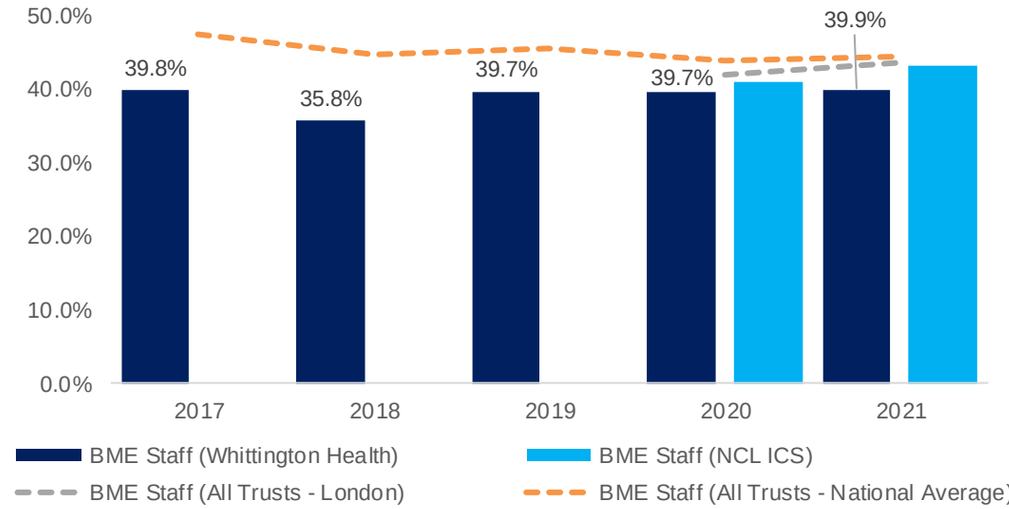


Fig 15: Percentage of staff believing that their trust provides equal opportunities for career progression or promotion: 2017 – 2021



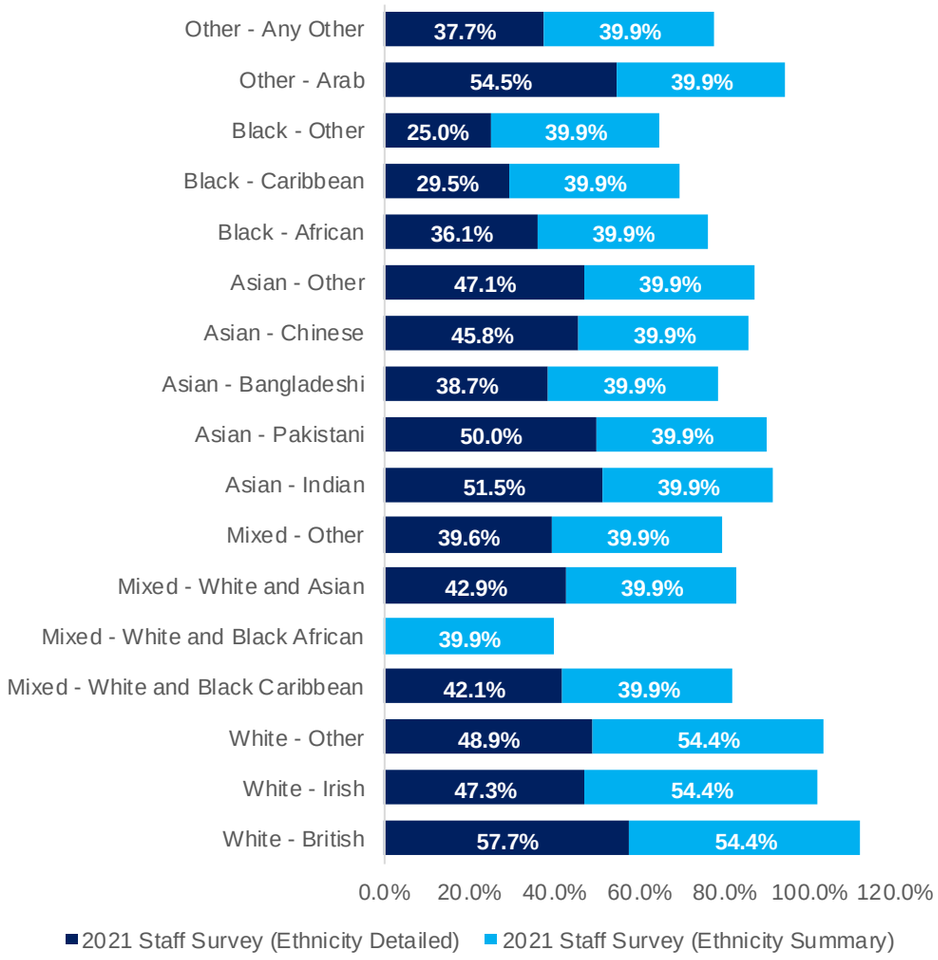
Key Findings

- Compared to 2020, about the same percentage of BME Trust staff belief that there are equal opportunities for career progression and promotion.
- Since 2017, Trust BME staff scores have been consistently lower than the national acute average. White staff in the Trust is broadly in line with the national acute average.
- Since 2019, the gap in experience of white and BME staff in the Trust has reduced from 18.5% to 14.5%.
- The experience of BME staff at the Trust has been consistently lower than the overall average for all trusts in the NCL ICS, London and England.

NB – due to a change in calculation of this indicator, there is limited data available for a comparative overview, and compared to previous reports will look much lower.

WRES indicator 7 (2)

Fig 16: Detailed breakdown of indicator 7 by ethnicity vs. summary of ethnicity



The graph on this page looks experience of staff highlighted in fig.16 , that has been further broken down by detailed ethnicity categories.

The dark blue part of the bar shows the experience of the detailed ethnicity categories, while the light part shows the summary e.g. white and BME staff.

About half of ethnicity categories have reported believing the Trust offers more equal opportunities for career development/promotion compared to the summary i.e. white 54.4% and BME 39.9%.

Groups that have an experience much worse than the summary average include:

- **Black – Caribbean**
- **Black - Other**

WRES indicator 7 (3)

Actions to take forward contained in:

- Development Action Plan
- Engagement Action Plan
- Infrastructure/Sustainability Action Plan
- Training Action Plan

- Continue rollout of band 2-7 staff development programme and evaluate impact.
- Deep-dive into specific professions and use to inform staff engagement activity
- Targeted career conversations
- Review effectiveness and impact of PDP within staff appraisals
- Further promote development opportunities

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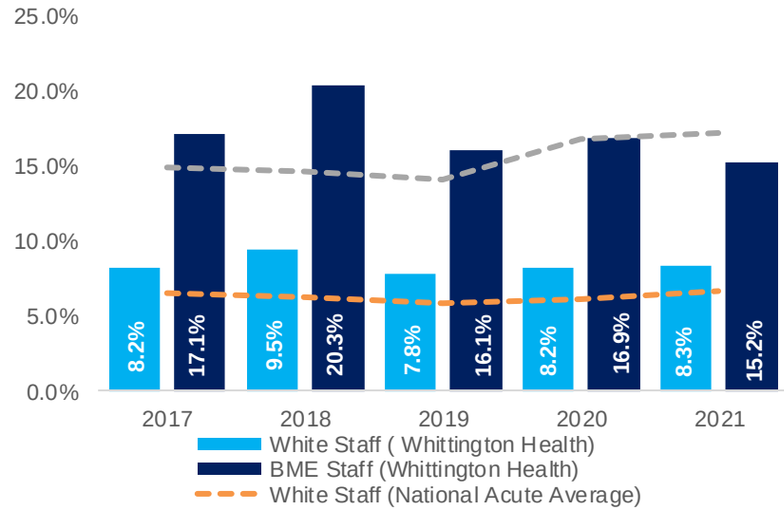
WRES indicator 8

Percentage of staff that personally experienced discrimination at work from a manager, team leader or other colleague

Fig 17: Percentage of staff that personally experienced discrimination at work from a manager, team leader or other colleagues: 2017 – 2021

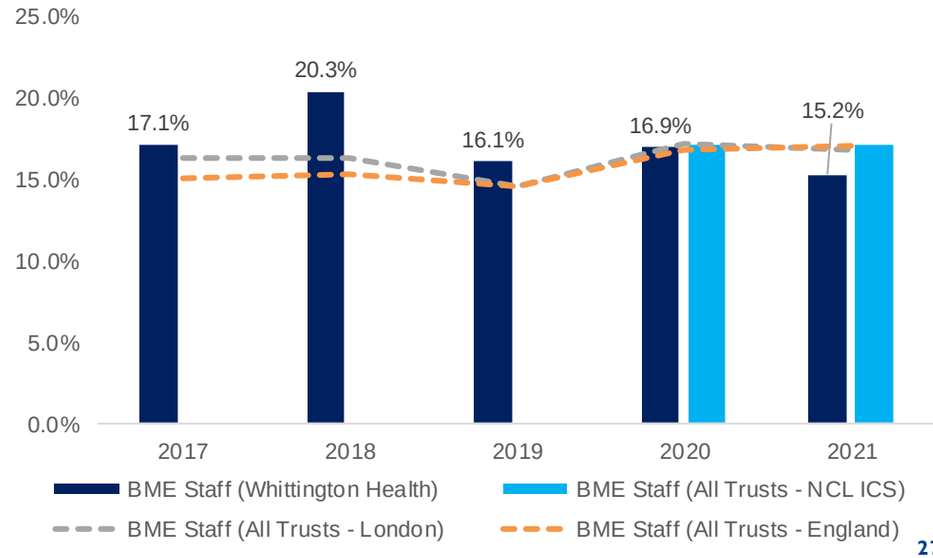


Key Findings

- In 2021 fewer Trust BME staff reported having experienced discrimination at work from another member of staff compared to the previous year.
- BME Trust staff are nearly twice as likely to report experiencing discrimination compared to white staff.
- White Trust staff consistently reported experiencing more discrimination when compared to the national acute average

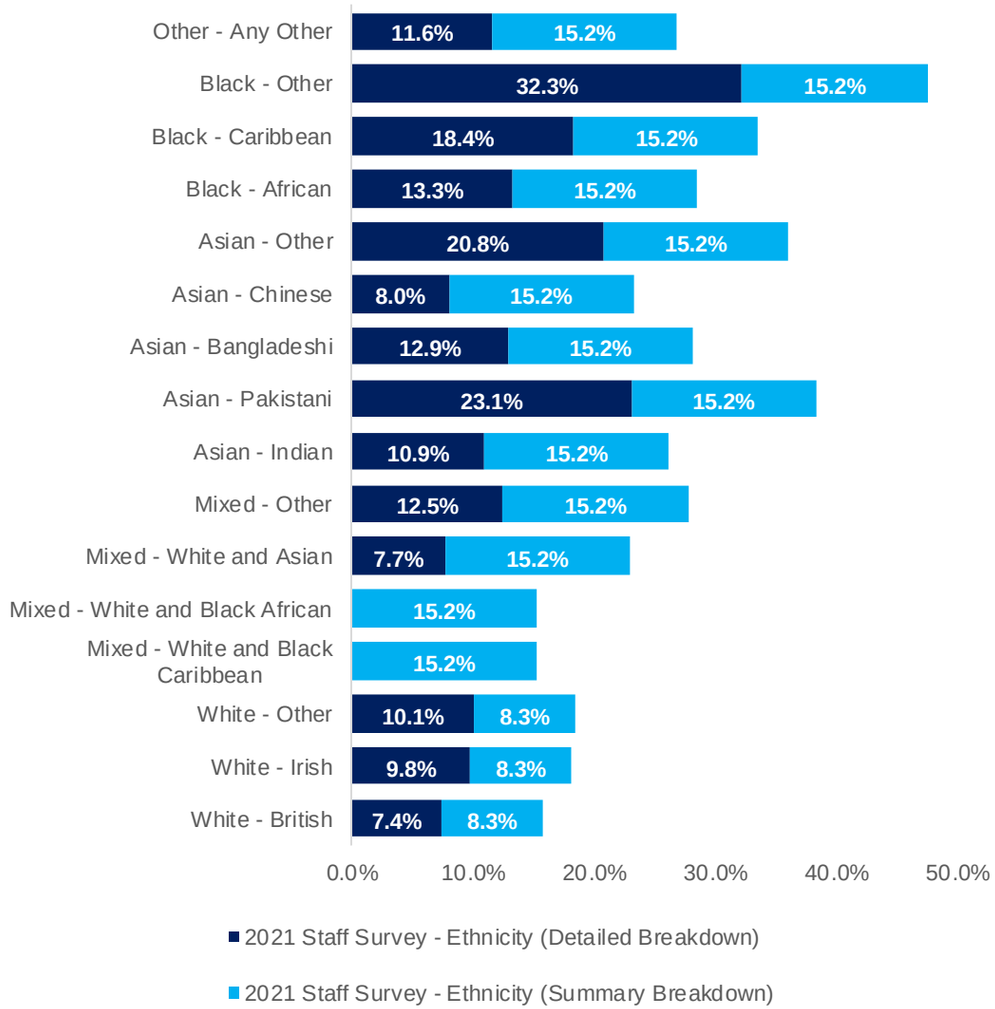
- Until 2019, BME Trust staff consistently reported experiencing discrimination when compared to the national acute average. In 2020 both Trust BME and national data were in line and in 2021, fewer Trust BME staff reported experiencing discrimination. This same pattern can be seen when comparing BME Trust staff experience to BME staff in NCL ICS, London and in England.

Fig 18: Percentage of staff that personally experienced discrimination at work from a manager, team leader or other colleagues: 2017 – 2021



WRES indicator 8 (2)

Fig 19: Ethnicity and gender in detail: 2021 NHS Staff Survey:



The graph on this page looks experience of staff highlighted in fig. 19, that has been further broken down by detailed ethnicity categories.

The dark blue part of the bar shows the experience of the detailed ethnicity categories, while the light part shows the summary e.g. white and BME staff.

The majority of ethnicity categories are either lower or broadly in line with the summary i.e. white 8.3% and BME 15.2%.

Groups that have an experience much worse than the summary average include:

- **Asian – Pakistani**
- **Asian – Other**
- **Black – Other**

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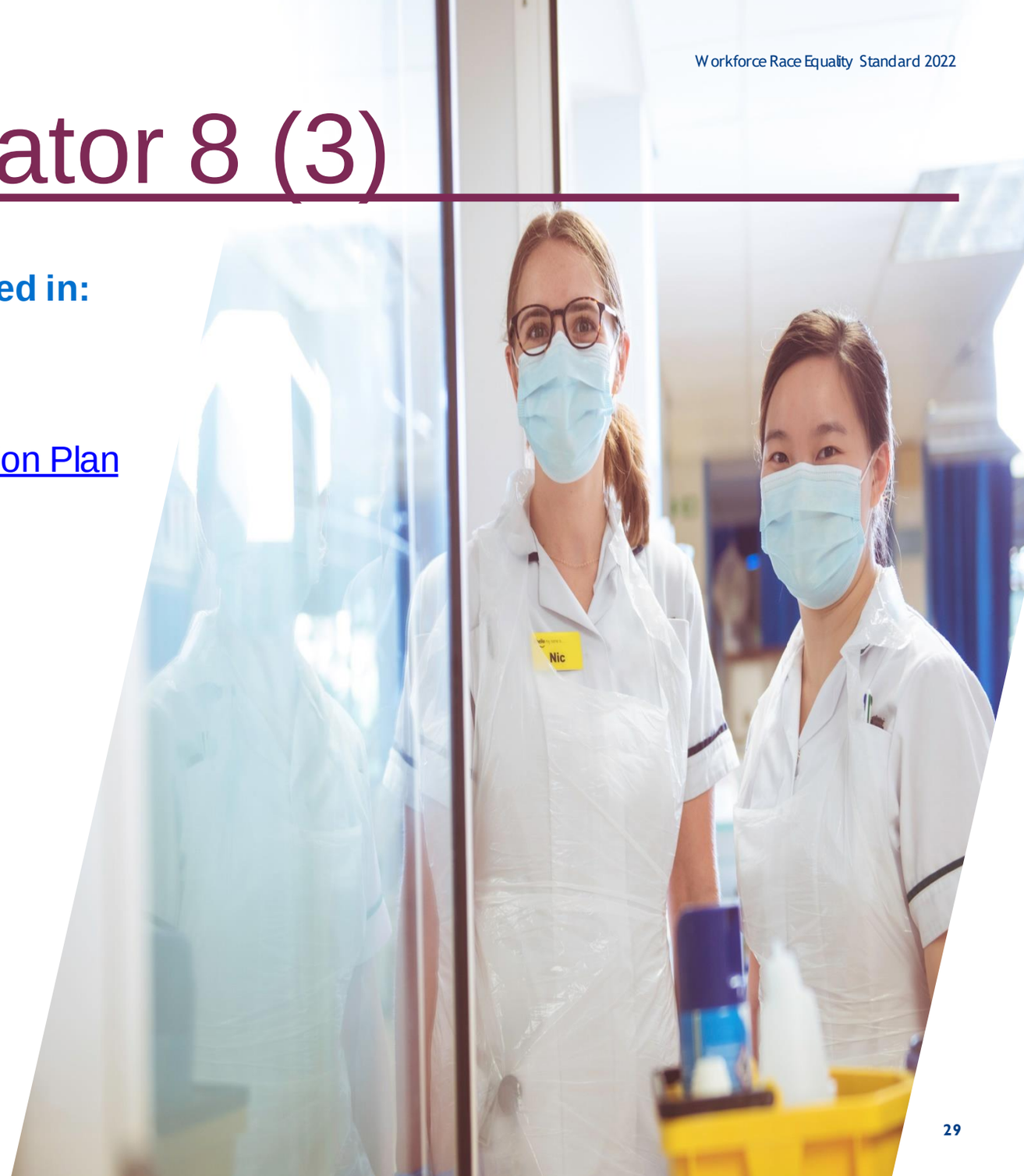
WRES indicator 8 (3)

Actions to take forward contained in:

- Development Action Plan
- Retention Action Plan
- Infrastructure/Sustainability Action Plan
- Training Action Plan



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WRES Indicator 9

compare the difference for white and BME staff: Percentage difference between;
(i) the organisations' Board voting membership and its overall workforce, and
(ii) the organisations' Board executive membership and its overall workforce

Table 4 Demographical breakdown of the board by ethnicity

	Total Board	Voting Members	Non-Voting Members	Executive Directors	Non-Executive Directors
BME	17.6%	8.3%	40.0%	0.0%	14.3%
White	76.5%	83.3%	60.0%	100.0%	71.4%
Unknown	5.9%	8.3%	0.0%	0.0%	14.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Table 5 Percentage difference between the board and the overall workforce

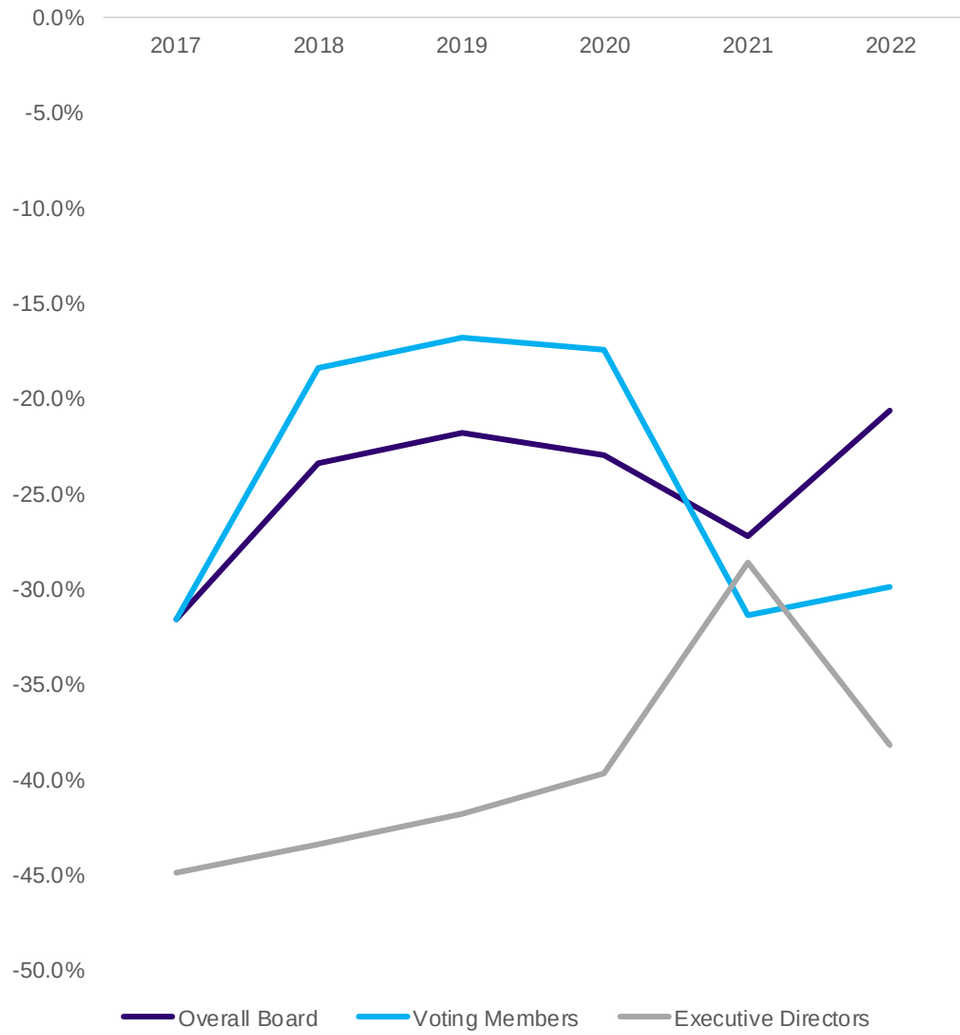
	Workforce Representation	Board overall	Voting members	Executives
BME	*38.20%*	-20.6%	-29.9%	-38.2%
White	*37.70%*	38.8%	45.6%	62.3%
Unknown	*24.10%*	18.2%	-15.8%	-24.1%

Key Findings

- 17.6% of the overall board are BME, comparing to the workforce there is an underrepresentation of 20.6%.
- 8.3% of the members of the board that are eligible to vote are BME; compared to the overall workforce, there is an underrepresentation of 29.9%.
- There are no BME executive directors on the board, this means that there is an underrepresentation of 38.2%.

WRES Indicator 9 (2)

Fig 20: Historical percentage difference of BME representation difference on the Trust's board compared to the workforce



- Since 2021 there has been an improvement in the representation of BME staff on the board (overall) and voting members.
- In 2022 there are no BME members of the board that are executive directors.

Actions to take forward contained in:

- Development Action Plan

Recruitment Action Plan

The following actions have been designed to deliver better equity within the Trust's recruitment processes, which will also have a positive impact on the representation of minority ethnic staff in the workforce

	WRES Indicators	Action	Leads	Target Completion
1	1 and 2	Implement the refreshed NCL-wide recruitment and selection policy and training to ensure that EDI is embedded and becomes mandatory for recruiting managers	Inclusion Directors, HRBPs, Recruitment team	Q1 2022/23
2	1 and 2	Implement strengthened guidance and policy on diverse panels	Inclusion Directors	Q1 2022/23, Recruitment team
3	1 and 2	Quarterly monitoring of recruitment outcomes by ICSU/department against targets	Recruitment Team	Q4 202122 onwards
4	1 and 2	Quarterly ICSU/corporate departments WRES dashboard for performance reviews	Inclusion Directors, Workforce & OD	Q4 202122 onwards
5	1 and 2	Use positive action and targeted engagement to attract and recruit ethnic minority staff	Inclusion Directors	Q1 – Q4 2022/23
5	1 and 2	Engage with local schools and colleagues to promote Whittington Health as an employer of choice	Inclusion Directors	Q1 – Q4 2022/23
7	1 and 2	Work with ICSUs and corporate departments to improve the coverage of our workforce disability and race data	Inclusion Directors	Q1 – Q4 2022/23

Development Action Plan

The following actions have been designed to support minority ethnic staff in, and into, leadership roles

	WRES Indicators	Action	Leads	Target Completion
1	1, 4, 7, 8 and 9	Highlight proposals to help increase the diversity of the Trust Board	Inclusion Directors	Q2 2022/23
2	1, 4, 7 and 8	In partnership with ICSUs' develop succession plans to help increase the diversity of senior teams to better reflect our diverse patient community	Inclusion Directors	Q2 2022/23
3	1, 4, 7 and 8	Review and promote career and interview skills training for staff	Inclusion Directors, Staff networks, OD	Q4 2021/22 (Completed)
4	1, 4, 7 and 8	Review and ensure all non-mandatory training learning and development opportunities are monitored and reported by protected characteristics to identify any potential inequalities	Chief Nurse's education team, Medical Education team	Q2 2022/23

Retention Action Plan

The following actions have been designed to improve workforce retention

	WRES Indicators	Action	Leads	Target Completion
1	1, 2, 3, 5, 6 & 8	Implement a mentoring scheme for WH staff with external mentors in NCL	Inclusion Directors	Q2 2022/23
2	1, 2, 3, 5, 6 & 8	Complete pilots in ICSUs and share learning for the implementation of a Trustwide talent management programme	EIM and ACS ICSUs, Inclusion Directors	Q2 2022/23
3	1, 2, 3, 5, 6 & 8	Implement Whittington Cultural calendar to celebrate and highlight events	Inclusion Directors	November 21 (in place)
4	1, 2, 3, 5, 6 & 8	Promotion of ICARE values and the new Equity underpinning value	Communications	Q4 2021/22
5	1, 2, 3, 5, 6 & 8	Develop welcome package & induction for international medical graduates	Inclusion Directors	
6	1, 2, 3, 5, 6 & 8	Provide input and support for the overseas nurse induction programmes	Inclusion Directors	November 21 (completed)
7	1, 2, 3, 5, 6 & 8	Trust wide Engagement - making EDI (WRES and WDES) everybody's business	Inclusion Directors and EDI Manager	Ongoing
8	1, 2, 3, 5, 6 & 8	Utilise ICSU board meetings, departmental and Trust middle management forums to highlight and provide updates on Trust activities	Inclusion Directors, EDI Manager	Ongoing
9	1, 2, 3, 5, 6 & 8	Implement EDI roadshows across Trust sites	Inclusion Directors, EDI Manager	Q4 2021/22 – Q1 2022/23
10	1, 2, 3, 5, 6 & 8	Build a network of 'WRES focussed inclusion champions/'allies' made up of clinical and non-clinical staff from all grade and professional group.	Inclusion Directors, EDI Manager	Q4 2021/22 – Q1 2022/23
11	1, 2, 3, 5, 6 & 8	Develop content for and revamp intranet and internet pages	Inclusion Directors, EDI Manager, Comms team	Q2-3 2022/23

Engagement Action Plan

The following actions have been designed to support minority ethnic staff in, and into, leadership roles

	WRES Indicators	Action	Leads	Target Completion
1	1, 4 and 7	Establish a Staff Inclusion Group to act as the engine room for inclusion work at Whittington Health and feedback from staff equality networks	Inclusion Directors	Q3 2021/22 (Completed)
2	1, 4 and 7	Develop a business case for protected time for staff equality network chairs and an annual budget for respective networks' activities.	EIM and ACS ICSUs, Inclusion Directors	Q3 2021/22 (Completed)
3	1, 4 and 7	Develop, consult on, and agree a revised Equality, diversity and inclusion policy	Inclusion Directors	Q4 2021/22
4	1, 4 and 7	Produce a Managers' Diversity Guide to help increase confidence and capability in managing diversity and diverse teams	Inclusion Directors, EDI Manager	Q1 2022/23
5	1, 4 and 7	Develop Diverse & Inclusion Panel Principles & Guidance including pre and post checklist for panel chair and members	Inclusion Directors	Q4 2021/22

Infrastructure and Sustainability Action Plan

The following actions have been designed to support delivering race equity

	WRES Indicators	Action	Leads	Target Completion
1	All	Develop a dashboard for ICSU/corporate departments to measure WRES progress	Inclusion Directors	Q4 2021/22 (Complete)
2	All	Annual review of outcomes of workforce policies/areas which have high relevance to the Equality Act's general and specific duties: • Recruitment • Probationary policy • Acting Up and Secondment • Learning and development • Bullying and Harassment • Disciplinary policy • Flexible working policy and procedure • Retire and return guidance • Sickness absence • NHS Staff survey	EDI Manager, EDI Directors	Q1 – Q3 2022/23
3	All	Collate and submit final returns for Workforce Race Equality Standard and Workforce Disability Equality Standard	EDI Manager, EDI Directors	Q1 – Q2 2022/23
4	All	Publish updated equality objectives	EDI Manager, EDI Directors	Q2 2022/23

Training Action Plan

The following actions have been designed to better support and educate our staff

	WRES Indicators	Action	Leads	Target Completion
1	All	Review and update the Building Inclusive Culture awareness for Trust leadership and preceptorship programme and ICSUs teams	EDI Directors / EDI Manager/ OD	Q3 – Q4 2021/22 (Complete)
2	All	Develop EDI/WRES Leadership Programme for Divisional managers, EDI leads & allies. This programme will provide robust baseline capacity building on legal compliance, equality analysis and practical application of embedding EDI in all Trust activities and functions, including equality of opportunity in career progression and development across all protected groups	EDI Directors / EDI Manager/OD	Q1- Q3 2022/23
3	All	In conjunction with OD colleagues, develop diverse and inclusive recruitment and selection training for recruiting managers and interview panel members on conscious and unconscious bias, favouritism, and prejudice and create accountability	EDI Directors / EDI Manager/OD	Q1- Q2 2022/23
4	All	In collaboration with OD and HR, aim to mandate recruitment and selection training for recruiting manager and interview panel chair. In due course, to extend this to all panel members	EDI Directors / EDI Manager/ Recruitment Team	Q2 2022/23

NHS
Whittington Health
NHS Trust

Workforce Disability Equality Standard

2022 data analysis report for Whittington Health NHS Trust

Contents

Foreword

Whittington Health NHS Trust is working to improve the everyday experiences for its patients and staff with Disabilities. This report focuses on staff with Disabilities and helps highlight their experiences.

This document is closely aligned to the principles set out within the NHS People Promise. One core principle the WDES supports is creating and inclusive environment where disabled staff are respected and can use their individual potential to develop and progress in their careers. Through the delivery of improvements highlighted in this report, we hope that Disabled staff will feel more supported and listened to.

The Workforce Disability Equality Standard (WDES) forms part of the NHS Standard Contract and requires NHS Trusts to report and publish annual data on the workplace and career experiences of Disabled staff. At the Trust we want to use the WDES as a catalyst for continuous improvement, which will help us better understand our workforce and provide opportunities to improve the representation of Disabled staff through every level and profession within the organisation.

The WDES will also help to develop and improve support offered to staff and monitor for effectiveness. The standard also helps to ensure that the Trust has favorable and attractive employment offers to Disabled Staff. This in turn will help with recruitment and retention of NHS staff through the challenging times we face in healthcare.

The COVID-19 pandemic shone a spotlight on our workforce's resilience and ability to adapt to meet unexpected challenges, while delivering high quality services to meet the needs of our patients and service users.

Disabled communities have been disproportionately impacted by the pandemic, and the societal measure put in place to protected those most vulnerable. Within the NHS many Disabled staff there have had additional challenges in their work and personal lives presented by the pandemic; in some circumstances these challenges persist today.

The long-term impact of the pandemic on our services and our workforce are yet to be fully understood. It makes our commitment to removing barriers and ensuring that Disabled people can thrive, wherever they are in the Trust, vital to the important task of recovering and rebuilding for the future.

Introduction

This the fourth Workforce Disability Equality Standard (WDES) report since the launch of the WDES in 2019. The report draws on analysis of data collected from the national NHS Staff Survey and several Trust systems that tracks the employment journey. The WDES metrics data analysis highlights the collective experiences of Disabled staff at Whittington Health and provides a basis for improvement.

While the data in this report demonstrates that there has been some progress, it also highlights areas where there are disparities between Disabled and non-disabled staff.

The report has been structured so that it aligns with NHS priorities; instead of reviewing the metrics in numerical order the report has been arranged into workforce supply and retention themes. These priorities include working through the challenges that are presented by the impact of the COVID-19 pandemic and recovery, and the changing landscape that is being witnessed thorough closer integration of health and social care.

It is recognised that disabled people continue to face barriers in employment, have common issues in seeking equity and are part of community. In this report a capital 'D' has been used to refer to Disabled staff, to highlight and recognise this fact.

Data and Methodology

The Workforce Disability Equality Standard (WDES) is mandated for all trusts in England with the aim of furthering equality and inclusion for Disabled staff in the NHS. Ten specific measures (metrics) are calculated from the data, which is obtained from two sources:

1. Data provided directly from trusts. As part of the NHS Standard Contract, trusts are required to provide data for the metrics 1, 2, 3, 9b and 10.

2. What Disabled staff tell us. Each trust is required to participate in the annual NHS Staff Survey. Data from the relevant questions is provided directly from the Staff Survey team and used to calculate metrics 4, 5, 6, 7, 8 and 9a.

In 2022 trusts are required to undertake:

- verification, completion, and submission of data by 31 August 2022.

- publication of a board ratified WDES 2022 annual report on the trust's external website by 31 October 2022.

For metrics 2 (Appointment from shortlisting) and 3 (Entry into the capability process), statistical significance is assessed using the "four-fifths" rule. If the relative likelihood of an outcome for one sub-group compared to another is less than 0.80 or higher than 1.25, then the process would be identified as having an adverse impact: relatively likelihoods between 0.8 and 1.25 suggest there is no significant difference between the sub-group and the rest of the population. A lack of statistical significance should not be interpreted as meaning that Disabled individuals, or even Disabled staff (as a group), do not experience inequalities in these areas.

For metrics (4-9a), extracted from the NHS Staff Survey, data for the national average of acute and acute & community trusts has been included to aid comparison. In the report, this comparator has been referred to 'national acute average' for brevity.

Aims

The aims of this report are to:

- Compare the workplace and career experiences of Disabled and non-disabled Trust staff, using data from reporting systems and staff survey.
- Provide a detailed analysis of the metrics data.
- Provide a year-on-year comparison with available results from earlier years.
- Highlight improvement actions that can be taken to improve the experiences of Disabled staff at Whittington Health NHS Trust.
- Continue to raise awareness of disability equality and outline some of the challenges that Disabled staff collectively experience at work.

Key findings

Workforce Representation

2022 data shows that **2.5%** of Trust staff have declared a disability.

Compared to the staff survey where **17.0%** of respondents stated they had a disability, leaves a disparity of **14.5%**.

Recruitment

Disabled applicants are more likely than non-disabled applicants to be appointed in the Trust's recruitment processes. **(relatively likelihood 0.84).**

Using the rule of 4/5ths, it does not suggest a statistical adverse impact.

Capability

Disabled staff are **nearly 2 ½ times more likely** to enter the formal capability process.

(Please note this is based on a two-year rolling average involving 9 capability cases).

Bullying, harassment and abuse

More Disabled staff have consistently reported experiencing bullying, harassment and abuse compared to non-disabled staff from patients and staff.

Presenteeism

Nearly a third of disabled staff felt pressure to attend work when not feeling well enough. However, the gap in experience for disabled and non-disabled staff is getting smaller.

Reasonable Adjustments

62.3% of Disabled staff report that they have the adjustments necessary to perform their duties effectively, a **decrease of 4.7** percentage points from 2021.

Summary analysis

The data in Table 1 has been collected since 2019. The data is based either as a snapshot 'as at' 31 March (in each year, for metrics 1 and 10), the year running to 31 March (for metric 2) or the average (mean) of the two years to 31 March (for metric 3).

Table 1: WDES metrics based on ESR and HR/Recruitment databases

Metric	Description	2019	2020	2021	2022
1	Percentage of Disabled staff.	2.00%	2.00%	2.09%	2.50%
2	Relative likelihood of non-disabled staff applicants being appointed from shortlisting across all posts compared to Disabled staff.	1.24	0.96	1.02	0.84
3	Relative likelihood of Disabled staff entering the formal capability process (performance management rather than ill health) compared to non-disabled staff.	1.74	0.00	0.00	2.44
10	Percentage of Disabled staff on Boards.	0.00%	13.0%	20.0%	20.0%

Table 2 presents metrics data calculated from responses to the NHS Staff Survey. Every year, NHS organisations are required to deliver a standard survey to all, or a significant random proportion, of their staff. The data for the following metrics has been collected consistently over the last five years. Although the WDES was introduced in 2019, for NHS Staff Survey data we can take a longer view of the data trends and any changes in the experiences of Disabled staff over this period.

Note: NHS Staff Surveys are identified by the year they were undertaken. Results of each survey is delivered in the following year. For this report, the latest survey available is the 2021 data, the results of which were delivered in 2022.

Table 2: WDES metrics based on NHS Staff Survey data

Metric	Description	Disability Status (Yes/No)	2017	2018	2019	2020	2021
4	Percentage of staff experiencing harassment, bullying or abuse in the last 12 months	Yes	27.4%	31.7%	30.1%	30.8%	27.9%
		No	21.4%	25.3%	23.7%	20.4%	20.4%
5	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	Yes	44.2%	42.3%	46.6%	41.8%	38.5%
		No	52.7%	47.8%	50.2%	49.7%	49.2%
6	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Yes	29.5%	32.0%	33.5%	37.4%	28.5%
		No	22.6%	23.7%	22.0%	21.6%	22.0%
7	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work	Yes	35.5%	36.8%	39.3%	37.1%	33.8%
		No	44.1%	48.4%	51.6%	53.7%	46.5%
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	Yes	68.8%	62.5%	68.1%	67.0%	62.3%
		No	Non-disabled staff are not asked this question				
9a	Staff engagement score (a composite of nine questions)	Yes	6.8	6.6	6.7	6.7	6.5
		No	7.1	7.1	7.2	7.3	7.0

Workforce supply

Under this heading we provide analysis for:

WDES metric 1 Workforce representation
WDES metric 2 Recruitment
WDES metric 5 Career progression
WDES metric 10 Board membership

WDES Metric 1
Workforce representation

Percentage of Disabled staff in each of the Agenda for Change (AfC) bands 1 – 9, VSM (including executive board members), medical/dental and other staff, compared with the percentage of non-disabled staff in these categories.

Summary findings

- 2.5% (118) of staff working for Whittington Health have recorded a disability on the NHS Electronic Staff Record (ESR). Since 2029, this has increased by 0.5 percentage points. Nationally, 3.7% of all staff employed by the NHS have declared a disability on ESR.
- 17.0% of staff who answered the 2021 NHS Staff Survey monitoring question indicated they have a disability (an increase of 2.8 percentage points from the previous year). There is a disparity of 14.5% of Trust staff that have declared a disability on ESR, compared to the responses to the Staff Survey.
- Overall, 2.5% of Trust medical and dental staff have declared that they have a disability on ESR.
- 1.4% of Trust medical consultants and 3.6% of trainee doctors have declared a disability.
- For clinical and non-clinical roles, there is a higher than expected representation of disabled staff (when compared to the overall workforce) in clusters 2 and 3 (band 5-8b). In all other clusters there is a lower than expected representation of disabled staff.
- Compared to the overall workforce, for clinical and non-clinical staff there is a lower than expected representation of disabled staff in senior manager roles (8c and above).
- 49.4% of all Trust staff have not declared their disability status.

Figure 1: Representation of disability status in non-clinical roles

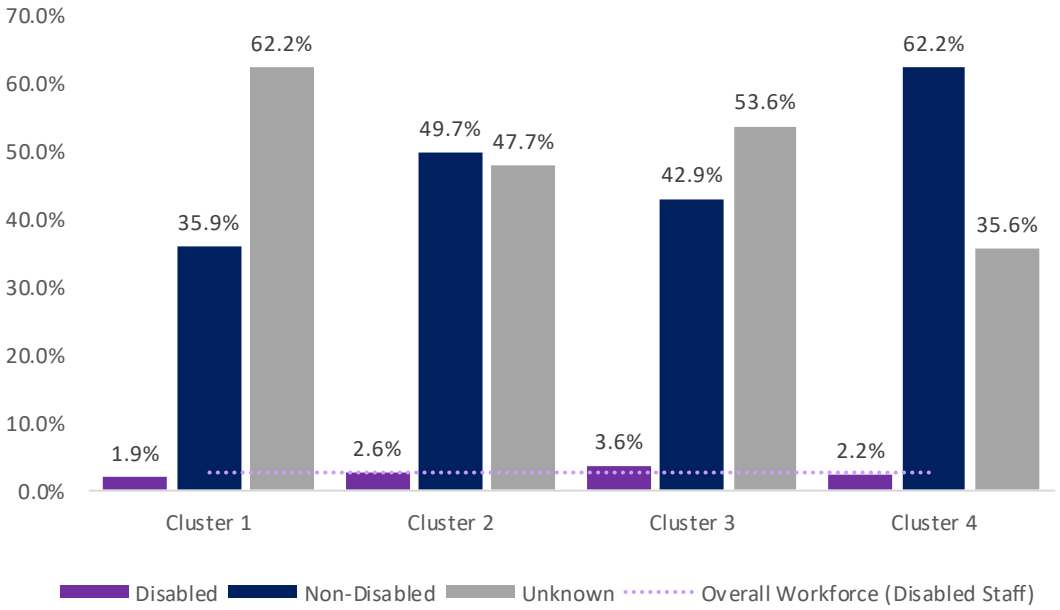
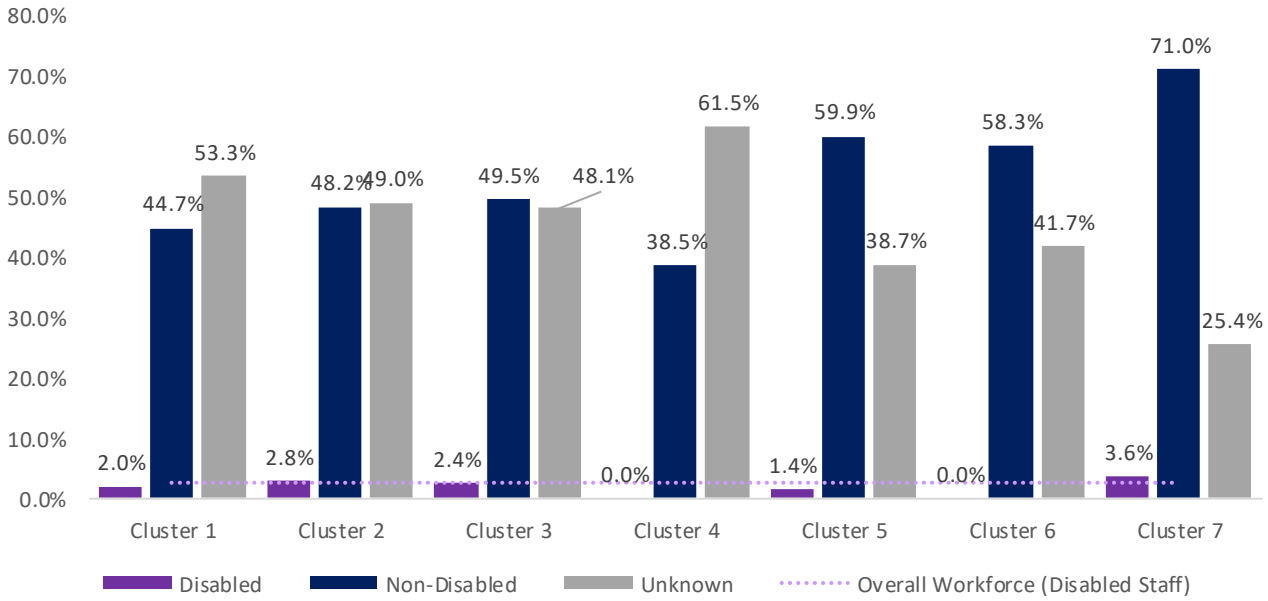


Figure 2: Representation of disability status in clinical roles



Cluster 1 – Agenda for change bands 1-4
Cluster 2 – Agenda for change bands 5-7
Cluster 3 – Agenda for change bands 8a-b
Cluster 4 – Agenda for change bands 8c-9 and very senior managers
Cluster 5 – Medical and dental, consultants
Cluster 6 – Medical and dental, middle grade
Cluster 7 – Medical and dental, trainee grade

Actions to take forward

- Update information on declaring disability that staff can use as a resource.
- Consult Disabled staff and networks to better understand the reasons why staff may not have declared a disability on ESR.
- Reduce the number of ‘unknown’ statuses on ESR.
- Take action that can positively increase disability declaration rates. This could include:
  - Running awareness campaigns about the organisational commitment to disability equality.
  - Publishing and promoting case studies, blogs, podcasts and lived experience videos to raise awareness of disability in the workplace.
  - Running a programme that regularly monitors disability declaration rates, with data and actions reviewed at senior trust workforce meetings.

WDES Metric 2
Recruitment

Relative likelihood of non-disabled staff compared to Disabled staff appointed from shortlisting across all posts.

Summary findings

- Disabled applicants are more likely than non-disabled applicants to be appointed from shortlisting in recruitment.
- Using the four-fifths rule, the relative likelihood does not suggest a statistically significant disadvantage for non-disabled applicants.

Trends

- Broadly, there has been a decreasing trend in the likelihood of non-disabled applicant being appointed over Disabled applicants.
- Since 2020, disabled applicants have been more likely to be appointed compared to non-disabled applicants.

Table 3: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to Disabled applicants 2019-2022

NB a figure less than 1.0 would suggest that disabled applicants are more likely to be appointed than non-disabled applicants

Year	Relative likelihood
2019	1.24
2020	0.96
2021	1.02
2022	0.84

Actions to take forward

- Review local data, including deep dives where relevant, and explore whether the evidence indicates a need to take action to address disparities in recruitment for Disabled staff. Extend the deep dive to look at ICSU and staff group/profession basis.
- Review how reasonable adjustments are managed within the recruitment and interview processes and identify actions for improvement.
- Review guidance and training provided to recruiting managers and make improvements to processes and materials e.g.
- Continue with Diverse and Inclusive Panel rollout.
- Audit the accessibility of the Trust's recruitment processes and compare against recommendations from Disability Confident Scheme.
- Develop opportunities for local unemployed Disabled people to gain work experience within the organisation.

WDES Metric 5
Career progression

Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.

Summary findings

- In 2021, 38.5% of Trust Disabled staff believed that they had equal opportunities for career progression or promotion. This is 10.7 percentage points lower than the figure for non-disabled staff (49.2%).
- Overall, 46.2% of Trust staff believe trusts provide equal opportunities for career progression.
- In 2021, compared to the acute national average for disabled staff, the experience of Trust disabled staff is 12.9 percentage points lower.
- There has been a change in the calculation of the question 15 in the NHS Staff Survey, that this metric relates to. As a result, the data will look much lower compared to previous WDES reports.

Trends

- The percentage of Trust Disabled staff believing that they have equal opportunities has been decreasing since 2019.
- The difference between Disabled and non-disabled Trust staff experience has increased, from 5.5 percentage points in 2018 to 10.7 percentage points in 2021.

Actions to take forward

- Continue, or develop bespoke career development/talent management programmes for Disabled staff.
- Review learning and development for line managers in relation to disability, to better support the career development and aspirations of Disabled staff.
- Review appraisal and effectiveness of personal development planning process.

WDES Metric 10
Board representation

Percentage difference between the organisation's board voting membership and its organisation's overall workforce.

Summary findings

- Overall, 5.9% of board members have declared a disability, which is greater than the overall workforce representation.
- When comparing to the overall workforce, there is a greater than expected representation of board members who are voting members and executive directors.
- The non-declaration of disability status remains quite high among the board (both executives and non-executive directors).

Table 4: 2022 Board membership

	Total Board	Voting Members	Non-Voting Members	Executive Directors	Non-Executive Directors
Disabled	5.9%	8.3%	0.0%	20.0%	0.0%
Not Disabled	64.7%	50.0%	100.0%	60.0%	42.9%
Unknown	29.4%	41.7%	0.0%	20.0%	57.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Trends

- Since 2019, there has been a higher-than-expected representation of disabled board members, compared to the overall workforce.

Actions to take forward

- Discuss equality monitoring and ask all Board members to review and update their equality information, including disability.
- Undertake a review of talent management and identify opportunities to identify and support the development of Disabled leaders of the future.
- Promote the Disabled NHS Directors Network2 to their board members, support the network's activities.

Table 5: Difference in representation of board members with a disability compared to the overall workforce

	Workforce Representation	% Difference Voting Members	% Difference Executive Directors
Disabled	2.5%	5.8%	17.5%
Not Disabled	48.1%	1.9%	11.9%
Unknown	49.4%	**-7.7%**	**-29.4%**

Retention

Under this heading we provide analysis for:

WDES metric 3 Capability
WDES metric 4 Harassment, bullying or abuse
WDES metric 6 Presenteeism
WDES metric 7 Feeling valued
WDES metric 9 Staff engagement

WDES Metric 3 **Capability**

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process.

Summary findings

- The 2022 relative likelihood is 2.44, indicating Disabled staff are nearly two and a half times as likely to enter the capability process as their non-disabled colleagues. By capability, only cases based on performance, not ill health will be counted.
- Using the rules of 4/5ths, the 2022 data would suggest that there is an adverse statistical impact for disabled staff entering into the capability process.
- In Whittington Health, the proportion of staff in the capability process is very low. Care should be taken when drawing conclusions at trust level when numbers are so small, but national comparisons and trends are still applicable.

Trends

- Overall, the relative likelihood of Disabled staff entering the capability process has increased since 2021.

Table 7: Relative likelihood of Disabled staff entering theformal capability process

Year	Relative likelihood
2019	1.74
2020	0.00
2021	0.00
2022	2.44

Actions to take forward

In partnership with Disabled staff and networks, trusts should:

- Review the trust's data and undertake further research to explore any disproportional representation of Disabled staff in capability processes.
- Review capability policies and processes with reference to disability.

WDES Metric 4
Harassment, bullying or abuse

Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months.

This metric is split into four parts:

4 (a)

Harassment, bullying or abuse from patients, service users or the public.

4 (b)

Harassment, bullying or abuse from a line manager.

4 (c)

Harassment, bullying or abuse from other colleagues.

4 (d)

Percentage of staff who reported harassment, bullying or abuse the latest time it happened.

Summary findings

- Harassment, bullying or abuse towards Disabled staff from patients or the public has increased in 2021 by 0.6 percentage points; over a third of Disabled staff continue to report that they have experienced harassment, bullying or abuse; this figure is 6% higher when compared to non-disabled staff.
- Incidents of harassment, bullying or abuse from managers towards Disabled staff decreased by 6.8 percentage points; nearly a third of Disabled staff continue to report that they have experienced harassment, bullying or abuse; this figure is 8.9% higher when compared to non-disabled staff.
- There has been small reduction of 2.4 percentage points in the level of harassment, bullying or abuse experienced by Disabled staff in 2021; the gap in experience between Disabled and non-disabled staff has remained around 9% since 2016.
- Compared to the previous years, there was an increase in the number of Trust staff with disabilities that reported incidents of bullying, harassment and abuse.

Table 6: Harassment, bullying or abuse 2018-2021

Year	From public (4a)		From manager (4b)		From colleagues (4c)	
	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
2017	32.4%	28.0%	25.5%	16.1%	24.4%	20.1%
2018	40.3%	32.0%	27.3%	19.3%	27.5%	24.5%
2019	33.4%	31.3%	24.1%	16.3%	32.9%	23.5%
2020	32.8%	28.8%	29.5%	13.4%	30.1%	19.0%
2021	33.4%	27.4%	22.7%	13.8%	27.7%	19.9%

Trends

- Since 2019, the number of Disabled staff that have experienced harassment, bullying and abuse from patients and other colleagues is relatively consistent.
- The difference in the level of harassment, bullying or abuse experienced by Trust Disabled staff and non-disabled staff has remained consistently higher for Disabled staff over the last five years.
- Consistently over the last five years Trust Disabled staff experience higher levels of bullying, harassment and abuse compared to the national acute average.
- Over the last four years, there has been a decrease in the number of Trust Disabled staff that have reported incidents of bullying, harassment and abuse. The opposite is true for non-disabled staff.
- From 2020, there have been less Trust Disabled staff that have reported incidents of bullying, harassment and abuse compared to the national average for acute trusts.

Figure 3: Metrics 4a-c, harassment, bullying or abuse for disabled staff at the Trust

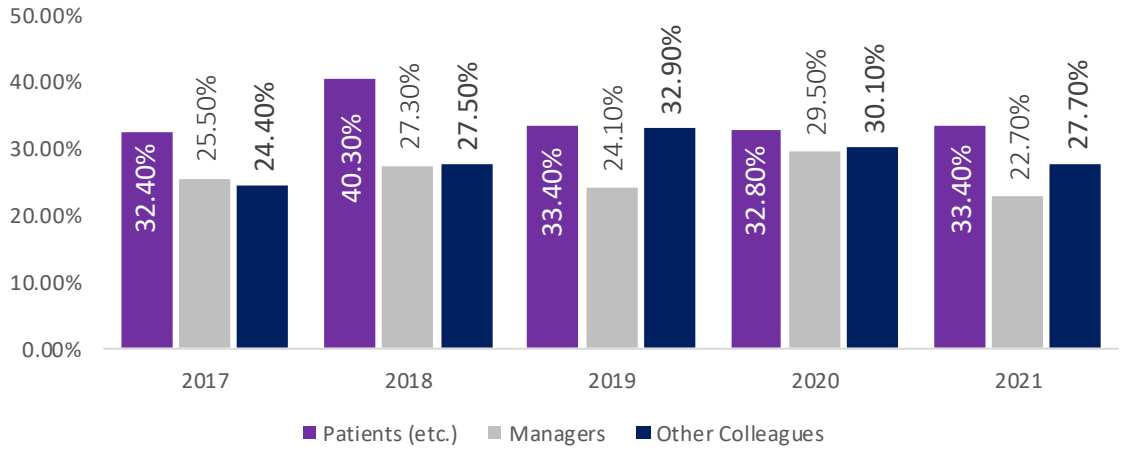


Figure 4: Metrics 4a-c, harassment, bullying or abuse in the national acute average for disabled staff

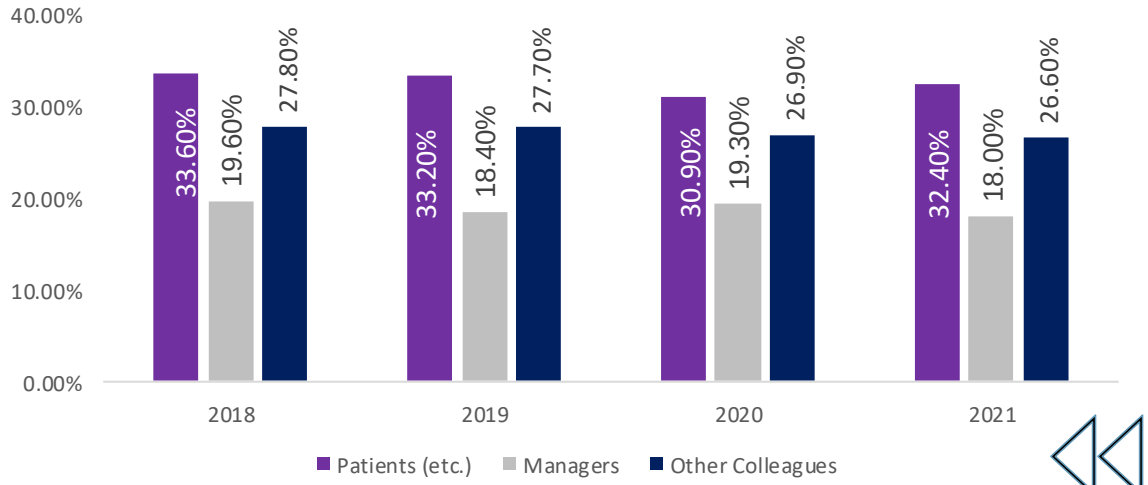
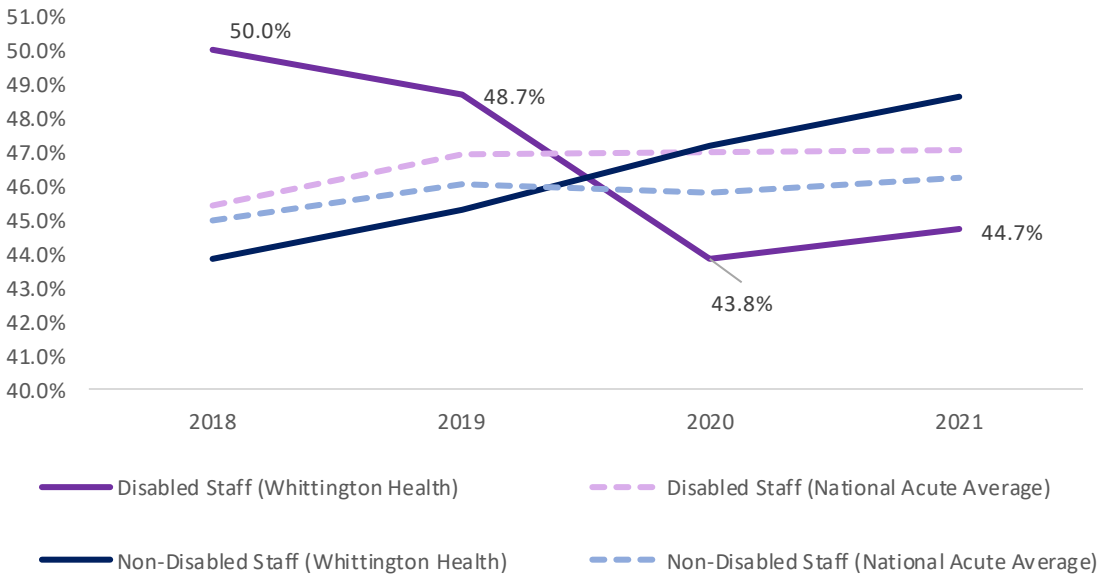


Figure 5: Metrics 4d, reporting of harassment, bullying or abuse



Actions to take forward

- Discuss experiences of harassment, bullying or abuse with Disabled staff,ensuring that there is a safe person/space for any discussions
- Launch a communications campaign focused on reducing harassment,bullying and abuse
- Consider having workplace advisers that specialise in harassment, bullying and abuse, working in conjunction with unions, freedom tospeak up guardians, and staff networks
- Consider and adopt the practices set out in the NHS Civility and RespectToolkit

WDES Metric 6
Presenteeism

Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties ("presenteeism").

Summary findings

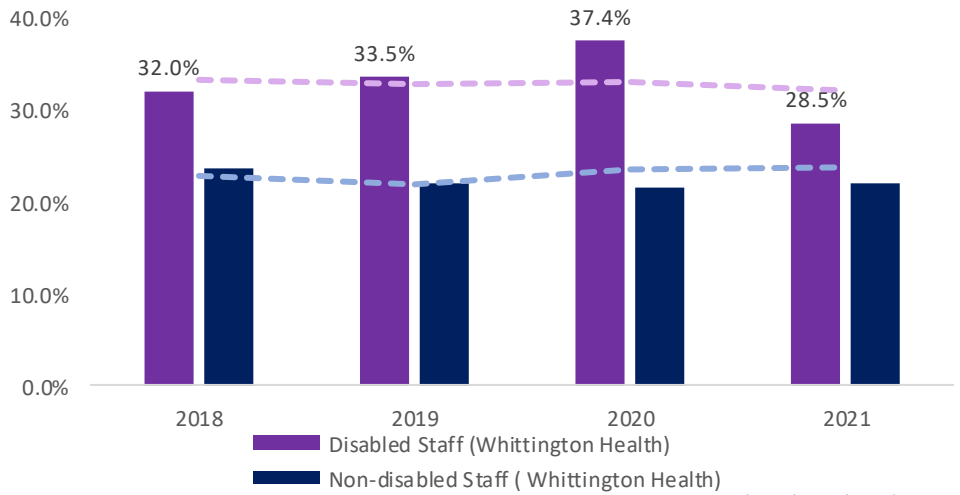
- Nearly a third of Disabled staff say that they have felt pressure from their manager to come to work, despite not feeling well enough
- Compared to the previous year, there has been a decrease in presenteeism in Trust staff with disabilities and an increase in non-disabled staff.
- The gap in experience between Trust Disabled and non-disabled staff has almost halved since 2020. In 2020 there was a gap of 15.8%, in 2021 it reduced to 6.5%.

Trends

- The level of presenteeism has been relatively stable, except in 2020 which may be impacted by the COVID-19 pandemic.
- The closing of the differential gap between Disabled and non-disabled staff in 2021 may be a direct consequence of the UK 'learning to live with COVID-19'.

- Compared to national acute trust data, Trust non-disabled staff is broadly in line while Disabled staff in 2018 and 2021 fewer staff report experiencing pressure from their managers, but in 2019 and 2020 more staff reported this.

Figure 6: Metric 6, presenteeism



Actions to take forward

- Introduce a Disability Leave policy.

- Undertake analysis to investigate whether the experience of requesting flexible working arrangements differs between Disabled and non- disabled staff within the trust. 'Improving access to flexible working opportunities' is a recommendation set out in the NHS Disabled staff experiences during COVID-19 report
- Reasonable Adjustment Guidelines to improve education on the process, and help to reduce unnecessary delays.

WDES Metric 7
Feeling valued

Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Summary findings

About a third of Trust Disabled staff feel valued by their employer: this compares to just slightly under half of non-disabled staff. Both groups saw a decrease in staff reporting that they feel valued.

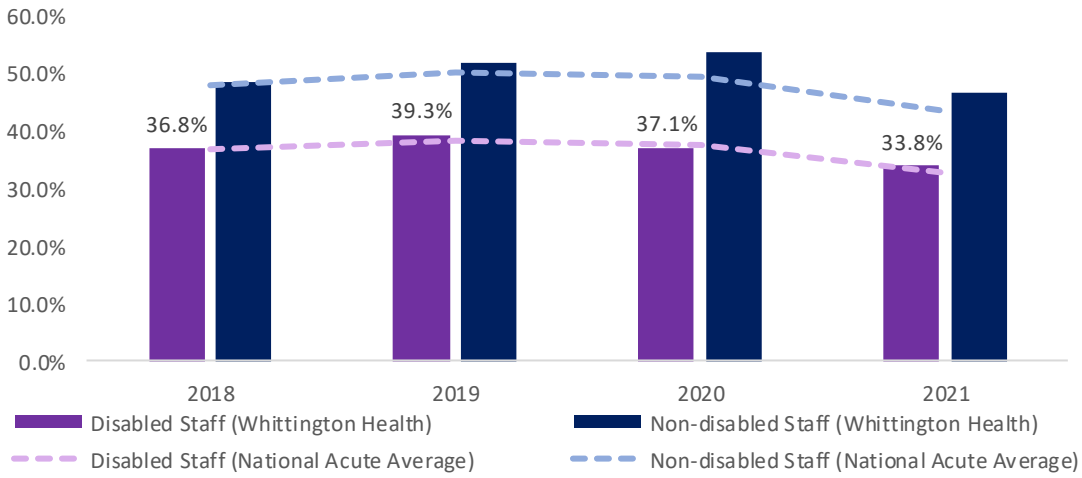
Trends

- Both staff groups broadly follow the national acute average; both in terms of pattern and percentage values.
- Except 2020, the gap in experience between the two Trust staff groups has remained consistent.

Actions to take forward

- Develop a communications campaign focused on the benefits of employing Disabled people, aligning these with the NHS People Promise values including the activities that support disability as an asset.
- Review WDES Metric 1 workforce data to understand pay clusters and seniority for Disabled staff
- Review entry to career development opportunities with reference to disability

Figure 7: Metric 7, feeling valued



WDES Metric 8
Workplace adjustments

Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Summary findings

- The number of Trust Disabled staff that reported having adequate reasonable adjustments decreased since 2020, this is in line with the reduction that can be seen in the national acute average.
- There is a consistent gap between Trust Disabled staff's experiences compared to the national acute average.
- Whilst there are over 60% of the Trust's Disabled staff that state they have adequate adjustments in place, that means nearly 40% of the Trust's Disabled staff do not.

Table 7: Adjustments for Disabled staff 2016-2021

Year	Whittington Health	National Acute Average
2018	62.5%	73.1%
2019	68.1%	73.3%
2020	67.0%	75.5%
2021	62.3%	70.9%

Trends

- This metric only had slight fluctuations over the four years to 2021.
- Staff in London consistently report lower levels of adjustments than other regions (typically four or more percentage points lower than any other region).
- With an increasing level of staff returning to workplaces, and the impact of health conditions such as Long Covid at this point unclear.

Recommendations for action

- Develop Reasonable Adjustments Guidelines
- Introduce Health Passport.

WDES Metric 9
Staff engagement

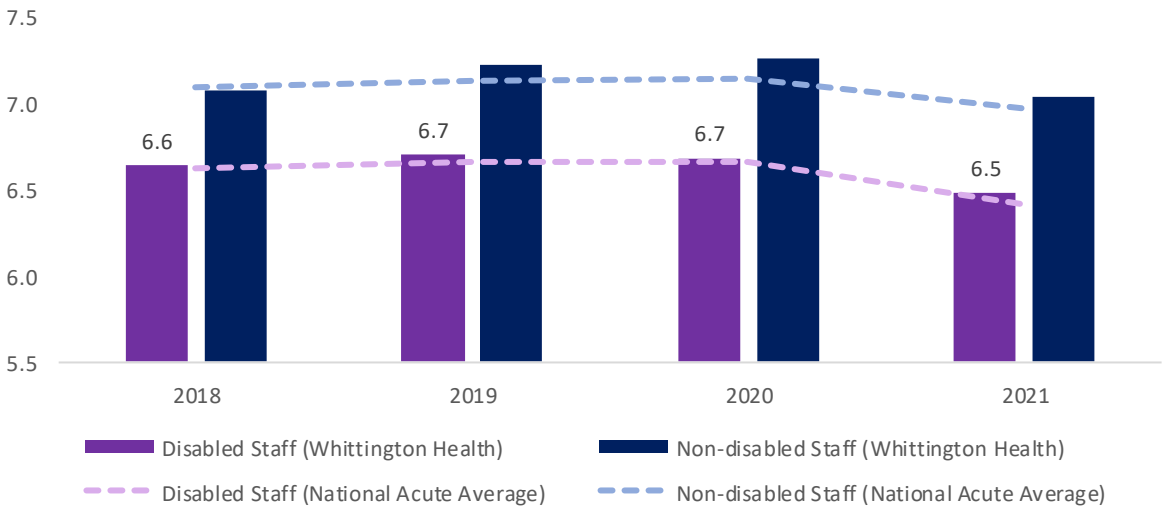
a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

b) has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

Summary findings

- Disabled staff feel less engaged than non- disabled staff at the Trust.
- (9b) The Trust has a staff network that has an executive sponsor/champion which enable the facilitation of the voices of Disabled staff to be heard in the organisation.

Figure 8: Metric 9a, staff engagement



Trends

- The staff engagement score has been consistent over five years, with Disabled staff scoring just under 0.5 less than their non-disabled colleagues.
- The reported experiences of Trust staff mirror that national acute average for both groups.

Actions to take forward

- Review and strengthen the governance arrangements of the Disabled Staff Network.
- The improved facilitation of Disabled staff voices is not being reflected in the staff engagement score, so trusts should look to identify additional ways to ensure that the voices of all Disabled staff are heard.
- In conjunction with regional leads, organise regional Disabled Staff Network activities and events.

Metric 1 Metric 2 Metric 3 Metric 4 Metric 5 Metric 6 Metric 7 Metric 8 Metric 9 Metric 10

Meeting title	**Trust Board – public meeting**	**Date: 22 July 2022**
Report title	**Innovation & Digital Assurance Committee Chair's report**	**Agenda item: 8**
Committee Chair	Junaid Bajwa, Non-Executive Director	
Executive director lead	Jonathan Gardner, Director of Strategy & Corporate Affairs	
Report author	Marcia Marrast-Lewis, Assistant Trust Secretary	
Executive summary	The Innovation and Digital Assurance Committee met on 12 July 2022 and take significant assurance from the following items considered: • Chair's report, Innovation & Digital Transformation Group • Board Assurance Framework – Sustainability entries • Progress against Digital Strategy • Virtual Ward – Deep Dive • Anchor Institution Update • Innovation and Agility – Capabilities and Partnerships There are no items for which the Committee is reporting limited assurance to the Board.	
Purpose	Note	
Recommendations	Board members are asked to note the Chair's assurance report for the meeting held on 12 July 2022	
Board Assurance Framework	Sustainable 3 – Digital strategy and interoperability strategic objective entry	
Appendices	None	

Committee Chair's Assurance report

Committee name	Innovation & Digital Assurance Committee
Date of meeting	12 July 2022
Summary of assurance:	

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

Chair's report, Innovation & Digital Transformation group
The Committee took good assurance from the Chair's report provided for the meeting held on 28 June 2022. It was noted that generally reasonable and moderate assurance was received on all projects save for *Population Health - Onboarding data to NCL Population Health Platform* (where progress has been hampered by delays in testing due to a lack of coordination (& requirements) between both the Central team and Cerner leading to testing being cancelled on several occasions.

Board Assurance Framework
The Committee considered the risks related strategic objective 3, Sustainable 3 – digital strategy and interoperability for which the Committee had oversight and responsibility. It was noted that currently, the risk carried a relatively low score of 6. The Committee discussed whether the right level of controls were in place agreeing that financial risks should be strengthened as the capital and revenue impact over the upcoming three years was potentially significant (e.g. referencing EPR procurement) which could negatively impact the achievement of the digital strategy. It was agreed that gaps and controls should be adjusted to highlight the difference in the risk which would not however change the current risk score

Progress against the Digital Strategy
The Committee received a verbal update on progress of the Electronic Patient Records (EPR) procurement explaining that the Trust needed to invest in writing the business case to take forward a new EPR as the Trust was coming to the end of its contract. A significant amount of work had taken place with EPIC (through the UCLH instance) and System C to agree costs. The work to create a compliant business case, however, was a considerable investment that ideally needs to be done this year; and will require further discussion and appropriate sign off.

Virtual Ward – Deep Dive
The Committee received presentation on virtual wards – a concept designed to provide a safe and efficient alternative to NHS bedded care enabled by technology. The ambition was that virtual wards would support patients who would otherwise be in hospital to receive the acute care, monitoring, and treatment required in their own homes. This included either preventing avoidable admissions into hospital or supporting early discharge out of hospital. The initiative was planned to be rolled out in five hospitals across North Central London which would significantly increase out of hospital care for the upcoming year using technology and remote monitoring to support the work going forward. The Committee agreed that the Virtual Ward and in

	particular remote monitoring concept did align well with the Trust's digital strategy and that the project should be prioritised as it would greatly enhance the Trust's long-term sustainability objective through innovation. The discussion emphasised the importance of focusing on the outcomes we are aspiring to achieve, engaging primary care, and consideration of novel healthcare roles (technical assistants, health coaches, pharmacists, AHPs). The Committee also agreed to receive regular updates as the project progressed. **Anchor Institution Update** The Committee reviewed an update which focused on progress of work carried out in partnership with the Islington Anchor Programme and the Haringey Place Board. The work was carried out as workstreams across all Integrated Clinical Support Units. The Committee received moderate assurance that workstreams were on track. The committee agreed that this was an important piece of work to be tracked by the committee (especially as it relates to data analytics + population health), but it will require commitment from the wider Exec, and consideration of a more direct connection to the strategy for the Hospital. **Innovation and Agility** The Committee received discussed the potential merits/challenges of implementing artificial intelligence within the new Community Diagnostic Centre agreeing that more information was needed before any decisions were taken.
2.	**Present:** Junaid Bajwa, Non-Executive Director (Committee Chair) Tony Rice, Non-Executive Director Jonathan Gardner, Director of Strategy and Corporate Affairs Dale-Charlotte Moore, Deputy Chief Operations Officer Jerry Francine, Finance Director Operations Helen Taylor, Clinical Director ACW Sam Barclay, Chief Clinical Information Officer Tawanda Maposa, Acting Chief Information Officer **In attendance:** Iolanda Pedrosa, Chief Nursing Midwifery & AHP Information Officer Maulin Thaker, Interim Joint Assistant Director of IM&T (Informatics) Marcia Marrast-Lewis, Assistant Trust Secretary **Apologies:** Kevin Curnow, Chief Finance Officer

Meeting title	**Trust Board – public meeting**	**Date: 22 July 2022**
Report title	**Integrated performance report**	**Agenda Item: 9**
Executive director lead	Carol Gillen Chief Operating Officer	
Report Owner	Paul Attwal, Head of Performance, Chloe Hubbard, Performance Manager	
Executive summary	**Areas to draw to Board members' attention are:** **Emergency Department (ED) four hours' wait** During June 2022, performance against the 4-hour access standard was 73.2%, higher than the NCL average 68.81%, the London average of 72.35% and national average of 72.11%. There were 10 12-hour trolley waits in June 2022, of which 2 were mental health patients and 8 were acute patients. 8 of these breaches were as a result of a challenging June bank holiday with limited discharges. Other challenges during the month included ongoing issues with downward flow capacity, IPC challenges due to side room requirements. Inability to board patients due to workforce/safety acuity risks. The Trust continues to experience a high number of medically optimised patients occupying beds. **Caring** Friends and Family test - Inpatient response rates have improved significantly this month to 29.1% and are now above target for the first time this year. The positive feedback has been consistently above target of 90% all year. Outpatient positive responses is now also above the 90% target for the first time February 2022. **Cancer** Compliance against the national cancer standards has not been achieved since April 2020. 28 Day Faster Diagnosis was at 64.8% against a standard of 83%. 62-day performance was at 54.2% for May 2022 after reallocation. **Referral to Treatment: 52 + week waits** At the end of June 2022 there were 442 patients waiting more than 52 weeks for treatment. Additional insourcing from 18-week Support for surgery has begun in July to help reduce the overall backlog. The contract is in place until the end of the financial year. **Workforce** Appraisal rates for June 2022 are at 71.5% against a target of >90%, an increase of 1.1% from May 2022. The compliance against Mandatory	

	Training was 85.1% in June 2022, no change from the previous month, against a target of >90%.
Purpose:	Review and assurance of Trust performance compliance
Recommendation (s)	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan
Risk Register or Board Assurance Framework	The following BAF entries are linked: Quality 1; Quality 2; Quality 3; People 1; and, People 2.
Report history	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
July 2022

Month 03 (2022 – 2023)

Scorecard

Deliver outstanding safe, compassionate care

Indicator	Target	Reporting Mth	Step Change	Control Limit	Prev. Month	Reporting Mth	2022-2023
Emergency Department waits (4 hrs wait)	>95%	Jun			75.3%	73.2%	75.1%
Cancer - 14 days to first seen	>93%	May			50.8%	54.9%	52.8%
Cancer - 62 days from referral to treatment	>85%	May			45.2%	54.2%	51.1%
DM01 - Diagnostic Waits (<6 weeks)	>99%	Jun			88.30%	87.54%	87.80%
RTT - Incomplete % Waiting <18 weeks	>92%	Jun			72.1%	69.8%	71.0%
Referral to Treatment 18 weeks - 52 Week Waits	0	Jun			375	442	1190
Community - FFT % Positive	>90%	Jun			99.2%	97.3%	98.0%
% seen <=2 hours of Referral to District Nursing Night Service	>80%	Jun			100.0%	100.0%	100.0%
% seen <=48 hours of Referral to District Nursing Service	>95%	Jun			94.1%	95.2%	94.8%

Transform and deliver innovative, financially sustainable services

Indicator	21_22 Target	Reporting Month	Step Change	Control Limit	Prev. Month	Reporting Month	2022-2023
Theatre Utilisation	>85%	Jun			74.67%	73.21%	73.69%
Acute DNA % Rate	<10%	Jun			10.4%	10.5%	10.7%
Community DNA % Rate	<10%	Jun			7.4%	7.8%	7.6%
Outpatients New:FUp Ratio	2.3	Jun			1.72	1.69	1.73
Elective and Daycase		Jun			2087	2075	5902
Outpatient Attendances		Jun			27127	25872	76625
Community Face to Face Contacts		Jun			44648	40763	123015

Integrate care with partners and promote health and wellbeing

Indicator	21_22 Target	Reporting Mth	Step Change	Control Limit	Prev. Month	Reporting Mth	2022-2023
Breastfeeding Initiated	>90%	Jun			93.6%	94.6%	92.8%
% e-Referral Service (e-RS) Slot Issues	<4%	Jun			33.0%	32.6%	32.8%
% of MSK pts with Improvement in function (PSFS)	>75%	Jun			74.2%	83.3%	79.9%
Rapid Response - % of referrals with an improvement in care		Jun			0.0%	0.0%	0.0%

Empower, support and develop engaged staff

Indicator	21_22 Target	Reporting Month	Step Change	Control Limit	Prev. Month	Reporting Month	2022-2023
Appraisals % Rate	>90%	Jun			70.4%	71.5%	69.6%
Mandatory Training % Rate	>90%	Jun			85.1%	85.1%	84.8%
Permanent Staffing WTEs Utilised	>90%	Jun			87.3%	86.9%	87.1%
Staff FFT % recommended work	>50%	Jun					51.7%
Staff FFT response rate	>20%	Jun					
Staff sickness absence %	<3.5%	May			4.79%	3.85%	4.31%
Staff turnover %	<13%	Jun			14.0%	14.2%	14.0%
Vacancy Rate against Establishment	<10%	Jun			12.7%	13.1%	12.9%

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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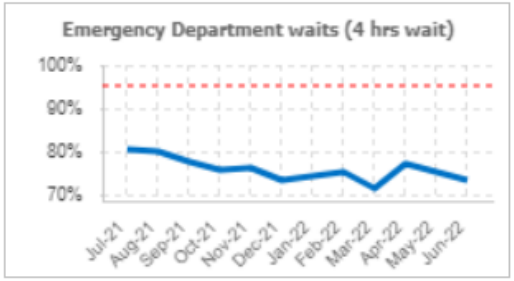
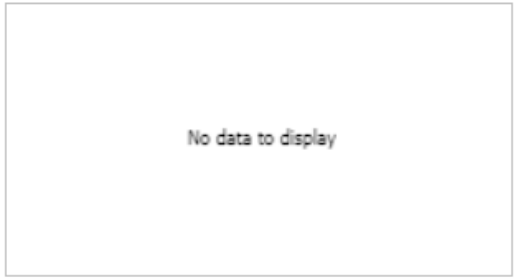
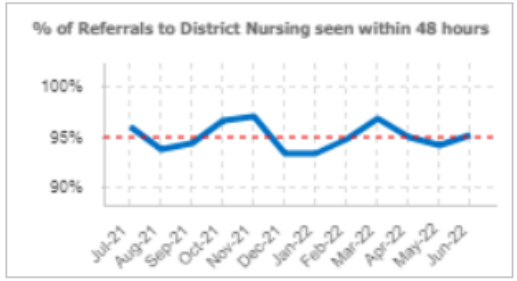
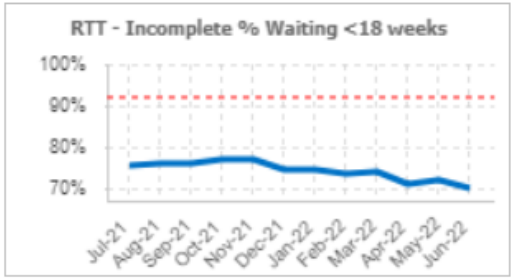
Summary

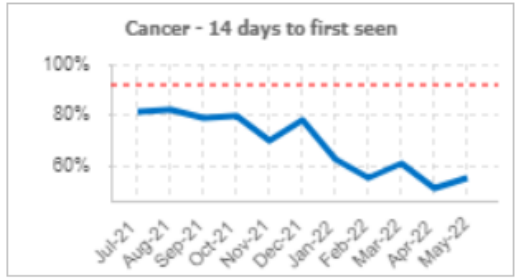
Category	Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	2022-2023	
ED	Emergency Department waits (4 hrs wait)	>95%	80.5%	80.1%	77.4%	75.6%	76.0%	73.3%	74.2%	75.1%	71.4%	77.1%	75.3%	73.2%	75.1%	!
Cancer	Cancer - 14 days to first seen	>93%	81.4%	81.8%	79.1%	79.3%	69.5%	77.6%	62.0%	55.1%	60.9%	50.8%	54.9%		52.8%	!
Cancer	Cancer - 62 days from referral to treatment	>85%	72.2%	77.6%	64.1%	58.0%	43.9%	59.5%	41.5%	50.0%	54.7%	45.2%	54.2%		51.1%	!
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.56%	4.92%	4.36%	4.14%	3.87%	5.35%	4.05%	4.30%	4.36%	4.43%	5.17%	4.23%	4.62%	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%														
Access	RTT - Incomplete % Waiting <18 weeks	>92%	75.5%	76.1%	76.0%	76.7%	76.7%	74.2%	74.4%	73.4%	73.8%	71.0%	72.1%	69.8%	71.0%	!
Outpatients	Outpatients - FFT % Positive	>90%	97.5%	97.7%	96.3%	75.0%	88.9%	90.0%	98.1%	93.3%	89.5%	75.0%	87.9%	90.0%	89.1%	
Community	Community - FFT % Positive	>90%	97.1%	97.0%	95.1%	96.5%	98.0%	98.2%	99.2%	99.4%	99.1%	97.2%	99.2%	97.3%	98.0%	
Staff	Staff - FFT % Recommend Care	>50%			65.5%				56.7%			0.0%			0.0%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	96.0%	93.8%	94.3%	96.7%	97.1%	93.3%	93.3%	94.7%	96.8%	95.0%	94.1%	95.2%	94.8%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	94.1%	91.0%	91.5%	93.6%	92.6%	87.7%	91.1%	91.7%	87.3%	93.7%	95.9%		94.8%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	95.2%	97.6%	94.3%	94.0%	95.0%	93.7%	93.7%	93.7%	94.9%	96.4%	94.8%		95.6%	

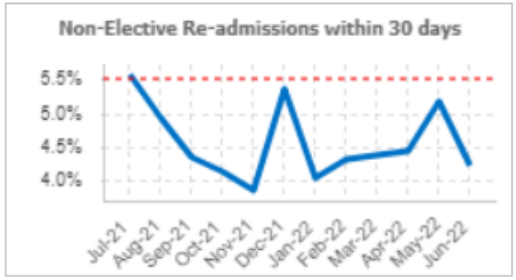


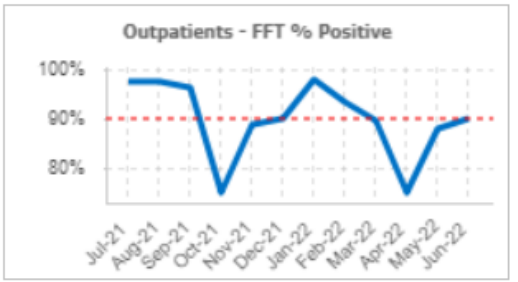












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Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	2022-2023	Performance
Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI C Difficile	<16	0	2	0	0	0	1	2	1	2	2		1	3	
Actual Falls	400	30	34	27	23	21	33	40	23	31	25	28	30	83	
Category 3 or 4 Pressure Ulcers	0	13	14	20	3	4	10	4	8	9	17	9	10	36	
Medication Errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
MRSA Bacteraemia Incidences	0	0	0	0	0	0	0	0	0	0	0		0	0	
Never Events	0	0	1	0	1	0	0	0	0	0	0	0	0	0	
Serious Incidents	N/A	1	1	3	1	1	3	2	1	5	3	2	2	7	
VTE Risk Assessment %	>95%	73.9%	76.3%	77.0%	77.8%	80.7%	84.1%	93.1%	92.0%	91.2%	95.2%	95.2%	94.9%	95.1%	
Mixed Sex Accomodation Breaches	0	0	0	0	2	14	7	2	4	5	4	5	0	9	
Summary Hospital Level Mortality Indicator (SHMI)	1.14			0.88			0.89								

**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, Deep Tissue Injury and Device Related Pressure Ulcers reported in 2022/2023 **Pan Trust Standard** 10% reduction in the total number of attributable PUs during 2022/23 compared to 2021/22 including a breakdown of Pressure Ulcers by category	**Variance against Plan:** **Total Trust numbers of all reported Pressure Ulcers in June 2022:** 66 (+ 9 deep tissue injuries). There were 7 medical device related pressure ulcers. **Breakdown:** Category 2: 43 (16 in hospital, 27 in community) 3 medical device related. Category 3: 9 in community. 1 medical device related Category 4: 1 in community Mucosal: 1 in hospital, medical device related Unstageable: 12 (3 in hospital, 9 in community). 1 medical device related Deep Tissue Injury: 9 (4 in hospital, 5 in community). This is a similar number of pressure ulcer incidents compared to May (Total 67 pressure ulcers). 9 patients across the trust developed confirmed full thickness pressure damage (category 3 or 4) In the hospital there were 20 pressure ulcers and 4 deep tissue injuries acquired on 19 patients. There were no confirmed full thickness pressure ulcers reported. In the community there were 46 pressure ulcers and 5 deep tissue injuries acquired on 42 patients, with 8 patients developing 2+ pressure ulcers. **Action to Recover:** • Weekly pressure ulcer incident review meetings in Adult Community services with an ICSU plan to undertake a deep dive into category 4 pressure ulcer incidents • Planned recommencement of OSCE (Objective Structured Clinical Examination) based practical training in Adult Community Services • Planned review of Trust based pressure ulcer education platforms to address training space deficits and capacity challenges • Active recruitment into Tissue viability Team vacancies to optimise	**Named Person:** Lead Specialist Nurse – Tissue Viability **Time Scale to Recover Performance:** 6 months

	support for clinical areas ICSU led review of pressure ulcer incidents in Quality & Risk meetings	

Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	2022-2023	Performance
ED - FFT % Positive	>90%	75.5%	77.8%	77.7%	78.0%	74.7%	77.1%	82.2%	79.2%	72.4%	79.1%	75.3%	74.6%	76.2%	
ED - FFT Response Rate	>15%	11.0%	11.5%	10.6%	10.6%	10.5%	11.3%	11.5%	10.8%	10.0%	10.6%	11.3%	12.4%	11.4%	
Inpatients - FFT % Positive	>90%	95.9%	96.4%	94.1%	94.7%	95.9%	96.5%	96.3%	96.4%	96.8%	94.2%	93.2%	93.3%	93.5%	
Inpatients - FFT Response Rate	>25%	16.6%	13.8%	18.8%	18.1%	23.9%	16.0%	18.7%	17.2%	14.9%	16.5%	19.1%	29.1%	20.7%	
Maternity - FFT % Positive	>90%	100.0%	100.0%		99.0%	94.9%	97.8%	96.5%	100.0%	77.8%	80.0%	100.0%	100.0%	87.5%	
Maternity - FFT Response Rate	>15%	24.6%	2.2%	0.0%	16.1%	20.1%	8.4%	9.6%	1.6%	0.9%	1.0%	0.4%	0.2%	0.5%	
Outpatients - FFT % Positive	>90%	97.5%	97.7%	96.3%	75.0%	88.9%	90.0%	98.1%	93.3%	89.5%	75.0%	87.9%	90.0%	89.1%	
Outpatients - FFT Responses	400	40	43	27	20	54	60	54	60	76	4	33	100	137	
Community - FFT % Positive	>90%	97.1%	97.0%	95.1%	96.5%	98.0%	98.2%	99.2%	99.4%	99.1%	97.2%	99.2%	97.3%	98.0%	
Community - FFT Responses	1500	383	367	509	567	611	547	486	462	572	470	627	672	1769	
National Quarterly Pulse Survey (NQPS)	800			686				314			327			327	
NQPS Staff % recommended work	>50%			57.3%				48.4%			51.7%			51.7%	
Complaints responded to within 25 or 40 working days	>80%	66.7%	66.7%	45.7%	63.0%	78.3%	13.3%	40.0%	40.7%	44.4%	61.1%	77.8%	52.2%	64.7%	
Complaints (including complaints against Corporate division)	N/A	24	36	35	27	23	15	20	27	18	18	27	23	68	

**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:	**Variance against Plan:** In month, there has been a slight increase to the response rate- which although below target, is the highest it has been in the last year. The positive feedback response rate has remained relatively stable. **Action to Recover:** Patient experience team continue to work with service leads to support with expected improvements over the next 6 months.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** December 2022
Community FFT Responses:	**Variance against Plan:** This month there has been a good increase to the response rate- which although below target, is the highest it has been in the last year. The positive responses have been consistently above target all year. **Action to Recover:** QR codes being rolled out. Community paediatrics are creating a dedicated Patient Experience Group to increase engagement in this.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** September 2022
Inpatient FFT Responses:	**Variance against Plan:** Response rates have improved significantly this month, and are now above target for the first time this year. The positive feedback has been consistently above target all year. **Action to Recover:** QR codes have been rolled out across all inpatient wards and engagement work is being carried out with these clinical areas. This includes regular ward walk arounds and with matrons to ensure FFT is on their agenda and embedded into processes. The increase is responses shows the impact of this work.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** September 2022

Maternity - FFT Response Rate:	**Variance against Plan:** The response rate is the lowest this has been for a year. The positive response cannot be relied upon as the overall responses were so low. **Action to Recover:** Maternity services working with patient experience team to adopt digital questionnaire via iPads and use of QR codes. Patient Experience team in regular contact with service leads in Maternity.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** October 2022
Outpatients – FFT Responses	**Variance against Plan:** This month, there has been a large increase in the response rate (over three times higher than the previous month) and although still below target, this is the highest it has been all year. This month also saw an increase in the positive responses, to bring it to target. **Action to Recover:** The Patient Experience team are hoping to get QR codes embedded into Outpatient letters, taking patient directly to feedback page. Posters with QR codes have also being placed around trust to increase visibility. The Outpatient FFT survey has also just been made available in 10 languages. Patient experience team continue to work with service leads within Outpatients to continue to drive improvements.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** September 2022
Complaints responded to within 25 or 40 days	After positive improvement in May, there has been slippage in complaint responses with a performance of 52.2% (12/23). There were 26 complaints received where a response was required in June 2022. Three of these were de-escalated leaving 23 complaints due a response. The Complaints Team continue to work closely with the ICSUs to support with the completion of these and all complaint investigations and meetings have been held with the Associate Directors of Nursing in the ICSUs. In the meantime, any urgent issues have been actioned and complainants have been kept informed re progress & delays.	**Named Person:** PALS & Complaints Manager **Time Scale to Recover Performance:** Ongoing

Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	2022-2023	Performance
Hospital Cancelled Operations	0	4	4	16	14	5	0	8	6	2	13	6	8	27	
Cancelled ops not rebooked < 28 days	0	0	0	0	2	0	0	0	0	0	1	0		6	
Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Theatre Utilisation	>85%	63.01%	63.23%	67.86%	69.25%	70.62%	69.54%	65.67%	71.34%	68.65%	73.02%	74.67%	73.21%	73.69%	
Breastfeeding Initiated	>90%	90.2%	89.3%	91.5%	92.0%	93.4%	92.1%	92.0%	89.7%	92.0%	90.3%	93.6%	94.6%	92.8%	
Mortality rate per 1000 admissions in-months	14.4	8.0	8.8	7.2	8.0	7.7	7.9	10.3	6.2	9.0	8.7	5.1	8.5	7.4	
Community DNA % Rate	<10%	7.6%	8.2%	7.7%	7.1%	7.4%	7.6%	6.9%	7.6%	7.5%	7.6%	7.4%	7.9%	7.6%	
Community Services - Provider Cancellations	<8%	8.2%	7.7%	7.3%	7.7%	7.8%	11.1%	11.0%	8.2%	8.6%	7.2%	7.5%	8.2%	7.7%	
Acute DNA % Rate	<10%	10.2%	10.9%	11.1%	10.4%	10.1%	10.9%	11.0%	10.6%	11.2%	11.3%	10.4%	10.6%	10.7%	
% e-Referral Service (e-RS) Slot Issues	<4%	31.1%	28.5%	35.7%	28.8%	31.2%	35.2%	29.4%	31.8%	31.6%	32.9%	33.0%	32.6%	32.8%	
Outpatients New:FUp Ratio	2.3	1.89	1.83	1.71	1.66	1.79	1.85	1.78	1.70	1.66	1.80	1.71	1.68	1.73	
Delayed Transfers Of Care % of Occupied Bed Days	<2.4%														
Non Elective Re-admissions within 30 days	<5.5%	5.56%	4.92%	4.36%	4.14%	3.87%	5.35%	4.05%	4.30%	4.36%	4.43%	5.17%	4.23%	4.62%	
Rapid Response - % of referrals with an improvement in care		52.2%	52.3%	55.2%	52.9%	55.5%	53.6%	59.6%	30.9%	0.0%	0.0%	0.0%	0.0%	0.0%	

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Theatre Cancellations on The Day:	**Variance against Plan:** 8 cancelled on the day, against a plan of zero all related to surgeon/anaesthetist availability, majority of which are Covid related. **Action to Recover:** 1.There is already a refreshed process for all cancellations to ensure appropriate troubleshooting and cancellation as last resort. 2. Continue to recruit to vacant posts in anaesthetics. 3. All day anaesthetic day cover is being redirected back to Whittington from beginning of September to provide increased resilience.	**Named Person:** Deputy Director of Operations SCD **Time Scale to Recover Performance: From** September 2022 will see reduction
Theatre Utilisation % Rates:	**Variance against Plan:** Utilisation of 73% against a standard of 85%. **Action to Recover:** 1. Refreshed and continuing to refine the 6-4-2 process to ensure all lists fully booked related to time available. 2. Pre-operative assessment capacity further increased post reduction in COVID testing, to increase throughput. 3. Fast tracking of cases of low anaesthetic risk via virtual Pre-operative assessment, allowing capacity for face to face clinics for higher risk patients. 4. Clinicians challenged if lists not fully filled, requires continued pressure to change.	**Named Person:** Deputy Director of Operations SCD **Time Scale to Recover Performance:** September 2022 to achieve 80%
Acute DNA % Rate:	**Variance against Plan: 10.6% against <10%** Acute DNA rates remain similar to last month's figure of 10.4%. This continues to be monitored through the outpatient transformation board with worst performing specialities targeted to make bigger improvements. Work continues to use text messaging to contact patients. **Action to Recover:** Outpatient programme board continues to focus on: • Reduction in follow up appointments • Reduction in DNA rates, especially in areas of high volumes • NCL reviewing use of PIFU from a system perspective and looking	**Named Person:** Head of Performance **Time Scale to Recover Performance:** Ongoing

	at specific pathway to make improvements	
Appointment Slot Issues (ASIs)	**Variance against Plan: 32.6% against a target of <4%.** Performance in June 2022 continues to remain behind the 4% target, and this is consistent with the last 12 months and a known trend. There are a number of specialties experiencing higher than planned ASI issues, these sit within Surgery and Cancer ICSU. Dermatology and ENT occupy 40% of the ASI backlog. **Action to Recover:** ENT is looking to carry out super-weeks of activity to reduce overall backlog and increase capacity. This is likely to be in September 2022. Dermatology currently has capacity constraints due to an increase in cancer referrals impacting overall capacity. The service is reviewing additional support from NCL.	**Named Person:** Head of Performance **Time Scale to Recover Performance:** September 2022

Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	2022-2023	Performance
Cancer - 14 days to first seen	>93%	81.4%	81.8%	79.1%	79.3%	69.5%	77.6%	62.0%	55.1%	60.9%	50.8%	54.9%		52.8%	
Cancer - 14 days to first seen - breast symptomatic	>93%	95.1%	97.6%	90.9%	93.5%	92.5%	87.5%	9.1%	11.8%	20.8%	0.0%	5.0%		3.3%	
Cancer - 62 days from referral to treatment	>85%	72.2%	77.6%	64.1%	58.0%	43.9%	59.5%	41.5%	50.0%	54.7%	45.2%	54.2%		51.1%	
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%	69.8%	76.6%	63.2%	56.9%	43.1%	58.1%	39.4%	52.4%	51.6%	40.0%	54.2%		48.9%	
Cancer ITT - % of Pathways sent before 38 Days	>85%	16.7%	28.6%	37.5%	33.3%	20.0%	20.0%	18.2%	33.3%	16.7%	20.0%	42.9%		29.4%	
Cancer - % Pathways received a Diagnosis within 28 Days of Referral		80.3%	79.3%	72.4%	71.7%	71.9%	70.5%	74.2%	81.4%	81.8%	63.9%	64.8%		64.4%	
Cancer - 31 days to first treatment	>96%	100.0%	92.9%	95.7%	96.7%	100.0%	87.2%	80.5%	94.6%	97.4%	83.3%	97.1%		92.3%	
Cancer - 31 days to subsequent treatment - surgery	>94%														
Cancer - 62 Day Screening	>90%		100.0%	60.0%	100.0%	66.7%	100.0%	25.0%	50.0%	66.7%		50.0%		50.0%	
DM01 - Diagnostic Waits (<6 weeks)	>99%	91.71%	92.17%	96.97%	98.96%	96.46%	93.10%	92.34%	94.71%	92.22%	87.55%	88.30%	87.54%	87.80%	
RTT - Incomplete % Waiting <18 weeks	>92%	75.5%	76.1%	76.0%	76.7%	76.7%	74.2%	74.4%	73.4%	73.8%	71.0%	72.1%	69.8%	71.0%	
Referral to Treatment 18 weeks - 52 Week Waits	0	651	639	569	558	514	547	486	457	384	373	375	442	1190	
% seen <=2 hours of Referral to District Nursing Night Service	>80%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
% seen <=48 hours of Referral to District Nursing Service	>95%	96.0%	93.8%	94.3%	96.7%	97.1%	93.3%	93.3%	94.7%	96.8%	95.0%	94.1%	95.2%	94.8%	
Haringey New Birth Visits - % seen within 2 weeks	>95%	94.1%	91.0%	91.5%	93.6%	92.6%	87.7%	91.1%	91.7%	87.3%	93.7%	95.9%		94.8%	
Islington New Birth Visits - % seen within 2 weeks	>95%	95.2%	97.6%	94.3%	94.0%	95.0%	93.7%	93.7%	93.7%	94.9%	96.4%	94.8%		95.6%	
% of Rapid Response Urgent referrals seen within 2 Hours of R...		50.0%	88.8%	94.2%	84.1%	88.7%	79.8%	75.2%	74.1%	71.8%	76.3%	81.8%	81.3%	79.3%	

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
28 days FDS Performance May 2022	**Going forward 28 day FDS will be the primary cancer performance measure.** **28 days FDS Performance:** 64.8% against the standard of 80% for May 2022. Similar to April's performance of 63.9%. • Breast, Colorectal, Gynaecology and Urology all below required target. • Dermatology's performance has deteriorated from April due to the increase of 2WW referrals **Action to Recover:** • Breast performance improved from April to May and will continue to improve as now booking at 14 days • Colorectal – prompt action to review all patients post first appointment/diagnostics – service booking • Gynaecology – continues to have support from Cancer Alliance with pathway • Dermatology – 2WW service is booking past 14 days and has impacted performance. Continuing to prioritise 2WW over urgent and routines • NCL are carrying out a review to adjust trajectory for performance of cancer targets.	**Named Person:** General Manager, Surgery and Cancer **Time Scale to Recover Performance:** Monthly review
2WW Performance May 2022	**2WW Performance:** 54.9% against the standard of 93% for May 2022. Improved on April's performance by 4.1% • Breast – There was a decrease in 2WW referrals of 30% from the capacity alert added by North Central London (NCL) ICS on the breast service in April 2022. • Dermatology – May 2WW referrals spiked with a total of 336 for the month that impacted the performance	**Named Person:** Service Manager Cancer, Breast & Plastics **Time Scale to Recover Performance:** Monthly review

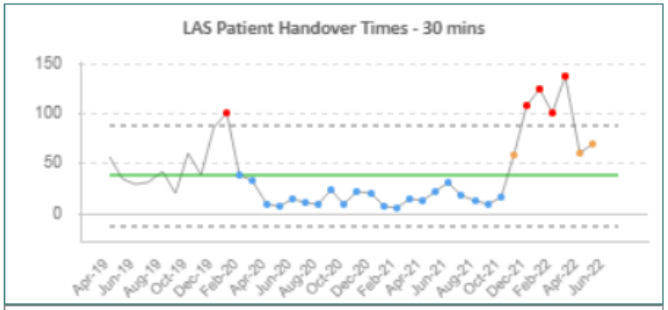
	• Gynaecology – Still in the same position as April 2022 with a number of known issues relating to demand, workforce, backlog numbers. The service is now booking at 28 days from 21 days in April • Urology – Whittington Heath continues to receive the highest number of referrals in North Central London. Capacity challenges with the Haematuria clinic **Action to Recover:** • Breast – Capacity alert has helped to work through the backlog of patients waiting for their first appointment now booking at 14 days • Dermatology – Has had to continue to prioritise 2WW patients and is now effecting routine and urgent referrals. NCL have been discussing and monitoring due to RFH & UCLH being in a similar situation. • Gynaecology – Are continuing to work with NCL reviewing pathways, Colposcopy and mutual aid with other trusts. • Urology – Additional Haematuria clinics to meet capacity demands, now reducing down to 14 days.	
62-day Performance May 2022	**62-day Performance 54.2**% against the standard of 85% for May 2022. A 14.2% improvement compared to April 2022. **Action to Recover:** • Urology continues to be the largest contributor to over 62 day breaches with the highest backlog of majority being prostate. Two mapping sessions have taken place and one more to be completed to improve pathway, sponsored by the Cancer Alliance. • Breast – Replacement surgeons now in place, capacity now back on track and the 14 day first appointment backlog should reduce. • Continued 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	**Named Person:** Service Manager Breast, Cancer & Plastics **Time Scale to Recover Performance:** Monthly review
DM01 Diagnostics	**Update**: Performance against the national diagnostic waiting target for June 2022 has not been achieved. Performance was 87.54% against the 99% target. Deterioration in performance as a result of: • Endoscopy capacity constraints. As part of the NCL review of	**Named Person:** Head of Performance

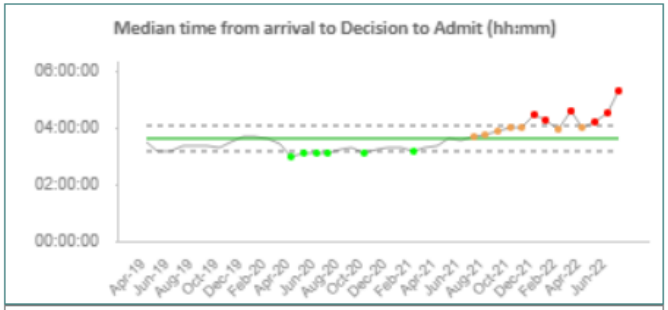
	diagnostic tests the service is looking to support overall reduction in diagnostic backlogs and have a plan to be compliant by September 2022. • CT scanning capacity due to vacancies, Covid-19 and leave. This continues to be an area of concern. Recruitment is ongoing and additional capacity to start in August. Service is looking to be compliant by September. • Community audiology action plan is in place. The service is reviewing their trajectories as new staff start. The service is looking to be compliant by the end of the financial year.	**Time Scale to Recover Performance:** Ongoing
Referral to Treatment: **Incomplete % waiting < 18 weeks** **52 + week waits**	**Update:** Performance against the national standards for incomplete pathways being below 18 weeks has not been achieved. Performance was at 69.84% for June 2022. The backlog of 78 week waiters is marginally behind target with 19 breaches in June. There was 442 52 week waiters in June 2022, this has increased as a result of tip ins and mutual aid support for the Royal Free Hospital. The Trust has one 104-week breaches in June 2022. This was a patient awaiting spinal surgery who transferred from the Royal Free as part of NCL mutual aid. **Action to Recover:** Additional capacity to support the general surgery waiting list has started in July 2022. There is continued monitoring of the elective recovery programme. Weekly review of the surgery specific patient tracking list is carried out to support delivery of compliance.	**Named Person:** Head of Performance **Time Scale to Recover Performance:** Ongoing

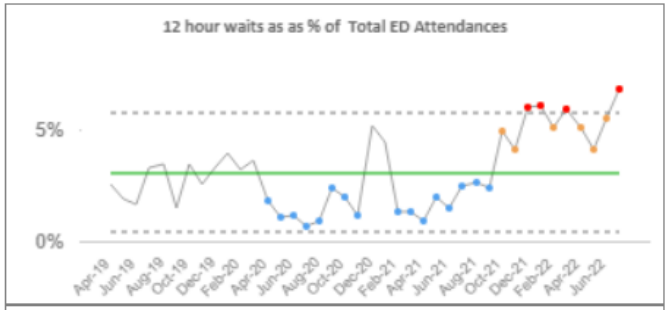
Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	2022-2023
Ambulance handovers waiting more than 30 mins	0	18	12	8	16	59	107	125	101	137	60	70		130
Ambulance handovers waiting more than 60 mins	0	0	2	0	2	27	96	50	43	56	14	3		17
% ED Attendances streamed to an onsite service		1.9%	1.6%	2.2%	2.4%	2.4%	2.2%	1.8%	2.2%	2.5%	2.3%	2.7%	2.6%	2.5%
Median wait for treatment (minutes)	<60 mins	90	82	97	107	102	96	89	91	128	92	111	115	105
% ED Attendances seen by clinician within 60 minutes of arrival		39.0%	40.7%	35.7%	33.7%	35.4%	38.5%	40.0%	38.3%	29.9%	39.4%	35.8%	34.7%	36.6%
Median time from Arrival to Decision to Admit		03:40	03:45	03:51	04:00	03:58	04:27	04:15	03:57	04:33	03:59	04:12	04:31	04:13
12 hour trolley waits in A&E		3	3	4	3	7	1	7	17	37	13	20	10	43
Total ED Attendances in dept for more than 12 hours (arrival to dept)		225	221	217	461	368	483	501	403	576	442	393	509	1344
% of ED Attendances over 12 hours from Arrival to Departure		2.4%	2.6%	2.3%	4.9%	4.0%	5.9%	6.0%	5.0%	5.9%	5.0%	4.0%	5.4%	4.8%
Emergency Department waits (4 hrs wait)	>95%	80.5%	80.1%	77.4%	75.6%	76.0%	73.3%	74.2%	75.1%	71.4%	77.1%	75.3%	73.2%	75.1%
% Left ED before being seen		7.5%	6.6%	8.6%	8.7%	9.2%	9.2%	7.2%	8.4%	11.5%	9.2%	10.2%	12.7%	10.7%
% ED re-attendance within 7 days		10.1%	10.1%	8.8%	8.7%	10.1%	9.2%	9.1%	9.3%	8.8%	9.8%	9.7%	10.2%	9.9%

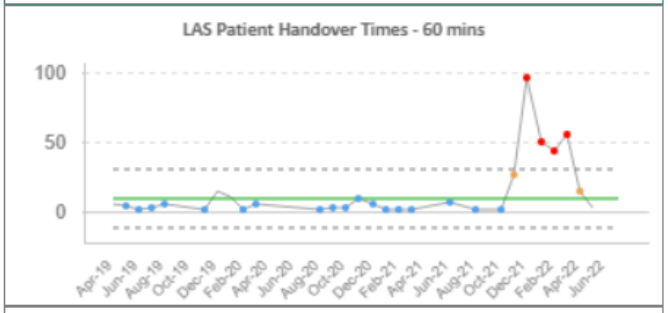
Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - 4 Hour Wait Performance:	**Variance against Plan:** **Emergency Department** activity saw 9387 presentations for the month. A&E performance was 73.2%, marginally above the London average of 72.35%. There were 890 emergency admissions, equating to 9.5% of all attendances for the month. **Paediatric** Performance was 86.6% against an attendance of 2123. The acuity remains high with paediatric presentations. **Adult UTC presentations** are on the rise at 4591 attendances and are 14.8% higher than the 2019-20 average. **Patient flow** through the emergency department remains challenged, particularly with the proportion of patients starting treatment within 60 minutes. The volume of patients with a decision to admit discharged within 4 hours continues on a downward trajectory. **Action to Recover:** Following closure of EMU, in order to create more capacity in SDEC, there was a 42% increase in streaming from ED to SDEC in the June compared to previous year. The department continues to aim to provide additional GP capacity and SDEC flow clinician to support our streaming pathways. However due to staffing challenges only 50% of the GP shifts were filled in June. LAS to SDEC pathway is continuing to be monitored and reviewed with LAS. Whittington ED are continually aiming to improve performance; the focus of July will be to continue to improve streaming to SDEC and development of the paediatric minor ailments pathway.	**Named Person:** ED General Manager **Time Scale to Recover Performance:** August 2022
ED – 12 Hour Trolley Waits and Patients in Department over 12 Hours:	**Variance against Plan:** There were 2 mental health trolley breach and 8 acute trolley breaches in June. This was a 50% drop in the number of breaches compared to the previous month.	**Named Person:** ED General Manager

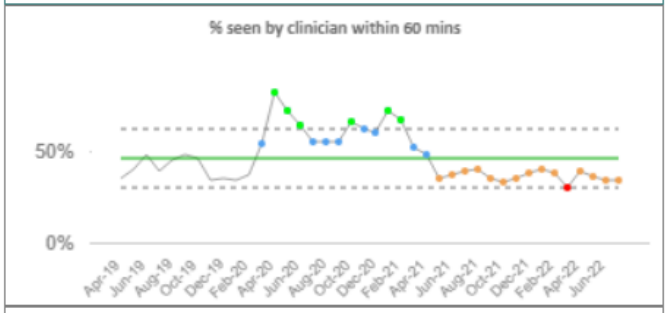
	The mental health breaches were due to lack of beds available in the system. Although these breaches were escalated to the relevant Mental Health providers, these breaches could not be prevented. The acute breaches were due to challenges in allocation of beds due to capacity, and high number of medically optimised patients in the trust. **Action to Recover:** All breached patients have been reviewed for potential harm and action plans are reported at the Serious Incident Executive Approval Group. The Trust flow programme continues to review downward flow for bed capacity and reduce the number of medically optimised patients in the hospital.	**Time Scale to Recover Performance:** August 2022
Ambulance Hand Overs delays:	**Variance against Plan:** LAS conveyances were stable for this time of year. Ninety five percent of all patient handovers completed within 30 minutes with 17 black breaches (60+ minutes). At time of report still waiting final data. **Action to Recover:** LAS and Whittington are continuing to work together to ensure LAS offload process are followed with the utilisation of green and red over flow spaces when RAT and Majors are full.	**Named Person:** ED General Manager **Time Scale to Recover Performance:** August 2022

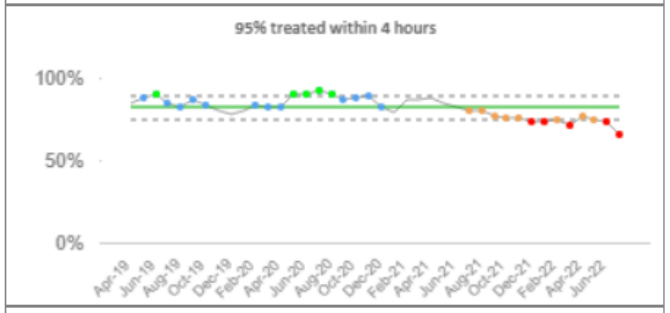


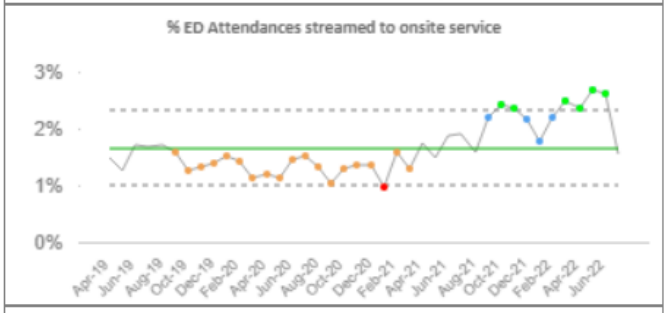


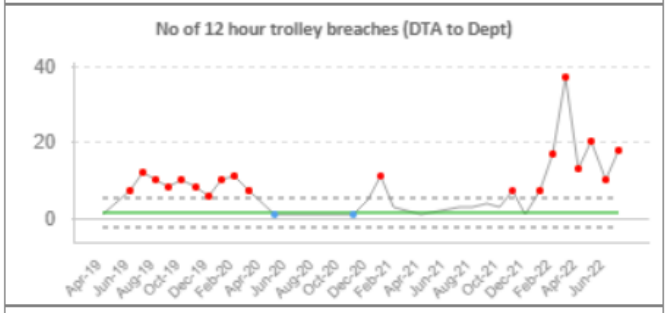


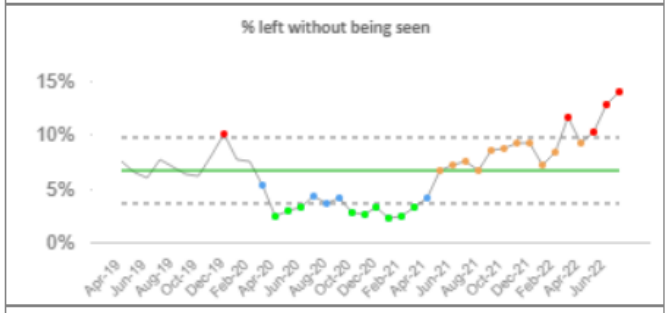


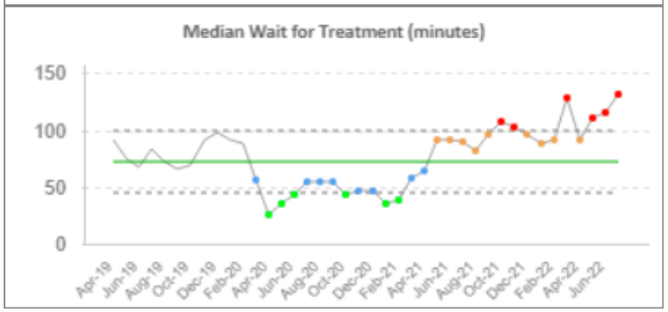


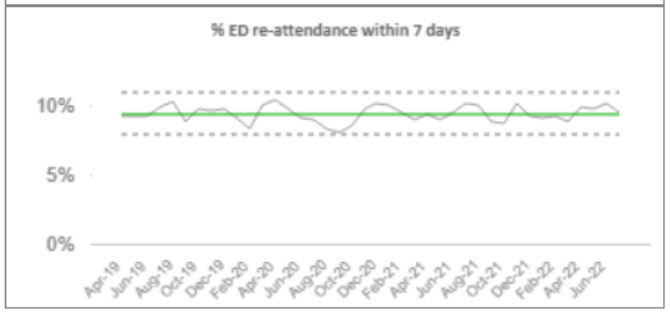












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Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	2022-2023	Performance
Appraisals % Rate	>90%	70.1%	70.1%	65.3%	66.8%	65.5%	66.0%	64.9%	65.6%	65.6%	66.9%	70.4%	71.5%	69.6%	
Mandatory Training % Rate	>90%	76.8%	74.7%	77.3%	78.8%	81.2%	82.2%	82.2%	82.5%	83.1%	84.1%	85.1%	85.1%	84.8%	
Permanent Staffing WTEs Utilised	>90%	87.6%	87.7%	88.1%	88.6%	88.0%	88.1%	87.9%	87.6%	87.6%	87.2%	87.3%	86.9%	87.1%	
National Quarterly Pulse Survey (NQPS)	800			686				314			327			327	
NQPS Staff % recommended work	>50%			57.3%				48.4%			51.7%			51.7%	
Staff sickness absence %	<3.5%	4.12%	4.20%	4.34%	4.32%	5.50%	5.30%	4.72%	4.86%	4.88%	4.79%	3.85%		4.31%	
Staff turnover %	<13%	12.8%	11.6%	14.3%	11.9%	12.4%	12.4%	12.5%	12.8%	13.6%	13.8%	14.0%	14.2%	14.0%	
Vacancy % Rate against Establishment	<10%	12.4%	12.3%	11.9%	11.4%	12.0%	11.9%	12.1%	12.4%	12.4%	12.8%	12.7%	13.1%	12.9%	
Average Time to Hire (Days)	<63 Days	62	64	63	59	66	59	70	61	61	64	71	92	76	
Nursing Staff Average % Day Fill Rate - Nurses		95.3%	92.4%	83.8%	74.9%	85.9%	79.2%	89.2%	92.5%	86.9%	92.1%	97.8%		95.1%	
Nursing Staff Average % Night Fill Rate - Nurses		94.5%	94.1%	91.3%	81.8%	93.1%	88.2%	100.3%	100.0%	92.8%	99.1%	100.4%		99.8%	
Safe Staffing Alerts - Number of Red Shifts		3	33	33	36	34	36	30	20	31	9	5	9	23	
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		10.0	11.0	11.7	9.1	9.1	9.6	9.4	10.4	9.1	10.0	10.1		10.0	

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

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Appraisals % Rate: 71.5% Target > 90%	**Variance against Plan: -18.5%** **Action to Recover:** This is 1% improvement on last month. It is likely that the pressure of work owing to the most recent increase in COVID and the shortage of staff is reducing staff time availability to complete appraisals. Therefore this small increase is a positive and continued movement in the right direction. Appraisal training continues monthly with full cohorts. Elev8 directions for recording are very simple and support quick logging.	**Named Person:** Assistant Director, Learning & Organisational Development **Time Scale to Recover Performance:** Six months dependent on continuation of COVID challenge
Mandatory Training % Rate: 85.1% Target >90%	**Variance against Plan: -4.9%** **Action to Recover:** Staff face the same challenge of time owing to challenges of COVID and staff shortage to be released for training. Renewed requirement for virtual training places Resus and Moving and Handling training under pressure (e.g. to reduce cohorts or to postpone until the requirement is relaxed). Elev8 provides a supportive and well received platform for training.	**Named Person:** Assistant Director, Learning & Organisational Development **Time Scale to Recover Performance:** Six months dependent on continuation of COVID challenge
Permanent Staffing WTEs Utilised: 86.9% Target > 90%	**Variance against Plan: -3.1%** **Action to Recover:** Permanent staff utilisation is increasing in line with increased turnover and issues within North London Partners Recruitment shared services. Work is currently ongoing to support recruitment campaigns and to make roles more appealing by offering flexibility. Utilisation continues to be unstable across the sector, with ongoing work NCL wide. A recovery Board and plan is in place to support the shared service.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** November 2022
Staff Sickness Absence; 3.85% Target < 3.5%	**Variance against Plan: -0.35%** **Action to Recover:** The Trust has seen a reduction in sickness absence rates across the board with a reduction 0.94% from April. Daily figures are being taken showing a reduction and stabilisation to just above Trust target. Monthly sickness surgeries and training for managers has been implemented, whilst also taking a targeted approach for those that are off long term to support them back to work.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** September 2022

Staff Turnover Rates: 14.2% Target < 13%	**Variance against Plan: -1.2%** **Action to Recover:** Turnover continues to be an issue across NCL and London as a whole with London having the second highest turnover rate nationally. In the Trust CYP and EIM have the highest turnover rates over the 12 month rolling period. The transfer of therapy services into CYP have contributed to the turnover rate. HR Business Partners continue to offer support to ICSU's and areas to address issues. A new Exit interview process is being embedded to establish reasons for leaving. As part of the workforce strategy, career conversations will be implemented. A cost of living group has been established internally to address turnover relating to Staff leaving London.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** November 2022
Vacancy Rates: 13.1% Target < 10%	**Variance against Plan: -3.1 %** **Action to Recover:** The vacancy rate continues to rise in conjunction with staff turnover. Corporate Services and ACW currently have the highest vacancy rates. Current focus to improve this rate is on converting bank and agency workers to permanent staff and improving the recruitment process via the implementation of the shared service.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** November 2022
Time to hire: 92 days **Target: 63 days**	**Variance against Plan: 29** There has been an increase in time to hire which is due to the transfer of services to North London Partners (NLP) recruitment shared services. There has been a 30% increase across all the Trusts in the partnerships activity which was not accounted for, this coupled with vacancies and issues with systems has caused a backlog across al Trusts. A recover Board and plan has been implemented, with additional resource put in place. Whittington has a dedicated account manager resource and internally meets weekly, while ensuing escalated issues are dealt with. A number of remediation actions have also been implemented.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** September 2022
Safer Staffing Zero Red shifts Trust CHPPD 9.6* *Peer Trusts Median (March 2021)	**Variance against Plan:** While there has been an overall improvement in trajectory, staffing challenges in June 2022 included the intermittent operation of Thorogood ward (escalation beds) in addition to increased sickness and other unavailability (parenting, staff isolation). • 9 red shifts reported in June 2022. This represents a small deterioration compared to May 2022 but it is an improvement from	**Named Person:** Lead Nurse for Safer Staffing **Time Scale to Recover Performance:** Ongoing

	previous months. 7 of the Red shifts were spread across EIM and 2 on Coyle (S&C ICSU). EIM had 6.3% sickness and 2.8% parenting with 28% total unavailability. S&C had 32% total staff unavailability with 7.7% sickness. • Care Hours per Patient Day (CHPPD) in June 22 dropped to 9.3 from 10.1. The average CHPPD of the adult wards also dropped from 8.3 to 7.9. The decrease in CHPPD reflects the decline in the fill rate of registered staff. • Fill rate of registered staff for inpatient settings declined to 87% from 97.8% for the day shifts. The night shifts had better fill rate though reduced from last month (90% from 100% in May). The fill rate for unregistered staff remains over 100% and static compared to last reports reflecting the acuity and ongoing need to support enhanced care requirement. **Action to Recover:** • Colleagues encouraged to raise staffing concerns as recommended in the Staffing Escalation policy. • Support empowerment of senior nurses to use professional judgement. • Staff redeployment to continue and become business as usual when identified suitable and safe to undertake. • Staff escalation roster implemented in some teams to identify in advance if flexibility to support vulnerable areas (clinical education team but can be extended to other corporate areas if suitable) • Visibility of safe staffing, workforce, education and recruitment teams to support retention, development and wellbeing • Staffing risk rating (RAG) and staffing escalation policy to be reviewed. Support international and local recruitment. New OSCE centre opened in Leeds. Aim to reduce delays to take exam and increase our cohort numbers	

Appendix 1. Community Performance Dashboard

Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	2022-2023	Performance
IAPT Moving to Recovery	>50%	54.8%	51.3%	53.4%	53.9%	51.4%	49.5%	57.2%	47.6%	47.5%	48.5%	52.1%		50.4%	
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	91.9%	92.1%	94.6%	90.9%	90.0%	93.4%	88.5%	89.6%	91.9%	91.9%	92.6%		92.3%	
Haringey - 8wk Review % carried out before child aged 8 weeks	N/A	82.8%	74.2%	78.0%	79.1%	82.3%	78.6%	70.1%	77.1%	74.0%	69.1%	81.5%		75.0%	
Haringey - HR1 % carried out before child aged 15 months	N/A	73.7%	73.3%	71.2%	74.1%	69.6%	61.7%	56.8%	52.9%	73.5%	76.3%	68.9%		72.4%	
Haringey - HR2 % carried out before child aged 30 months	N/A	73.8%	76.3%	75.5%	74.9%	65.5%	66.4%	68.4%	61.6%	64.5%	53.9%	54.1%		54.0%	
Islington - 8wk Review % carried out before child aged 8 weeks	N/A	80.8%	79.7%	81.4%	82.1%	82.1%	83.8%	61.1%	74.6%	72.7%	73.2%	76.2%		74.5%	
Islington - HR1 % carried out before child aged 15 mths	N/A	85.9%	83.9%	86.2%	80.9%	86.2%	77.7%	78.4%	66.7%	80.9%	80.5%	80.4%		80.5%	
Islington - HR2 % carried out before child aged 30 mths	N/A	81.7%	78.2%	74.9%	84.7%	82.9%	81.1%	72.7%	73.5%	78.4%	79.5%	73.7%		76.7%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	91.1%	89.7%	90.6%	93.8%	78.4%	81.0%	88.9%	94.8%	91.5%	83.6%	74.2%	83.3%	79.9%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	92.3%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%			100.0%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	71.0%	79.3%	80.6%	77.0%	77.9%	70.0%	71.7%	74.7%	72.2%	70.7%	74.4%	73.5%	73.0%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	93.9%	93.8%	96.3%	93.0%	96.3%	94.9%	96.3%	93.2%	88.6%	92.9%	90.6%	93.4%	92.1%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	0.0%	100.0%	88.9%	50.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%			100.0%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 we...	>45%			58.6%			57.0%			61.5%					
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	**Health visiting** In Haringey the New Birth visit target was met for the first time in 12 months. This is the result of work over the last 6 months to introduce a centralised system for allocating visits across the service. There are still significant staffing challenge in the teams – 25% of posts are vacant. **Community paediatrics** In Haringey we are recruiting to medical posts (permanent and temporary) and this will support a reduction in waiting times for NDC clinics over the next 6 months. Islington paediatrics is managing staff member on long term sick, clinics are being covered through additional bank capacity. **SLT** Short term funding continues to help to reduce waits for initial appointments and therapy intervention. **OT** The OT service continues to experience longer waiting times due to staffing gaps and challenges. In Haringey and Islington posts have been recruited to and waits will start to reduce once new postholders are in place. **Looked after children** In Haringey temporary cover is in place for the named and designate doctor role. Islington continues to have an increase in UAAS and increase in care leavers, an investment bid for additional nursing support has been submitted as part of NCL CLA workstream. **Social communication** In Haringey we are working with the CCG and other local providers to agree how additional recurrent funding will be used to reduce waiting times. This autumn work led by WH to provide additional autism assessments across NCL will further help reduce waiting times, however will have limited affect on waiting times in U5, the NCL work stream is looking at new models of assessment and diagnosis across universal and targeted services **Dietetics** In Haringey the increase in waiting times is due to staffing absence and vacancies in	**Named person:** Director of Operations, Children and Young People's Services

	the team. **School Nursing** A small number of children who had been waiting a long time to be seen in the Enuresis clinic had appointments in June. This meant the percentage seen within timeframe reduced	
Adult Community Waiting Times	There remains a focus of three key areas for recovery: MSK, Podiatry, Pulmonary Rehabilitation (PR). **MSK** The number of patients waiting for an MSK appointment was last month the largest it has been prior to the pandemic at 11,500 (April 2022) down to 10,000 (May 2022) however since the last report the waiting list has begun to fall and now stands at 9,140. The service has begun to work on a number of areas to turn this around i.e. additional agency staffing, cleansing lists for duplicates, job planning, optimising clinic utilisation and a series of 4 Super Saturdays. A capital bid business case has also been agreed to pilot a self-referral portal to reduce the number of patients requiring practitioner involvement. Average waiting time: CATS – 14.2 weeks in June 2022 up from 9.8 weeks in May 2022 (waiting times are yet to improve until the service clears some of the backlog as referrals are being seen from the longest waiters) Routine Physio – 15.5 weeks in June up from 14.8 weeks in May 2022 (waiting times are yet to improve until the service clears some of the backlog as referrals are being seen from the longest waiters) **Podiatry** Workforce issues continue to be the main issue with this service as well as recent sickness. However, orthotics continues to be paused to concentrate on follow up appointments for 6 weeks. The impact will begin to be seen in the next couple of months. Average waiting time: Average waiting time in June 2022 is 16.2 up from 14.2 in May 2022 **Pulmonary Rehabilitation** Pulmonary Rehabilitation are working with the NCL network on a project to increase capacity across NCL and are developing a road show to support recovery as well as hiring new venues closer to patient homes. The impact will be seen over the next couple of months. Average waiting time: 17.6 in May 2022 with no change in June 2022 also due to working from the back end of the waiting list.	**Named person:** Director of Operations, Adult Community Services

Appendix 2. Community Waiting Times Dashboard

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Apr-22	May-22	Jun-22	Avg Wait (Jun)	No. of Pts Seen	% Threshold	Target Weeks	Apr-22	May-22	Jun-22	Avg Wait (Jun)	No. of Pts Seen
CAMHS	>95%	8	68.8%	53.8%	56.7%	18.1	97	>95%	2	75.0%	75.0%	50.0%	1.6	2
Child Development Services	>95%	12	76.5%	62.5%	75.0%	8.5	8	>95%	2				-	0
IANDS	>95%	18	76.8%	80.4%	78.7%	13.5	122	>95%	2				-	0
Community Children's Nursing	>95%	2	74.6%	77.0%	68.5%	1.7	73	>95%	1	100.0%	100.0%	100.0%	0.0	10
Community Paediatrics Services	>95%	18	71.9%	69.4%	69.5%	12.3	82	>95%	1				12.3	0
Family Nurse Partnership	>95%	12	100.0%			-	0	>95%	-				-	0
Haematology Service	>95%	12	100.0%			-	0	>95%	-				-	0
Looked After Children	>95%	4	55.6%	56.5%	56.3%	4.3	16	>95%	2				-	0
Occupational Therapy	>95%	18	43.5%	22.2%	26.7%	29.7	15	>95%	2				-	0
Physiotherapy	>95%	18	93.0%	96.0%	98.6%	8.5	71	>95%	2				-	0
PIPS	>95%	12	100.0%	90.0%	100.0%	2.7	16	>95%	-				-	0
School Nursing	>95%	12	90.8%	96.2%	89.8%	3.8	98	>95%	-				-	0
Speech and Language Therapy	>95%	8	53.2%	60.9%	57.6%	13.4	144	>95%	2	0.0%	25.0%	0.0%	4.0	1
Bladder and Bowel - Children	>95%	12				-	0	>95%	-				-	0
Community Matron	>95%	6	89.3%	89.2%	100.0%	0.4	13	>95%	2				-	0
Adult Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	2.9	32	>95%	2	66.7%	0.0%	100.0%	0.3	7
Community Rehabilitation (CRT)	>95%	12	87.7%	84.1%	78.3%	10.7	69	>95%	2	48.3%	56.3%	81.1%	3.9	37
ICTT - Other	>95%	12	97.2%	72.9%	87.2%	4.6	109	>95%	2	46.2%	23.5%	0.0%	4.7	24
ICTT - Stroke and Neuro	>95%	12	75.0%	63.2%	66.7%	8.9	30	>95%	2	33.3%	0.0%	0.0%	3.5	3
Home-based Intermediate Care Se...	>95%	6	50.0%	48.0%	61.8%	7.8	34	>95%	2				-	0
Community Bed-based Intermediat...	>95%	6	100.0%	100.0%	100.0%	0.0	3	>95%	2				-	0
Paediatric Wheelchair Service	>95%	8	66.7%	100.0%	100.0%	4.8	6	>95%	2			0.0%	7.0	1
Bladder and Bowel - Adult	>95%	12	39.5%	39.8%	34.5%	14.5	165	>95%	-				-	0
Musculoskeletal Service - CATS	>95%	6	39.6%	47.2%	21.0%	14.2	544	>95%	2	15.4%	20.6%	0.0%	5.8	23
Musculoskeletal Service - Routine	>95%	6	41.0%	33.3%	30.8%	15.5	1447	>95%	2	24.7%	48.0%	32.3%	4.0	133
Nutrition and Dietetics	>95%	6	79.6%	88.0%	92.9%	3.3	155	>95%	2	100.0%	100.0%		-	0
Podiatry (Foot Health)	>95%	6	41.7%	31.9%	26.6%	16.4	334	>95%	2	20.0%	33.3%	0.0%	9.0	6
Lymphodema Care	>95%	6	100.0%	100.0%	100.0%	2.3	30	>95%	2	100.0%			-	0
Tissue Viability	>95%	6	97.7%	97.9%	100.0%	2.0	24	>95%	2				-	0
Cardiology Service	>95%	6	100.0%	90.3%	81.5%	4.9	54	>95%	2		100.0%	0.0%	2.9	1
Diabetes Service	>95%	6	76.3%	75.4%	87.0%	4.5	69	>95%	2	100.0%			-	0
Respiratory Service	>95%	6	71.1%	54.1%	64.0%	7.0	50	>95%	2		0.0%	100.0%	1.0	4
Spirometry Service	>95%	6	20.8%	24.2%	40.6%	6.3	69	>95%	2	100.0%			-	0

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Appendix 2. Community Waiting Times Dashboard

Haringey

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Apr-22	May-22	Jun-22	Avg Wait (Jun)	No. of Pts Seen	% Threshold	Target Weeks	Apr-22	May-22	Jun-22	Avg Wait (Jun)	No. of Pts Seen
CAMHS	>95%	8	100.0%	100.0%	100.0%	0.7	1	>95%	-				-	0
Child Development Services	>95%	12	75.0%	60.0%	71.4%	9.1	7	>95%	-				-	0
IANDS	>95%	18	50.0%	100.0%	100.0%	4.9	2	>95%	-				-	0
Community Children's Nursing	>95%	2	90.0%	87.5%	100.0%	0.8	4	>95%	1				-	0
Community Paediatrics Services	>95%	18	63.4%	62.7%	68.4%	12.5	57	>95%	1				12.5	0
Family Nurse Partnership	>95%	12				-	0	>95%	-				-	0
Haematology Service	>95%	12				-	0	>95%	-				-	0
Looked After Children	>95%	4	0.0%	87.5%	50.0%	6.4	2	>95%	-				-	0
Occupational Therapy	>95%	18	45.0%	24.0%	28.6%	30.4	14	>95%	-				-	0
Physiotherapy	>95%	18	92.3%	95.7%	98.6%	8.5	69	>95%	2				-	0
PIPS	>95%	12	100.0%	87.5%	100.0%	3.1	14	>95%	-				-	0
School Nursing	>95%	12	91.1%	88.4%	75.7%	6.6	37	>95%	-				-	0
Speech and Language Therapy	>95%	8	41.1%	50.0%	41.7%	14.6	72	>95%	2	0.0%	0.0%	0.0%	4.0	1
Bladder and Bowel - Children	>95%	-				-	0	>95%	-				-	0
Community Matron	>95%	6				-	0	>95%	2				-	0
Adult Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	2.9	31	>95%	2	66.7%	0.0%	100.0%	0.3	7
Community Rehabilitation (CRT)	>95%	12	100.0%	0.0%		-	0	>95%	2	0.0%		0.0%	3.4	1
ICTT - Other	>95%	12	96.8%	72.1%	86.3%	4.8	102	>95%	2	41.7%	23.5%	0.0%	4.8	21
ICTT - Stroke and Neuro	>95%	12	75.0%	58.8%	64.0%	9.0	25	>95%	2	33.3%	0.0%	0.0%	3.5	3
Home-based Intermediate Care Se...	>95%	6				-	0	>95%	2				-	0
Community Bed-based Intermediat...	>95%	-				-	0	>95%	2				-	0
Paediatric Wheelchair Service	>95%	8	66.7%	100.0%	100.0%	4.8	6	>95%	2			0.0%	7.0	1
Bladder and Bowel - Adult	>95%	12	30.6%	38.3%	32.1%	15.4	81	>95%	-				-	0
Musculoskeletal Service - CATS	>95%	6	42.1%	56.5%	22.0%	13.7	286	>95%	2	14.3%	21.1%	0.0%	5.5	13
Musculoskeletal Service - Routine	>95%	6	41.9%	35.8%	31.3%	15.9	745	>95%	2	23.5%	51.7%	28.8%	4.3	52
Nutrition and Dietetics	>95%	6	73.1%	91.1%	87.5%	4.0	80	>95%	2	100.0%	100.0%		-	0
Podiatry (Foot Health)	>95%	6	47.2%	36.6%	29.4%	16.3	160	>95%	2	33.3%	50.0%	0.0%	9.0	3
Lymphodema Care	>95%	6	100.0%	100.0%	100.0%	2.6	14	>95%	2	100.0%			-	0
Tissue Viability	>95%	6	95.8%	100.0%	100.0%	2.4	13	>95%	-				-	0
Cardiology Service	>95%	6	100.0%	87.0%	75.6%	5.8	41	>95%	2		100.0%	0.0%	2.9	1
Diabetes Service	>95%	6	68.8%	75.7%	85.7%	4.3	42	>95%	2	100.0%			-	0
Respiratory Service	>95%	6	66.7%	44.1%	50.0%	8.5	18	>95%	2				-	0
Spirometry Service	>95%	6	20.8%	24.2%	41.8%	6.2	67	>95%	2	100.0%			-	0

Appendix 2. Community Waiting Times Dashboard

Islington

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Apr-22	May-22	Jun-22	Avg Wait (Jun)	No. of Pts Seen	% Threshold	Target Weeks	Apr-22	May-22	Jun-22	Avg Wait (Jun)	No. of Pts Seen
CAMHS	>95%	8	66.3%	45.6%	53.5%	19.7	86	>95%	2	75.0%	75.0%	50.0%	1.6	2
Child Development Services	>95%	12	100.0%	100.0%		-	0	>95%	-				-	0
IANDS	>95%	18	77.2%	79.6%	78.4%	13.4	116	>95%	2				-	0
Community Children's Nursing	>95%	2	69.8%	74.4%	66.7%	1.6	63	>95%	1	100.0%	100.0%	100.0%	0.0	10
Community Paediatrics Services	>95%	18	100.0%	94.1%	68.4%	13.4	19	>95%	1				13.4	0
Family Nurse Partnership	>95%	12	100.0%			-	0	>95%	-				-	0
Haematology Service	>95%	12				-	0	>95%	-				-	0
Looked After Children	>95%	4	40.0%	40.0%	66.7%	3.8	9	>95%	2				-	0
Occupational Therapy	>95%	18	0.0%	0.0%	0.0%	20.3	1	>95%	-				-	0
Physiotherapy	>95%	18	100.0%	100.0%	100.0%	8.3	2	>95%	-				-	0
PIPS	>95%	12	100.0%	100.0%	100.0%	0.0	2	>95%	-				-	0
School Nursing	>95%	12	89.7%	100.0%	100.0%	2.0	50	>95%	-				-	0
Speech and Language Therapy	>95%	8	75.0%	67.3%	69.6%	12.3	46	>95%	2		100.0%		-	0
Bladder and Bowel - Children	>95%	12				-	0	>95%	-				-	0
Community Matron	>95%	6	88.9%	87.9%	100.0%	0.4	13	>95%	2				-	0
Adult Wheelchair Service	>95%	8			100.0%	3.4	1	>95%	-				-	0
Community Rehabilitation (CRT)	>95%	12	86.4%	83.3%	80.0%	10.3	65	>95%	2	51.9%	56.7%	84.4%	4.2	32
ICTT - Other	>95%	12	100.0%	66.7%	100.0%	1.0	5	>95%	2			0.0%	4.5	3
ICTT - Stroke and Neuro	>95%	12		100.0%	100.0%	3.8	3	>95%	2			-	-	0
Home-based Intermediate Care Se...	>95%	6	51.0%	49.3%	61.3%	8.0	31	>95%	2				-	0
Community Bed-based Intermediat...	>95%	6	100.0%	100.0%		-	0	>95%	2				-	0
Paediatric Wheelchair Service	>95%	-				-	0	>95%	-				-	0
Bladder and Bowel - Adult	>95%	12	46.2%	40.5%	34.6%	14.0	81	>95%	-				-	0
Musculoskeletal Service - CATS	>95%	6	34.0%	31.5%	19.9%	14.8	246	>95%	2	16.7%	20.0%	0.0%	6.1	9
Musculoskeletal Service - Routine	>95%	6	39.6%	29.4%	29.8%	15.2	631	>95%	2	20.4%	44.2%	34.4%	3.3	61
Nutrition and Dietetics	>95%	6	87.5%	83.8%	98.5%	2.6	67	>95%	2		100.0%		-	0
Podiatry (Foot Health)	>95%	6	37.2%	27.8%	24.1%	16.8	166	>95%	2	0.0%	0.0%	0.0%	9.1	3
Lymphodema Care	>95%	6	100.0%	100.0%	100.0%	2.0	16	>95%	-				-	0
Tissue Viability	>95%	6	100.0%	95.7%	100.0%	1.7	10	>95%	-				-	0
Cardiology Service	>95%	6	100.0%	100.0%	100.0%	2.1	13	>95%	2		100.0%		-	0
Diabetes Service	>95%	6	89.3%	75.0%	88.9%	4.7	27	>95%	2				-	0
Respiratory Service	>95%	6	76.0%	61.5%	70.0%	6.5	30	>95%	2		0.0%	100.0%	1.0	4
Spirometry Service	>95%	6			0.0%	8.5	2	>95%	-				-	0

Children's Community Waits Performance

SERVICE	ROUTINE REFERRALS							URGENT REFERRALS						
	% Threshold	Target Weeks	Apr-22	May-22	Jun-22	Avg Wait (Jun)	No. of Pts Seen	% Threshold	Target Weeks	Apr-22	May-22	Jun-22	Avg Wait (Jun)	No. of Pts Seen
CAMHS	>95%	8	68.8%	53.8%	56.7%	18.1	97	>95%	2	75.0%	75.0%	50.0%	1.6	2
Community Children's Nursing	>95%	2	74.6%	77.0%	68.5%	1.7	73	>95%	1	100.0%	100.0%	100.0%	0.0	10
Community Paediatrics - Haringey	>95%	18	65.9%	66.2%	66.1%	13.2	62	>95%	1				-	0
Community Paediatrics - Islington	>95%	18	100.0%	94.1%	93.3%	8.2	15	>95%	1				-	0
Family Nurse Partnership - Islington	>95%	12	100.0%			-	0	>95%	-				-	0
Haematology Service - Islington	>95%	12	100.0%			-	0	>95%	-				-	0
Haringey - SCT	>95%	20	0.0%	0.0%	0.0%	47.7	25	>95%	2				-	0
IANDS - SCT	>95%	20	0.0%	0.0%	9.1%	39.7	22	>95%	2				-	0
IANDS	>95%	18	100.0%	87.5%	100.0%	4.1	7	>95%	2				-	0
Looked After Children - Haringey	>95%	4	66.7%	100.0%	0.0%	6.7	2	>95%	2				-	0
Looked After Children - Islington	>95%	4	50.0%	33.3%	61.5%	4.0	13	>95%	2				-	0
Occupational Therapy - Barnet	>95%	18	63.0%	95.8%	73.3%	33.0	15	>95%	6				-	0
Occupational Therapy - Haringey	>95%	18	43.5%	22.2%	26.7%	29.7	15	>95%	2				-	0
Occupational Therapy - Islington	>95%	18	10.5%	43.8%	25.0%	28.5	8	>95%	2				-	0
Paediatrics Nutrition and Dietetics - Haringey	>95%	12	100.0%	100.0%	80.0%	7.1	5	>95%	2				-	0
Paediatrics Nutrition and Dietetics - Islington	>95%	12	82.8%	100.0%	100.0%	5.6	25	>95%	2				-	0
Physiotherapy - Barnet	>95%	18	59.6%	28.1%	41.3%	50.1	63	>95%	6			0.0%	21.0	1
Physiotherapy - Haringey	>95%	18	93.0%	96.0%	98.6%	8.5	71	>95%	2				-	0
Physiotherapy - Islington	>95%	18	97.0%	93.5%	100.0%	6.9	46	>95%	2				-	0
PIPS	>95%	12	100.0%	89.5%	100.0%	2.7	15	>95%	-				-	0
SALT - Barnet	>95%	18	20.0%	40.0%	6.3%	69.7	16	>95%	6				-	0
SALT - Haringey	>95%	13	40.3%	50.8%	48.7%	13.1	76	>95%	2	0.0%	0.0%	0.0%	4.0	1
SALT - Islington	>95%	13	84.6%	70.6%	66.7%	13.7	36	>95%	2				-	0
SALT - MPC	>95%	18	50.0%	71.4%	78.6%	12.3	28	>95%	-				-	0
School Nursing - Haringey	>95%	12	92.9%	90.6%	75.0%	7.0	36	>95%	-				-	0
School Nursing - Islington	>95%	12	87.5%	100.0%	98.0%	2.2	51	>95%	-				-	0

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

Cancer - 62D Performance by Tumour Group

Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	2022-2023	Performance
Breast	>85%	57.1%	76.5%	25.0%	60.0%	0.0%	58.3%	66.7%	40.0%	20.0%	0.0%	25.0%		11.8%	
Gynaecological	>85%	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%		33.3%			33.3%	
Haematological (Excluding Acute Leukaemia)	>85%	100.0%		100.0%		100.0%	50.0%	28.6%	100.0%	100.0%		100.0%		100.0%	
Lower Gastrointestinal	>85%	75.0%	71.4%	100.0%	0.0%	50.0%	0.0%	45.5%	60.0%	85.7%	25.0%	16.7%		20.0%	
Lung	>85%	66.7%	100.0%	50.0%		100.0%	0.0%	0.0%	0.0%	50.0%	100.0%			100.0%	
Other	>85%				100.0%					100.0%					
Skin	>85%	100.0%	100.0%	95.2%	88.2%	66.7%	83.3%	60.0%	100.0%	100.0%		100.0%		100.0%	
Testicular	>85%	100.0%					100.0%								
Upper Gastrointestinal	>85%	0.0%	100.0%	66.7%			50.0%	0.0%	0.0%	0.0%		100.0%		100.0%	
Urological (Excluding Testicular)	>85%	88.9%	85.7%	54.2%	35.3%	33.3%	65.0%	33.3%	33.3%	27.3%	72.7%	30.4%		44.1%	

Cancer - 2WW Performance by Tumour Group

Indicator	20_21 Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	2022-2023	Performance
Breast	>93%	96.7%	96.1%	96.0%	98.2%	91.5%	94.4%	10.1%	18.1%	19.2%	9.4%	6.9%		8.3%	
Childrens	>93%						0.0%								
Gynaecological	>93%	74.2%	91.5%	91.3%	93.1%	68.7%	44.8%	44.4%	35.6%	40.3%	37.0%	47.7%		42.9%	
Haematological	>93%	100.0%	96.2%	95.7%	95.0%	75.0%	100.0%	100.0%	95.5%	93.8%	95.7%	100.0%		97.7%	
Lower Gastrointestinal	>93%	61.8%	35.1%	21.8%	3.0%	5.8%	52.3%	91.7%	68.5%	51.5%	70.8%	41.0%		60.4%	
Lung	>93%	50.0%	100.0%	66.7%	81.8%	91.3%	88.0%	85.7%	71.4%	80.0%	94.4%	93.8%		94.1%	
Skin	>93%	95.6%	96.2%	92.9%	96.7%	87.7%	93.0%	88.7%	85.0%	94.1%	65.2%	72.8%		69.9%	
Upper Gastrointestinal	>93%	96.2%	98.5%	96.6%	96.2%	100.0%	100.0%	98.1%	98.2%	96.7%	100.0%	100.0%		100.0%	
Urological	>93%	58.9%	68.0%	52.4%	53.6%	65.9%	55.4%	43.8%	48.6%	49.4%	54.6%	74.6%		62.8%	

Appendix 4. Trust Level Activity

Category	Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Activity
ED	ED Attendances	8285	9351	8531	9273	9432	9089	8179	8285	7990	9763	8787	9742	9387	
ED	ED Admission Rate %		13.7%	13.2%	12.6%	12.5%	12.1%	12.8%	12.6%	12.1%	11.5%	11.0%	9.8%	9.5%	
Community	Community Face to Face Contacts		37377	33329	38853	41245	44400	35364	37887	37884	45282	37603	44647	39982	
Admissions	Elective and Daycase		2048	1945	2036	1915	2000	1628	1668	1787	2007	1740	2087	2075	
Admissions	Emergency Inpatients		2058	1937	1940	1973	1934	1779	1725	1583	1910	1700	1706	1713	
Referrals	GP Referrals to an Acute Service		13426	12394	12669	14752	14999	12344	14218	14335	16041	12639	15031	13647	
Referrals	% of GP Referrals that were completed via ERS		86.2%	85.6%	83.9%	86.3%	85.2%	82.9%	83.5%	83.6%	85.3%	84.3%	84.5%	86.5%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	31.1%	28.5%	35.7%	28.8%	31.2%	35.2%	29.4%	31.8%	31.6%	32.9%	33.0%	32.6%	
Maternity	Maternity Births	320	309	323	288	319	324	279	249	237	271	265	244	262	
Maternity	Maternity Bookings	377	369	306	327	319	326	339	320	250	343	323	388	284	
Outpatients	Outpatient DNA Rate % - New	<10%	10.8%	11.8%	11.6%	10.6%	10.3%	11.3%	11.6%	10.7%	11.2%	11.7%	10.7%	10.5%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	9.8%	10.2%	10.7%	10.2%	10.0%	10.7%	10.5%	10.4%	11.1%	10.9%	10.2%	10.5%	
Outpatients	Outpatient New Attendances		9336	8472	10385	10288	9952	8389	8701	8707	10173	8445	9991	9627	
Outpatients	Outpatient FUp Attendances		17612	15539	17742	17113	17770	15506	15468	14845	16863	15180	17135	16231	
Outpatients	Outpatient Procedures		5826	5260	5778	5737	5762	5244	5250	5467	6245	5251	6338	5885	

Meeting title	**Trust Board – public meeting**	**Date: 12.7.2022**
Report title	**Finance Report June (Month 03) 2022/23**	**Agenda item: 10**
Executive director lead	Kevin Curnow, Chief Finance Officer	
Report author	Finance Team	
Executive summary	The Trust is reporting a deficit of £5.07m at the end of June which is £1.35m worse than plan. The planned deficit for June was £3.72m. The year-to-date adverse financial performance to plan is mainly driven by non-delivery of savings on Cost Improvement Programmes (CIP), pay pressures relating to Covid above funded levels, unfunded escalation beds and ongoing costs relating to PFI. The cash position at the end of April was £76.3m Trust has spent £1.51m on its Capital projects as of the 30th of June 2022. This low figure reflects that the capital projects are yet to get fully underway for this financial year. The Trust is currently forecasting to deliver its planned deficit of £112k. In the coming weeks, the Trust will be working on developing a more detailed initial forecast position which will be shared in Q2.	
Purpose	Discussion of June's performance	
Recommendation(s)	To note June financial performance, recognising the need for improve savings delivery.	
BAF	BAF risks Sustainability 1 and Sustainability 2	
Report history	Finance and Business Development Committee	
Appendices	none	

CFO Message **Finance Report M03**

Trust reporting £5.07m deficit at the end of June – £1.35m worse than plan

The Trust is reporting a deficit of £5.07m at the end of June which is £1.35m worse than plan. The planned deficit for June was £3.72m.

The year to date adverse financial performance is mainly driven by;

- Underperformance of £0.86m against year to date Cost Improvement Programmes (CIP) target; The Trust delivered £0.99m savings year to date against a target of £1.85m.
- Use of temporary staffing for covid related reasons mainly to cover red and green areas within the Accident and Emergency (A&E) and sickness and agency premium within theatres.
- Unfunded escalation medical beds and pay overspends within ITU.
- Non-pay overspends within theatres and ongoing costs relating to PFI
- Elective/Day case performance continues to be below plan. The Trust is currently assuming no adverse variance on its Elective Recovery Fund (ERF) income. This will be adjusted once further guidance on ERF calculation is published.

Some of the adverse variances above were partly offset non-recurrently by slippage in planned investments.

Cash of £76.3m at end of June

As at the end of June, the Trust's cash balance stands at £76.3m – a decrease of £5.1m from 31 March 2022. The Trust's ongoing cash requirements have not changed materially in terms of staff pay and capital expenditure, and the Trust continues to strive to pay suppliers early in the current economic climate

Year to date capital spend of £1.51m

The Trust's capital plan for 2022-23 is £30.4m. This includes self-funded schemes of £25.4m and £5m relating to elective recovery (Targeted Investment Fund yet to be approved). The Trust's internal capital plan of £25.4m is funded through depreciation (£11.4m) and cash reserves (£13.9m).

Capital expenditure as at the 30th June 2022 totals £1.51m, which is £2.69m below plan, a reflection that the Trust's principal capital projects are yet to get fully underway for this financial year.

Better Payment Practice Performance – 92.8% 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 95.0% by volume and 90.4% by value. The BPPC for non-NHS invoices is 92.8% by value and 95.6% by volume.

2022-23 Forecast Outturn

The Trust is currently forecasting to deliver its planned deficit of £112k. In the coming weeks the Trust will be working on developing a more detailed initial forecast position which will be shared in Q2.

1. Summary of Income & Expenditure Position – Month 03

	In Month			Year to Date			
	Plan	Actual	Variance	Plan	Actual	Variance	Annual Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income							
NHS Clinical Income	27,847	27,933	86	82,411	82,556	146	333,421
High Cost Drugs - Income	898	914	16	2,518	2,518	(1)	10,699
Non-NHS Clinical Income	1,147	1,197	51	3,441	3,552	111	13,772
Other Non-Patient Income	2,277	2,303	25	6,334	6,798	464	25,072
Elective Recovery Fund	656	656	0	1,984	1,984	0	7,891
	32,826	**33,003**	**178**	**96,688**	**97,408**	**720**	**390,855**
Pay							
Agency	(38)	(1,528)	(1,489)	(38)	(4,777)	(4,739)	(77)
Bank	(444)	(2,698)	(2,254)	(1,183)	(7,680)	(6,497)	(4,138)
Substantive	(22,922)	(19,743)	3,179	(69,291)	(60,289)	9,002	(271,641)
	(23,405)	**(23,969)**	**(564)**	**(70,513)**	**(72,747)**	**(2,234)**	**(275,856)**
Non Pay							
Non-Pay	(6,958)	(7,690)	(732)	(21,554)	(21,649)	(95)	(82,812)
High Cost Drugs - Exp	(811)	(669)	142	(2,433)	(2,328)	106	(8,779)
	(7,769)	**(8,359)**	**(590)**	**(23,987)**	**(23,976)**	**11**	**(91,591)**
EBITDA	**1,652**	**676**	**(976)**	**2,188**	**685**	**(1,503)**	**23,408**
Post EBITDA							
Depreciation	(1,436)	(1,347)	89	(4,310)	(4,287)	22	(17,244)
Interest Payable	(84)	(75)	10	(276)	(243)	33	(1,288)
Interest Receivable	51	65	14	53	153	100	512
Dividends Payable	(457)	(458)	(1)	(1,374)	(1,375)	(1)	(5,500)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(1,926)	**(1,816)**	**111**	**(5,906)**	**(5,752)**	**154**	**(23,520)**
Reported Surplus/(Deficit)	**(275)**	**(1,140)**	**(865)**	**(3,718)**	**(5,067)**	**(1,349)**	**(112)**

- The Trust is reporting a deficit of £5.07m (excluding donated asset depreciation and impairments) at the end of June which is £1.35m worse than plan.
- The planned deficit to the end of June was £3.72m excluding donated asset depreciation.
- Adverse variance on CIP delivery and other expenditure overspends are currently being offset by slippage on planned investments.
- The reported position includes non-recurrent benefits of £0.41m.
- The normalised position excluding non-recurrent beneefits is £5.5m deficit.

2.0 Income and Activity Performance

2.1 Income Performance - June

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	1,599	1,632	33	4,852	4,942	90
Elective	2,123	1,765	(358)	6,579	5,157	(1,421)
Non-Elective	4,913	4,448	(465)	14,902	13,227	(1,676)
Critical care	575	629	54	1,743	1,137	(606)
Outpatients	4,162	3,847	(315)	12,900	11,801	(1,098)
Ambulatory	513	592	79	1,558	1,667	109
Direct Access	951	1,097	146	2,948	3,214	266
Community	6,293	6,293	0	18,878	18,878	0
Other Clinical income NHS	7,615	8,544	929	20,569	25,051	4,481
NHS Clinical Income	**28,745**	**28,847**	**102**	**84,929**	**85,074**	**145**
Non NHS Clinical Income	1,147	1,197	51	3,441	3,552	111
Elective recovery fund (ERF)	656	656	0	1,984	1,984	0
Income From Patient Care Activities	**30,548**	**30,701**	**152**	**90,354**	**90,610**	**256**
Other Operating Income	**2,277**	**2,303**	**25**	**6,334**	**6,798**	**464**
Total	32,826	33,003	178	96,688	97,408	720

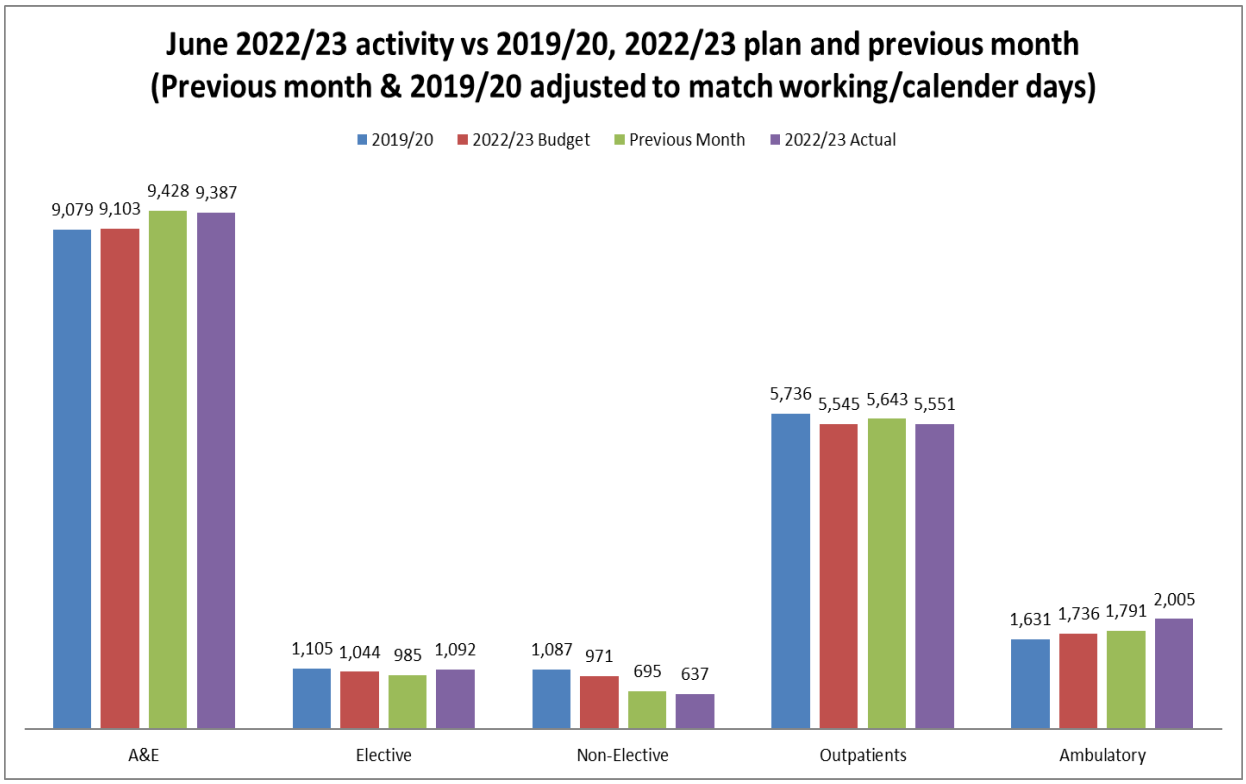
- Income was £0.2m favourable to plan in month and £0.7m YTD.
- In month overperformance mainly driven by £0.1m NHS clinical income.
- NHS clinical income is mainly CCG and NHSE block contract income, with small variable element for provider to provider income. The income shown against the points of delivery, e.g. A&E are notional activity based values, with the balancing amount to block values shown against other clinical income NHS.
- Significant underperformance in elective, non-elective and outpatients, with slight overperformance in A&E, Ambulatory and direct access. Critical care is showing a slight overperformance due to non discharged patients (WIP – work in progress) now being reported.
- ERF is assumed at 100% based on notification that NHSE likely to suspend any clawback from CCGs for quarter one.

2.2 Activity Performance – June

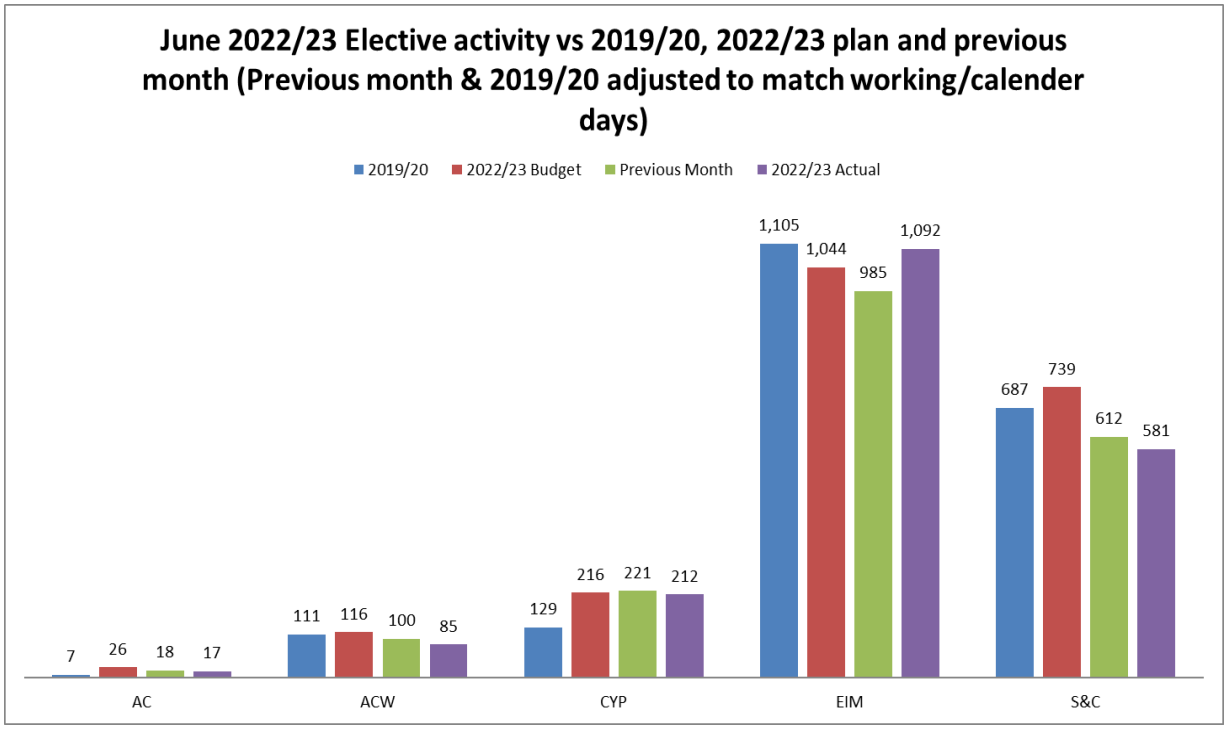
Activity	In Month Activity Plan	In Month Activity Actual	In Month Variance	In month Activity Diff%	YTD Activity Plan	YTD Activity Actual	Activity Diff	YTD Activity Diff%
A&E	9,103	9,387	284	3%	27,613	27,916	303	1%
Elective	2,142	1,989	(153)	(7%)	6,640	5,710	(930)	(14%)
Non-Elective	1,848	1,541	(307)	(17%)	5,606	4,606	(1,000)	(18%)
Critical care	436	412	(24)	(5%)	1,322	765	(557)	(42%)
Outpatients	30,249	27,234	(3,016)	(10%)	93,742	81,891	(11,851)	(13%)
Ambulatory	1,736	2,005	269	15%	5,267	5,639	372	7%
Direct Access	81,004	96,458	15,454	19%	251,111	283,723	32,611	13%

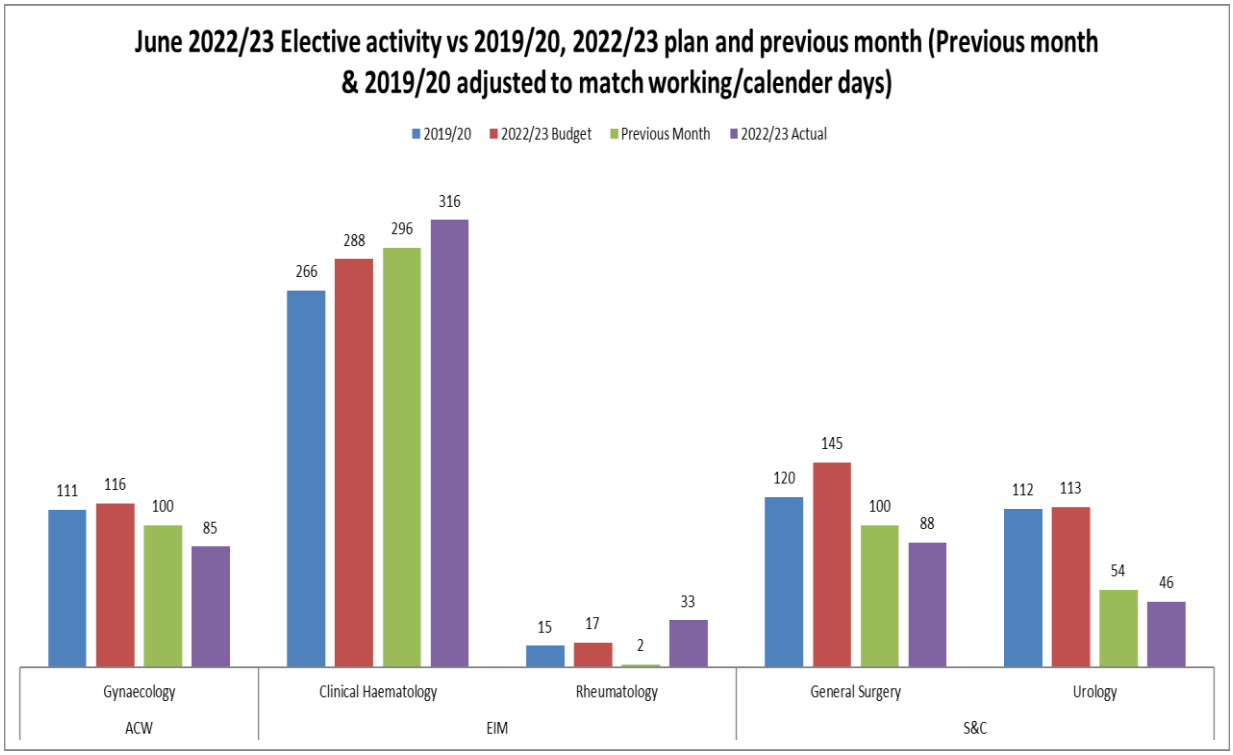
- Except for A&E, ambulatory and direct access, activity continues to be under plan. Based on this initial early data it strongly suggests that the Trust will not achieve the 109% activity target needed to achieve 100% of the £8m planned ERF.

- Activity increased compared to previous month adjusted for calendar/working days, except for outpatients.

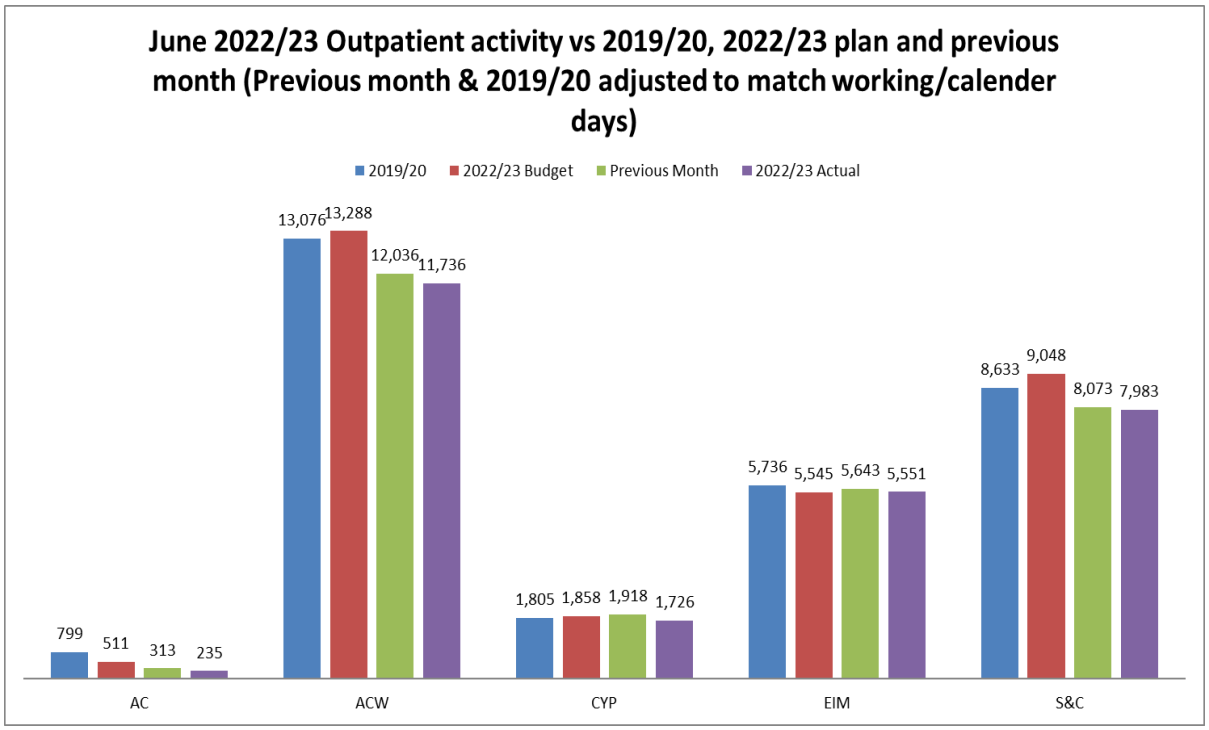


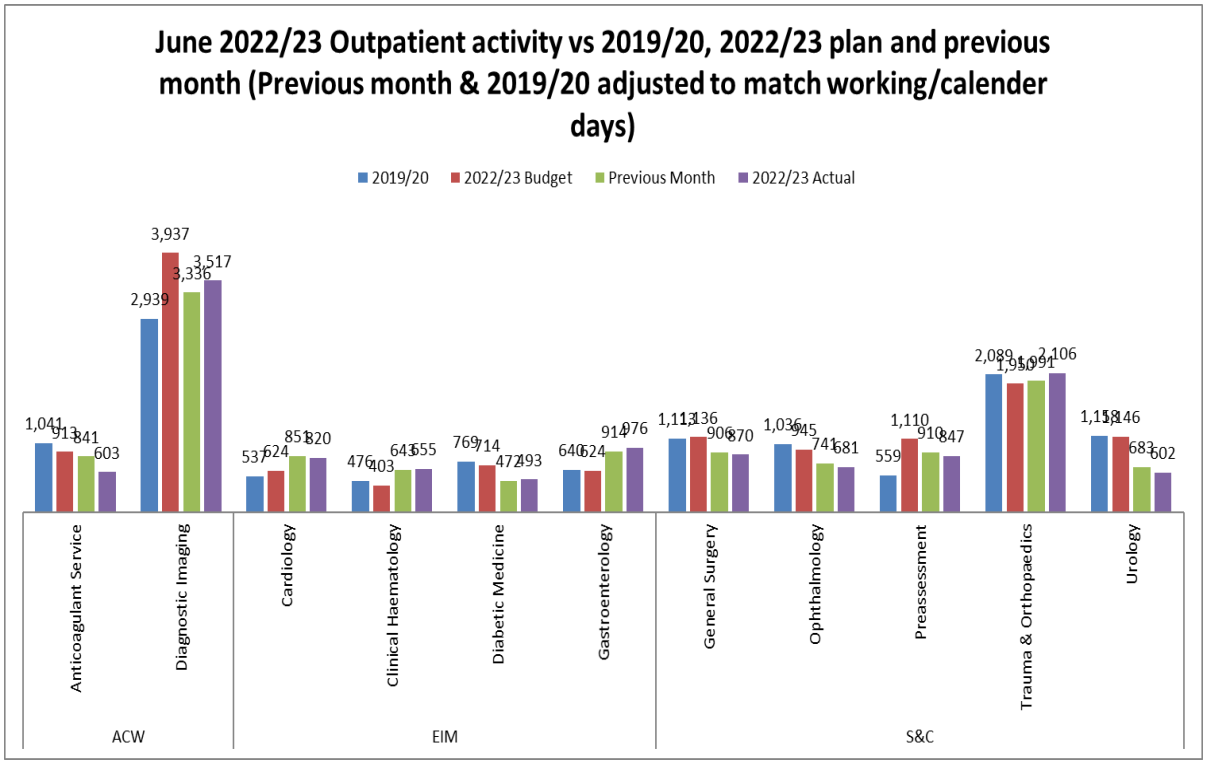
- 7% underperformance in total elective activity driven mainly by Urology (59% under plan), General Surgery (39%) and Gynaecology (27%). Offset by over performance in Clinical haematology (10% over plan) and Rheumatology (89%)





- 10% underperformance in outpatient activity driven mainly by Urology (47% under plan), Diagnostic Imaging (11%), Anticoagulant service (34%), General Surgery (23%), Ophthalmology (28%), Preassessment (24%) and Diabetic Medicine (31%). Offset by overperformance in Gastroenterology (56% over plan), Clinical Haematology (62%), Cardiology (31%) and Trauma & Orthopaedics (8%)





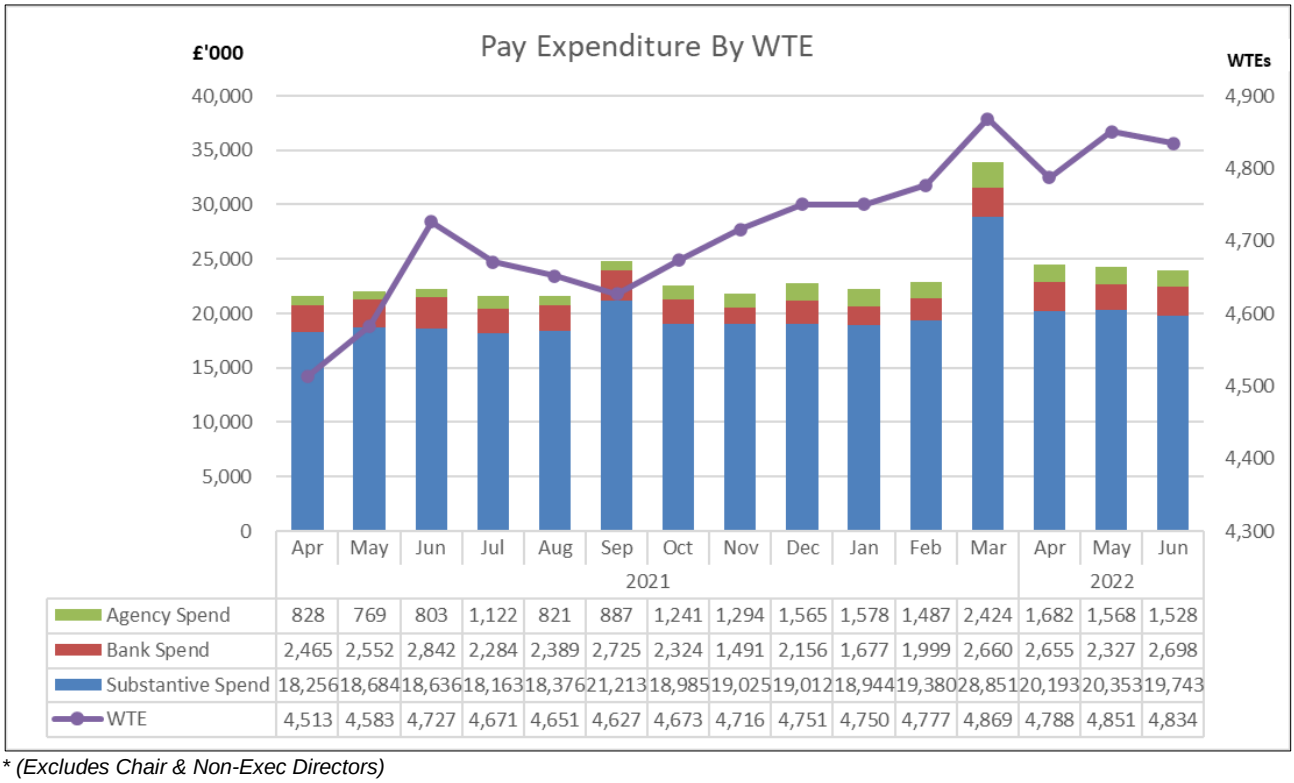
3. Expenditure – Pay & Non-pay

3.1 Pay Expenditure

Overall pay is overspent by £2,234k year to date compared to plan. The overspend is mainly driven by unachieved CIPs of £884k across all ICSUs, covid requests to cover red/green areas (£808k ED and £94k in Theatres), unfunded escalation beds open (£839k in Wards and £187k Enhanced Care) and £506k in ITU which is related to increased acuity on the wards, and agency staff required to cover staff on limited duties. Some of the unachieved CIPs is currently being offset by vacancies and slippages in some of the planned investments.

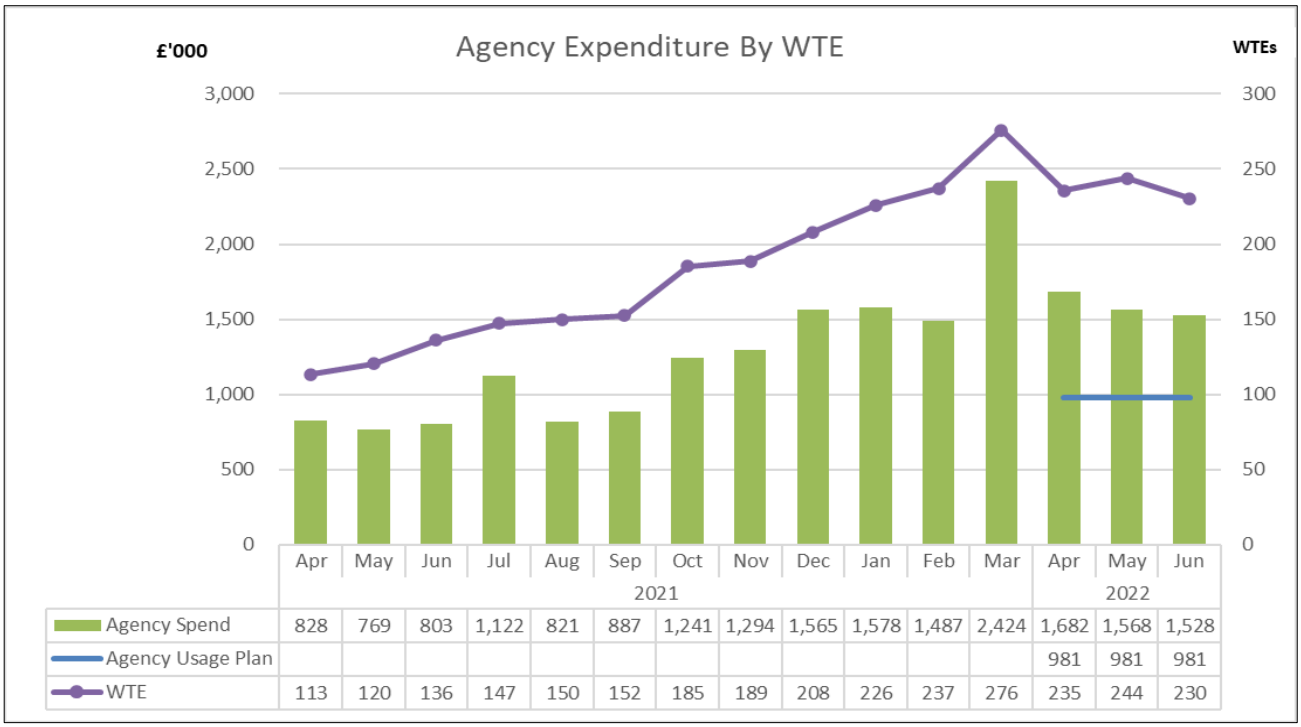
Pay expenditure for June was £23,969k which was £279k less compared to previous month. The reduction in pay costs compared to previous month its mainly due to reduction in non operational pay costs. Operational pay spend remained similar to last month, it includes national insurance uplift of 1.25% for employers and vaccination pay costs which are offset by income. Non-operational costs includes an estimate for expected pay uplift for 2022-23 and annual leave costs for bank staff.

	2021-22			2022-23			
	Jan	Feb	Mar	Apr	May	Jun	Mov^t
Agency	1,170	1,145	1,568	1,678	1,615	1,528	(87)
Bank	2,045	2,310	2,644	2,551	2,424	2,586	162
Substantive	18,880	19,178	20,037	19,170	19,366	19,283	(83)
Total Operational Pay	**22,095**	**22,632**	**24,249**	**23,399**	**23,405**	**23,397**	**(9)**
Non Operational Pay Costs	103	234	9,686	1,131	843	572	(271)
Total Pay Costs	**22,198**	**22,866**	**33,934**	**24,530**	**24,248**	**23,969**	**(279)**



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Agency Spend	828	769	803	1,122	821	887	1,241	1,294	1,565	1,578	1,487	2,424	1,682	1,568	1,528
Bank Spend	2,465	2,552	2,842	2,284	2,389	2,725	2,324	1,491	2,156	1,677	1,999	2,660	2,655	2,327	2,698
Substantive Spend	18,256	18,684	18,636	18,163	18,376	21,213	18,985	19,025	19,012	18,944	19,380	28,851	20,193	20,353	19,743
WTE	4,513	4,583	4,727	4,671	4,651	4,627	4,673	4,716	4,751	4,750	4,777	4,869	4,788	4,851	4,834

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



**2022-23 agency cap figures will be issued by NHSI in Q2.*

Review actions on pay expenditure include

- Review use of additional staffing for Covid
- Review additional staffing related to IPC guidance
- Review vacancies to help with non-recurrent CIP delivery

3.2 Non-pay Expenditure

Overall non pay is £11K underspent year to date compared to plan. Overspends relates to unachieved CIPs (£240k), clinical supplies (£308k), general supplies (£106k), use of independent sector (£142k) and PFI costs (£362k) which are related to legal and consultancy fees along with increased staffing for fire safety. The over spends are being offset by slippages in planned investments.

In month increase in spend relating to premises and fixed plant is due to IFRS16 reclassification of finance leases costs as per the new accounting standards and backdated electricity charges (£457k) which are currently an estimate with specific amounts expected to be received in July.

	2022-22			2022-23			
Non-Pay Costs	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Mov^t**
Supplies & Servs - Clin	3,624	2,633	3,103	2,616	2,884	2,537	(348)
Supplies & Servs - Gen	447	488	316	24	262	512	250
Establishment	260	305	210	287	214	207	(7)
Healthcare From Non Nhs	210	282	293	87	226	71	(155)
Premises & Fixed Plant	2,193	2,977	6,010	2,203	1,482	2,701	1,219
Ext Cont Staffing & Cons	175	(2)	85	142	147	120	(27)
Miscellaneous	2,225	2,374	8,377	1,653	1,651	1,517	(134)
Chairman & Non-Executives	12	12	12	11	11	11	
Non-Pay Reserve				(8)	66	14	(52)
Total Non-Pay Costs	**9,146**	**9,068**	**18,404**	**7,016**	**6,943**	**7,690**	**747**

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

Miscellaneous Expenditure Breakdown

	2022-22			2022-23			
Miscellaneous Breakdown	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Mov^t**
Ambulance Contract	157	152	144	168	176	208	32
Other Expenditure	58	324	4,993	52	51	14	(37)
Audit Fees	9	9	107	8	8	8	
Provision For Bad Debts	612	364	(266)	100	161	35	(126)
Cnst Premium	837	837	735	827	827	827	(0)
Fire Security Equip & Maint	0	15	3	5	11	12	1
Interpretation/Translation	24	19	1	21	16	9	(6)
Membership Subscriptions	196	126	113	128	134	135	1
Professional Services	244	422	1,535	298	188	171	(17)
Research & Development Exp		11	296	1	(1)	(2)	(1)
Security Internal Recharge	20	10	10	10	10	10	(0)
Teaching/Training Expenditure	65	85	698	34	65	86	20
Travel & Subs-Patients	1	1	8	1	4	4	(1)
Total Non-Pay Costs	**2,225**	**2,374**	**8,377**	**1,653**	**1,651**	**1,517**	**(134)**

3.3 Cost Improvement Programmes (CIP)

The CIP target for 2022-23 is £13.83m. The targets have been allocated to ICSU and corporate divisions as part of 2022-23 budgets.

ICSU	22/23 CIP Target Allocated £'000
ADULT COMMUNITY	1,192
CHILDREN & YOUNG PEOPLE	1,839
EMERGENCY & INTEGRATED MEDICINE	1,653
SURGERY & CANCER	1,569
ACW	1,728
ICSU TOTAL	**7,980**
CORPORATE SERVICES TOTAL	2,020
CENTRAL	3,829
CIP GRAND TOTAL	**13,829**

CORPORATE DIRECTORATES	22/23 CIP Target Allocated £'000
CHIEF OPERATION OFFICER	75
ESTASTES & FACILITIES	1,006
FINANCE	186
ICT	252
MEDICAL DIRECTOR	67
NURSING & PATIENT EXPERIENCE	183
TRUST SECRETARIAT	74
WORKFORCE	177
CORPORATE TOTAL	**2,020**

Year to Actuals

At the end of June, the Trust is reporting actual delivery of £0.99m year to date of CIP against a target of £1.85m.

ICSU	22/23 CIP Target Allocated £'000	YTD Plan £'000	YTD Actuals £'000	YTD Variance £'000	YTD Actuals vs YTD Plan %
ADULT COMMUNITY	1,192	174	147	(27)	84.6%
CHILDREN & YOUNG PEOPLE	1,839	270	232	(38)	86.0%
EMERGENCY & INTEGRATED MEDI	1,653	243	14	(229)	5.9%
SURGERY & CANCER	1,569	231	-	(231)	0.0%
ACW	1,728	252	67	(185)	26.6%
ICSU TOTAL	**7,981**	**1,170**	**461**	**(709)**	**39.4%**
CORPORATE SERVICES	1,014	150	87	(63)	57.8%
ESTASTES & FACILITIES	1,006	147	56	(91)	38.2%
PROCUREMENT	-	-	-	-	0.0%
CENTRAL	3,829	383	383	-	100.0%
CIP GRAND TOTAL	**13,829**	**1,850**	**987**	**(863)**	**53.3%**

4.0 Statement of Financial Position (SoFP)

The net balance on the Statement of Final Position as at 30th June 2022 is £228.7m, £5.1m down from March 2022, as shown in the table below.

Statement of Financial Position as 30th June 2022

Statement of Financial Position as at 30th June 2022	BFWD 31 MAR 2022 (£000)	30th JUNE 2022 (£000)	MOVEMENT IN YR (£000)
NON-CURRENT ASSETS:			
Property, Plant And Equipment	246,194	287,182	40,988
Intangible Assets	9,711	9,076	(636)
Trade & Other Rec -Non-Current	415	487	72
TOTAL NON-CURRENT ASSETS	**256,321**	**296,745**	**40,424**
CURRENT ASSETS:			
Inventories	788	807	19
Trade And Other Receivables	12,742	17,027	4,285
Cash And Cash Equivalents	81,416	76,300	(5,116)
TOTAL CURRENT ASSETS	**94,946**	**94,134**	**(812)**
CURRENT LIABILITIES			
Trade And Other Payables	(66,576)	(65,951)	625
Borrowings: Finance Leases	(79)	(132)	(53)
Borrowings: Dh Revenue and Capital Loan - Current	(118)	(131)	(13)
Provisions for Liabilities and Charges	(704)	(4,251)	(3,547)
Other Liabilities	(1,859)	(2,392)	(533)
TOTAL CURRENT LIABILITIES	**(69,337)**	**(72,857)**	**(3,520)**
NET CURRENT ASSETS / (LIABILITIES)	**25,609**	**21,277**	**(4,332)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**281,930**	**318,022**	**36,092**
NON-CURRENT LIABILITIES			
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,740)	(1,740)	0
Borrowings: Finance Leases	(4,754)	(45,937)	(41,183)
Provisions for Liabilities & Charges	(41,622)	(41,622)	0
TOTAL NON-CURRENT LIABILITIES	**(48,116)**	**(89,300)**	**(41,183)**
TOTAL ASSETS EMPLOYED	**233,813**	**228,722**	**(5,091)**
FINANCED BY TAXPAYERS EQUITY			
Public Dividend Capital	113,854	113,854	0
Retained Earnings	21,147	16,056	(5,091)
Revaluation Reserve	98,813	98,813	(0)
TOTAL TAXPAYERS EQUITY	**233,813**	**228,722**	**(5,091)**

IFRS16 is the new accounting standard implemented across the NHS on 1st April 2022, which requires the Trust to recognise an increased range of its leases as finance leases. This reclassification requires the assets, and a corresponding finance lease creditor, to be added to the SoFP.

- A summary of the SoFP impacts arising from implementation of IFRS16 is as follows:
- Increase assets for the leases coming onto SoFP £42,491k: this is less than the £46,983k reported at Month 2 as it has emerged that two of the premises' leases were terminated during 2021/22.
- Increase finance lease (liabilities) for the same assets (£42,491k).

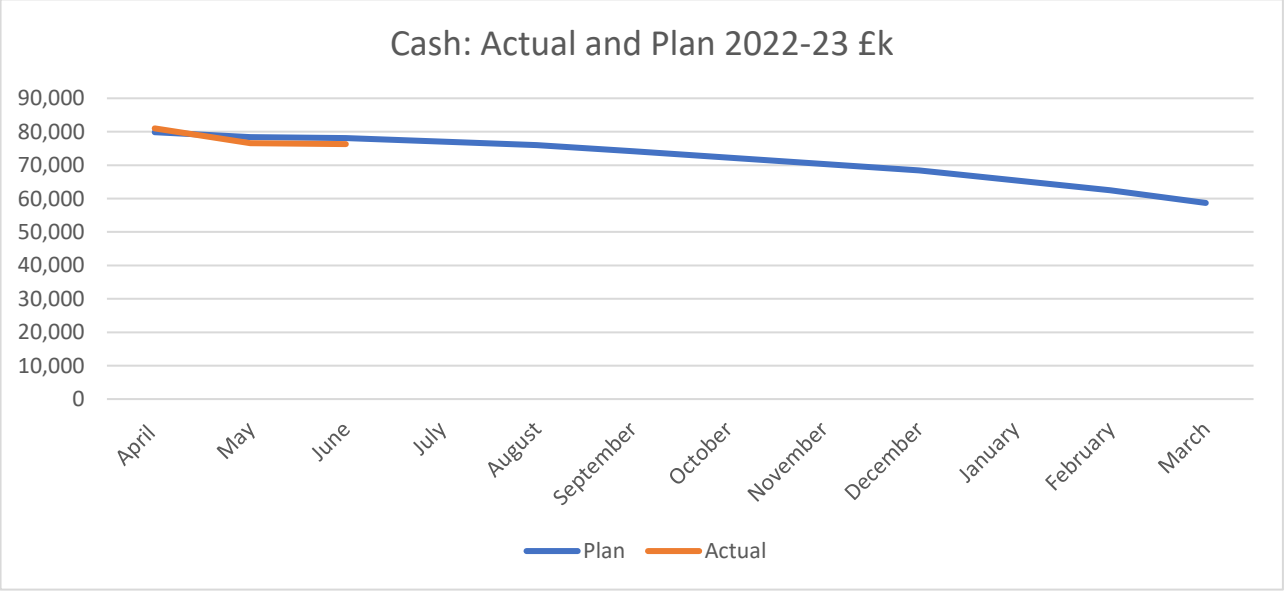
- Total assets less current liabilities have decreased by £5,839k since May 2022. This is principally due to the derecognition of two leased premises which had been included in the Trust's IFRS16 adjustment at Month 2.

- Total assets employed have decreased by £1,148k in month; of which
    - Non-current assets are £4,473k lower than at May 2022. Depreciation continues to exceed capital expenditure in the month of June 2022.
    - Cash held is now £76,300k, a decrease of £306k in month.

- Total Liabilities (Current & Non-Current) have decreased by £4,086k, of which £4,492k is the result of the IFRS16 accounting adjustment regarding the two leased premises above.
    - Borrowings and loans continue remain in line with their planned repayment profile. The next capital repayment is in September 2022.
    - Finance Lease borrowings have decreased by £4,691k in month, with £4,492k relating to the IFRS16 adjustment.
    - Provision balances have decreased by £0.9m in month.
    - Trade & Other payables have increased by £1,572k in-month.
    - Other liabilities have decreased by £1,088k, comprised principally of NHS deferred income.

4.1 Cash & Cash Equivalents

As at the end of June, the Trust's cash balance stands at £76.3m – a decrease of £5.1m from 31 March 2022, £0.3m less than May's figure and £1.8m below Plan. The balance has reduced since 31st March as the Trust reports a deficit and pays down capital creditors from the year-end. The Trust's ongoing cash requirements have not changed materially in terms of staff pay and capital expenditure, and the Trust continues to strive to pay suppliers early in the current economic climate. The plan balances in the chart below have been updated to reflect the Trust's latest updated Plan which was submitted during June.



Statement of cash flows for the 3 months ended 30th June 2022

	(£000)
Cash flows from operating activities	
Operating surplus/(deficit)	(3,626)
Non-cash income and expense:	
Depreciation and amortisation	4,311
(Increase)/decrease in trade and other receivables	(4,285)
(Increase)/decrease in inventories	(19)
Increase/(decrease) in trade and other payables	798
Increase/(decrease) in other liabilities	533
Increase/(decrease) in provisions	3,547
Net cash generated from / (used in) operations	**1,259**
Cash flows from investing activities	
Interest received	153
Purchase of property, plant, equipment and investment property	(4,680)
Net cash generated from/(used in) investing activities	**(4,527)**
Cash flows from financing activities	
Capital element of finance lease rental payments	(230)
Interest paid	(14)
Interest element of finance lease	(230)
PDC dividend (paid)/refunded	(1,375)
Net cash generated from/(used in) financing activities	**(1,848)**
Increase/(decrease) in cash and cash equivalents	**(5,116)**
Cash and cash equivalents at start of period	**81,416**
Cash and cash equivalents at end of period	**76,300**

The recent increases in interest rates have resulted in a total of £153k interest being reported for the first three months of the year. This is £100k in excess of Plan. The Trust continues to monitor the interest rates available, and the monthly sum of interest received, in these times of high volatility.

5.0 Capital Expenditure

Capital expenditure as at the 30th June 2022 totals £1,508k, which is £2,690k below plan, a reflection that the Trust's principal capital projects are yet to get fully underway for this financial year.

The final plan was presented to CMG in June 2022, with a total of £25,406k internally funded from depreciation (£11.5m) and cash reserves (£13.9m).

The final plan was presented to CMG in June 2022, with a total of £30.4m. This includes self-funded schemes of £25.4m and £5m relating to elective recovery (Targeted Investment Fund TIF). Funding for TIF scheme is yet to be confirmed. The Trust's internal capital plan of £25.4m is funded through depreciation (£11.4m) and cash reserves (£13.9m).

Meeting title	**Trust Board – public meeting**	**Date: 22 July 2022**
Report title	**2022/23 Q1 Delivery of corporate objectives and Q2 Board Assurance Framework**	**Agenda item: 11**
Director leads	Deborah Clatworthy, Acting Chief Nurse & Director of Allied Health Professionals, Clare Dollery, Medical Director, Carol Gillen, Chief Operating Officer (Quality entries); Norma French, Director of Workforce, (People entries); Jonathan Gardner, Director of Strategy & Corporate Affairs (Integration and Sustainability 3 entries); Kevin Curnow, Chief Finance Officer (Sustainability 1 and 2 entries)	
Report authors	Swarnjit Singh, Joint Director of Inclusion and Trust Secretary, executive risk leads, and Jonathan Gardner	
Executive summary	Board members are presented with the outcomes for delivery of our corporate objectives in quarter one and the updated Board Assurance Framework for quarter two showing risks to the delivery of Whittington Health's strategic objectives.	
Purpose	Approval	
Recommendation	Board members are invited to note the outcomes for the quarter one delivery of the corporate objectives and to approve the 2022/23 quarter two, Board Assurance Framework entries for risks to the delivery of Whittington Health's strategic objectives.	
BAF	All entries	
Report history	May 2022, Quality Assurance Committee and Finance & Business Development Committee; June 2022, Audit and Risk Committee; July 2022, Trust Management Group, Workforce and Quality Assurance Committees	
Appendices	1: 2022/23 Q1 Delivery of corporate objectives 2: 2022/23 Q2 Board Assurance Framework	

2022/23 objectives
QUARTER ONE
UPDATE
V7

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		0.9 June 2022	
Readmission rate	5.5%	4.61%	
Pressure ulcers grd. 4 and 3	Reduce	Average 12in q1 Average 7 in q4	
FFT % satisfaction	90%	Average q 4 89%	

Key metrics	Target	Score	RAG
RTT	92%	72.1%	
ED 4hr	95%	73.2%	
Adult community metrics green	Improve		
Child community	Improve		

Key metrics	Target	Score	Direction and RAG
PALS response time	80%	52%	
48hrs DN referral	95%	95.2%	
2hr referral	N/A	70.5%	

Objective	Progress in last quarter (Q2)
Improve trust safety rating to "good" by completing CQC action plan and • Embedding role and function of learning from deaths with medical examiners • Improve learning from serious incidents and never events • Improve medicine management • Implement recommendations within the Ockenden Review (two reports published) of Maternity services • Enhance our Better Never Stops programme following our QI strategy, and listening to patients and staff	• Continuing to prepare for introduction of PSIRF (Patient Safety Incident Response Framework) with use of alternative investigation tools focused on identifying and implementing learning quickly. • Recruitment for Head of Patient of Safety role who will act as the Patient Safety Specialist, supporting local delivery of the National Patient Safety Strategy • Ockenden visit on 27th June with positive feedback • Internal Audit of CQC action plan received significant assurance with some improvement actions • Launch of CareFlow Medicines Management system
Recover backlogs efficiently • by working with the system in surgical hubs to rapidly build capacity, focussing on reducing inequalities. • Maintain expanded rapid response services across adult and CYP	• Backlogs recovered via demand smoothing across NCL, use of independent sector, insourcing solutions, additional capacity through waiting list initiatives and continuing review of performance against trajectory to flag and seek external support where required through mutual aid • Rapid response in place across ACS and CYP with 48 hour DN referral target achieved
Deliver quality (year 3) and patient experience (year 1) priorities • Improving communication (between staff and patients, and across multi-disciplinary teams) • Reducing harm from hospital acquired deconditioning • Improving blood transfusion safety culture at the hospital • Improving understanding of human factors and making healthcare as safe as possible • Reducing health inequalities in our local population • Monitor against Equality Delivery System 2 (EDS2) patient outcomes (to be restarted after the COVID-19 pandemic**).**	• Consultation period for new Patient Experience Strategy extended into Quarter 2 following appointment of new Head of Patient Experience • New objectives for Year 3 of Quality Account priorities agreed, following consultation with staff, patients, Healthwatch and the CCG. • Quarter 1 has focused on consultation and planning for 2022/23 including; • New delirium pathway being piloted • New Falls Pick up Service in the Rapid Response Team and • Increasing prostate cancer awareness through 'Barber shop' pop-up

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%	14%	
Vacancy rate	10%	12.7%	
Appraisal rate	90%	70.4%	
Mandatory training	90%	85.1%	

Key metrics	Target	Score	Direction and RAG
Staff Sickness	3.5%	4.9%	
Likelihood BAME candidate being appointed	1	1.42	
Staff FFT/Pulse response rate	20%	*52% staff survey*	

Key metrics	Target	Score	Direction and RAG
Relative likelihood of disciplinary for BAME	1	3.75	
% staff recommending WH as place to work	65%	*59.2%*	

Objective	Progress last quarter
Continually improve morale • in line with the People Promise implement a new workforce strategy • continue with the cultural action plan focussing on engagement and bullying and harassment • promote inclusive, compassionate leadership, accountability and team working • care for staff and support staff recovery through a range of offerings including mental health support, celebrations, and time to reflect and recuperate	• Directors of REDI in post since Sept 2021 with regular reports to TMG, People Committee, Partnership Group and WAC , TMG and Trust Board. • Equality Strategy ratified by Trist Board and TMG and Partnership Group • Inclusion Committee in Place • EDI Action Plan Approved for 12 months • Disability Confident status secured • Review of learning and development interventions • Bid for resourcing Staff Networks approved • EDI Lead commenced in May 2022 • Business case to resource staff networks approved • Increased resources within the EDI structure will provide some much needed support
Recruit, develop and retain talent • working with NCL ICS and Provider Alliance, • improve occupational health services across the ICS, and • improve the diversity of our senior workforce in line with our Model Employer targets • develop and support clinical leads and managers, and • improve professional standards and ways of working – hospital and community – Practice Development Practitioners and Clinical Nurse Specialists leadership development • recruit local and develop new roles	• North London Partners Shared Service approved by NCL CEOs – hosted by RFL approved. Recruitment shared services planned went live-in December 2021. Employment law tender awarded October 2021 . Collaborative Bank to go live in June 2022 . OH hub and spoke model took place in May 2022 • 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 and Trust Board update on H&WB offerings in January 2022 • Manager's Forum now an active part of Trust architecture with programme of events in place. • Rolling out the national Core Managers Inclusion development programme

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
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	*54%*	

Objective	Progress last quarter
Be a beacon for integrated care, • lead on new models in NCL, • expand and improve the new model of care in localities with our primary care, PCN, council and voluntary sector partners • proactively care for vulnerable people in the community.	• 4 nursing associates have now started as our employees but working for the Haringey PCNs • We are leading on the virtual ward model for the community review in NCL, and that is progressing well • We are leading on the community children's review work.
Play our role as an anchor institution to reduce inequalities and improve population health • make every contact count, • engage with the community, • become a source of health advice and education	• Several mentoring programmes for local residents have started recently with our staff participating. • Further work and analysis required to decide how and if we take forward a major programme on 'make every contact count' • The consultation with the community around the Wood Green hub has concluded positively, we are presenting to the OSC 25th July. • Further work on health advice and education is needed
Make the most of our strengths for system benefit • implement a joint oncology model with UCLH, and • deliver the General Surgery, Urology, Dermatology and Gynae hub models for NCL, • support any system changes in paediatrics and maternity • work with C&I on development of new hospital • Shape and steer borough partnerships, ICB and Provider Alliance. • Lead the transformation of children's community and rapid response / virtual ward in NCL. • Host CDC in Wood Green • Maintain strength of orthopaedics collaboration	• The joint oncology model discussions are progressing. A UCLH@ model is deemed to be the best way forward, however, we need to work through the implications for pharmacy and other linked services. • We are doing work for RFL and UCLH for general surgery and urology. Gynae model still to be confirmed. • The "start well" case for change has now been published, and we are engaged in finding solutions. • The provider alliance articles have been approved now by our board. We are supporting multiple streams in the ICB. • See above for virtual ward update • CDC is still on track to open in August/September. Staffing is an issue particularly for ultrasound. Business case for phase 2 has been submitted. • Orthopaedics continues to work well with UCLH.

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	Annual Target 100% (£13.83m) Q1 Target 13% (£1.85m)	£0.99m Delivered (7%) in Q1.	
Average beds used	197	223	
Financial position	Annual Plan (£0.1m deficit) Q1 Plan (£3.7m deficit)	£5.1m deficit reported in Q1 which is £1.4m worse than plan.	
Capital spend against plan	Annual Plan is £30.4m (£25.4m internally funded and £5.0m PDC).	£2.2m utilised in Q1.	
Average LOS Non-elective	4	5	
Predicted versus actual discharges		142%	

Key metrics	Target	Score	RAG
% super stranded pts	18%	17.7%	
Elective activity against recovery plan	104%	98.3% Q1	
Theatre utilisation	>85%	73.21%	
Virtual vs face to face outpatients	25%	17.3%	
Maternity project status	Green	Amber	
Estates transformation plan	Green	Amber	

Objective	Progress since last quarter
Deliver productivity gains to achieve cost improvement plan targets	• 2022/23 financial plan to be breakeven as a system and a small, £0.1m deficit as a Trust. CIP programme and non recurrent solutions as mitigation for slippage being developed. • The Trust is reporting a deficit of £5.07m at the end of Q1 which is £1.35m worse than plan. The planned deficit for Q1 was £3.72m.
Design and deliver financial recovery plan • working with system partners to achieve financial sustainability • Deliver in year financial targets	
Deliver hospital and community estate transformation plans (Maternity and Neonates, and Wood Green Community Hub)	• Maternity and neonatal planning permission has been submitted aiming for Sept approval. Business case for phase 2 being written aiming for late summer review. • Wood Green hub business case being written, currently at risk due to increased costs.
Deliver year 1 of the new digital strategy • Roll-out agile and hybrid working and ensuring that we support working safely in offices, at home and clinical environments • Progress OBC for new EPR • Improve & innovate in digital, data, and analytics, using data to transform	• We now have two workable digital options for agile working. The Highgate Wing will be our first pilot. Aim is to bring HR over to the Highgate Wing by squeezing the best out of the desks. • We are interviewing companies to support us with an EPR business case. Further conversations have been had with System C and with Epic to ascertain costs of the two main options available to us. • Exploring virtual monitoring for community services and AI for CDC, see Innovation committee report for more in detail
Conclude PFI deal and continue rectification of PFI	• Survey work of the building ongoing 22/23 Q1/Q2. Legal dispute remains. Fire door remediation work complete. Fire Door replacement complete. Mediation set for mid July
Develop education and research and make the most of our participation in the BRC	• WEC due to open imminently with benefit to rehouse R and D team to optimise their performance and transform the education offer at WH. Recent CMO visit very positive

Appendix 2: 2022/23, Q2 Board Assurance Framework summary

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		I	L	R		
Quality 1 – quality and safety of services	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 and families, due to errors, or lack of care or lack of resources, results in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation	4	4	16	4	Chief Nurse / Medical Director
Quality 2 – capacity and activity delivery	Due to a lack of capacity, capability, and clinical attention and continuing pressures from the pandemic, there is an inability to meet elective recovery and clinical performance targets, resulting in a deterioration in service quality and patient care such as: • long delays in the emergency department and an inability to place patients who require high dependency and intensive care • patients not receiving the care they need across hospital and community health services • patients on a diagnostic and/or treatment pathway at risk of deterioration and the need for greater intervention at a later stage • an unsuccessful rollout of the Covid-19 pandemic booster and winter flu vaccination programmes	4	4	16	4	Chief Operating Officer / Chief Nurse / Medical Director

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		I	L	R		
People 1 – staff recruitment and retention	Lack of sufficient substantive staff, due to increased staff departures and absence, and difficulties in recruiting and retaining sufficient staff, results in further pressure on existing people, a reduction in the quality of care, insufficient capacity to deal with demand, and increased temporary staffing costs	4	5	20	9	Director of Workforce
People 2 – staff wellbeing, engagement and equity, diversity and inclusion	Failure to improve staff health, wellbeing, equity, diversity and inclusion, empowerment, and morale, due to the continuing post-pandemic pressures, and the restart of services, poor management practices, and an inability to tackle bullying and harassment and behaviours unaligned with the Trust's values result in: • a deterioration in organisational culture, morale and the psychological wellbeing and resilience • adverse impacts on staff engagement, absence rates and the recruitment and retention of staff • poor performance in annual equality standard outcomes and submissions • a failure to secure staff support, buy-in and delivery of NCL system workforce changes and an increased potential for unrest	4	4	16	4	Director of Workforce

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		I	L	R		
Integration 1 – ICB/S and Alliance changes	Changes brought about by the Health and Social Care Bill, the NCL health and care system and Provider Alliance such as corporate services' rationalisations, the review of community services, and "Start Well" and the reconfiguration of pathways through lead provider arrangements impact adversely on patient services, particularly fragile ones, and the strategic viability of the Trust	4	3	12	8	Chief Executive / Director of Strategy & Corporate Affairs
Integration 2 – population health and activity demand	Local population health and wellbeing deteriorates, due to the impact of the pandemic, because of a lack of available investment in, or focus on ongoing care and prevention work, and due to unsuccessful collaboration with local sector health and social care partners, resulting in continued high demand for services which is insufficiently met	4	3	12	8	Director of Strategy & Corporate Affairs
Sustainable 1 – control total delivery and underlying deficit	Adverse funding arrangements regionally or nationally; or failure to a) manage costs, b) reduce the run rate, c) properly fund cost pressures, due to poor internal control systems, or inability to transform services and deliver the cost improvement programme savings, or due to insufficient flexibility under a block contract along NCL system and provider alliance changes, result in an inability deliver the annual control total, a deterioration in the underlying deficit for the Trust, increased reputational risk and pressure on future investment programmes, or cancellation of key Whittington Health investment projects,	4	5	20	8	Chief Finance Officer

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		I	L	R		
	and improvements in patient care and savings not being achieved					
Sustainable 2 – estate modernisation	The failure of critical estate infrastructure, or continued lack of high-quality estate capacity, due to insufficient modernisation of the estate or insufficient mitigation, results in patient harm, poorer patient experience, or reduced capacity in the hospital	4	4	16	8	Chief Finance Officer
Sustainable 3 – digital strategy and interoperability	Failure by the Trust to effectively resource and implement a digital strategy focussed on improving patient care through collaborative system working and efficient, digitally enabled processes, and underpinned by a modern secure, standards-based infrastructure, will adversely impact on key transformation projects across the organisation and our ability to be an effective system partner and leader	3	3	9	6	Director of Strategy & Corporate Affairs

2022/23 Q2, Board Assurance Framework detail

Quality

Strategic objective		**Deliver outstanding safe, compassionate care in partnership with patients**
Executive leads		Chief Nurse and Director of Allied Health Professionals; Medical Director; Chief Operating Officer
Oversight committees		Quality Governance Committee, Trust Management Group, Quality Assurance Committee
Principal risks	**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 and families, due to errors, or lack of care or lack of resources, results in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation
	Quality 2	A lack of capacity to restart elective and other key services, capability, and attention to clinical performance targets, due to priorities in planning for and responding to future pandemic waves, or winter pressures result in a deterioration in service quality and patient care such as: • long delays in the emergency department and an inability to place patients who require high dependency and intensive care, • patients not receiving the care they need across hospital and community health services • patients on a diagnostic and/or treatment pathway at risk of deterioration and the need for greater intervention at a later stage • an unsuccessful rollout of the winter Covid-19 pandemic booster

Risk scores (I (Impact) L (Likelihood) S (Score))

Risk	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Target
	I	L	S	I	L	S	I	L	S	I	L	S	
Quality 1	4	3	12	4	4	16							4
Quality 2	4	4	16	4	4	16							4

Controls and assurances

Key controls	Assurances
Maintain expanded rapid response services across ACS and CYP and re-start other community services in a safe way, prioritising the vulnerable and maintain as much business as usual as possible to prevent escalation of other illnesses	• 1st tier - Weekly executive team meeting is alerted to any areas of concern • 1st tier - Trust Management Group monitors the delivery of targets for elective, outpatient, and community services each month. Currently meeting daily during COVID-19 surge period. • 1st tier - Quality Governance Committee quarterly meetings review the risk register at each meeting 2nd tier – the Quality Assurance Committee reviews the risk register at each meeting
Work with partners in the system to manage flow and demand to ensure patients are in the right place to receive care	• 1st tier – Monthly Trust Management Group meeting reviews the elective recovery dashboard KPIs for WH and NCL partners • 2nd tier – Weekly NCL Operational Implementation Group
Partner with service users to deliver our quality, safety, and patient experience priorities, with a focus on protecting people from infection and implement actions from the CQC inspection report	• 1st tier – the bi-monthly 'Better Never Stops' steering group reviews progress with delivery of the Trust's Care Quality Commission (CQC) actions and reviews divisional self-assessments • 2nd tier – Quarterly Quality Assurance report is reviewed by the Quality Assurance Committee • 2nd tier - Clinical and national audit findings, (compliance with Getting it Right First Time and National Institute of Clinical Excellence guidance) are reported to Quality Assurance Committee on a quarterly period, along with any identified actions within the quarterly quality report • 2nd tier - Quality Account priorities (monitoring of priorities is included within the quarterly quality report presented to Quality Assurance Committee • 3rd tier – CQC Relationship Assurance meetings • 3rd tier – Peer review visits include and Clinical Commissioning Group and other trust leads • 1st tier - Delivery of Patient Experience Strategy annual implementation plan presented to Patient Experience Group (PEG)

Key controls	Assurances
	• 2nd tier –Annual and bi-annual report is produced for complaints, claims and legal cases, medicine optimisation, health and safety safeguarding and infection prevention and control presented to Quality Assurance Committee
Re-start planned care in a 'COVID-19 protected' safe way, prioritising with the system those most urgently in need	• 1st tier - Adherence to Public Health England's Infection Prevention and Control (IPC) guidance and FFP3 mask fit testing results presented to TMG monthly • 1st tier – As part of COVID-19, communication issued once a week or more to staff on adherence to IPC requirements • 1st tier – Zoned areas in healthcare settings to meet IPC needs • 1st tier – Monthly Trust Management Group meeting focused on COVID-19 care management • 1st tier - Staff wellbeing is a priority for the Trust, offering resources to meet physical, social, and emotional wellbeing needs –to keep staff and patients safe - a COVID-19 symptom checks and lateral flow testing process Standard Operating Procedure implemented • 1st tier – Progress with FFP3 mask staff fit testing reported to TMG monthly • 1st tier – rollout of staff and patient COVID-19 and flu vaccination uptake reported monthly to TMG (in season) • 2nd tier – NCL Operational Implementation Group and Clinical Advisory Group
Serious incident (SI) reporting and action plans monitored to ensure learning and incidents, risks and complaints entered on Datix system	• 1st tier - Incident and Serious Incident reporting policies monitoring of progress of the national patient safety strategy and response framework roll out. • 1st tier - Weekly incident review meeting with Integrated Clinical Service Units (ICSU) risk managers • 2nd tier - Trust Risk Register reviewed by Quality Governance Committee, Quality Assurance Committee, Audit & Risk Committee and Trust Board

Key controls	Assurances
Mortality review group learning from deaths process and reporting	2nd tier – quarterly Learning from deaths report to Quality Assurance Committee; 2nd tier – COVID-19 updates to Quality Assurance Committee and Trust Board
Continued use of the full integrated performance report to monitor all areas of quality and activity	• 1st tier - Considered by TMG monthly; 2nd tier - also by the Trust Board monthly • 1st tier – Reviewed monthly by respective ICSU Boards and committees e.g., Infection prevention and control and drugs and therapeutics
Project Phoenix Quality Improvement (QI) drive now on	• 1st tier – Trust Better Never Stops steering group regular meeting
Tracker in place to monitor progress against the Quality Account priorities on a quarterly basis, with updates to the relevant sub-groups	1st tier – updates on Quality Account priorities provided quarterly to patient safety, patient experience and clinical effectiveness groups and to the Quality Governance Committee
Level 1 Quality Impact Assessments (QIAs) for service/pathway changes are monitored by operational managers and clinical managers. Level 2 QIAs (deemed moderate to high risk) are reported and approved by Medical Director and Chief Nurse at the QIA panel	• 1st tier – QIA panel 1st tier – Better Never Stops Improving Value meeting

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
Security audits and fire safety mandatory training levels as raised in the health and safety report	• Remedial actions agreed with monitoring of progress by the Health and Safety Group, Quality Assurance Committee and Trust Management Group	Monthly reports on fire training safety to TMG

People

Strategic objective		**Empower, support and develop an engaged staff community**
Executive lead		Director of Workforce
Oversight committees		People Committee; Trust Management Group; Workforce Assurance Committee (WAC)
Principal risks	**People 1**	Lack of sufficient substantive staff, due to increased staff departures and absence, the impact of the UK's exit from the EU, and difficulties in recruiting sufficient staff, result in increased pressure on staff, a reduction in quality of care, insufficient capacity to deal with demand, and increased temporary staffing costs
	People 2	Failure to improve staff health, wellbeing, equity, empowerment, and morale, due to the continuing post pandemic pressures and the restart of services, poor management practices, a poorly developed and implemented Workforce Race Equality Standard action plan, an inability to tackle bullying and harassment result in: • behaviours displayed which are out of line with Whittington Health's values • a deterioration in organisational culture, morale and the psychological wellbeing and resilience of staff • adverse impacts on staff engagement, absence rates and the recruitment and retention of staff • poor performance in annual equality standard outcomes and submissions • a failure to secure staff support, buy-in and delivery of NCL system workforce changes

Risk scores (I (Impact) L (Likelihood) S (Score))

Risk	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Target
	I	L	S	I	L	S	I	L	S	I	L	S	
People 1	4	5	20	4	5	20							9
People 2	4	4	16	4	4	16							4

Controls and assurances

Key controls	Assurances
Implemented Public Health England infection control and prevention guidance for staff and completed risk assessments for staff	• 1st tier assurance through monthly fit testing dashboard report at TMG. • 1st tier assurance – 95% completion rate reported to TMG on 11 August 2020 against a national target of 100%
Provided psychological/wellbeing support to staff	• 1st tier assurance – Trust Board, TMG, People Committee (PC), Partnership Group, and WAC update on activities • 1st tier – the importance of staff rest and recuperation emphasised and the ability to take annual leave was agreed by the executive team and TMG members during quarter four 2020/21 and remains important • Implementing health and wellbeing discussions with all staff as part of annual appraisal reports • Ensuring Health and Wellbeing intranet hub is kept up-to-date and accessible
Implemented corporate and local staff survey action plans	• 1st tier – ICSU Boards and Directorates consider quarterly pulse surveys, annual staff survey results and create local action plans • 1st tier assurance – Quarterly People Pulse report to TMG, Partnership Group (PG) and PC; 2nd tier assurance at WAC • 1st tier assurance - Templates provided for ICSU/Directorate level and for team level to maximise empowerment through participation in making improvements • 2nd tier – NHS staff survey outcomes and action plans report to the Trust Board, WAC, People Committee and Partnership Group
Implemented activities under the #Caringforthosewhocare initiative	• 2nd tier – the range of interventions provided for staff under the #Caring for those who care activities are reported to each meeting of the Workforce Assurance Committee, TMG, PG and PC
Implemented updated action plan for recruitment and retention strategy	• 2nd tier assurance from Workforce report to quarterly meeting of the Workforce Assurance Committee and PC (April 2021) and from well led KPIs on the Trust Board's monthly integrated performance report

Key controls	Assurances
Develop and implement a WRES improvement plan	• 2nd tier assurance – Annual workforce disability and race equality standard submissions paper to Workforce Assurance Committee, Trust Management Group and Trust Board • 2nd tier – Workforce Assurance Committee reviews progress with the equality and inclusion action plan
Complete annual grading of workforce domains of the NHS Equality Delivery System	• In line with national guidance, this is to be taken forward in Q3 and completed in Q4
Appoint Director REDI lead and resourced team to drive forward work on the action plan	• EDI lead appointed and started in Q1 2022/23
EDI plan in place	• 1st tier assurance – People Committee and TMG; 2nd tier - WAC
Trust-wide Talent management and succession planning arrangements	• Development of a Bands 2 -7 development programme for black, Asian and minority ethnic staff . launched in June 2022.

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
Review, engage and communicate a WH People Strategy from 2023 onwards	Currently being consulted and being developed to align with the NCL people strategy and with the NHS People Plan	Q3 2022/23

Integration

Strategic objective		**Integrate care with partners and promote health and wellbeing**
Executive leads		Chief Executive; Director of Strategy and Corporate Affairs
Oversight committees		Trust Management Group, Finance and Business Development Committee; Trust Board
Principal risks	**Integration 1**	Changes brought about by the Health and Social Care Bill, the NCL health and care system and Provider Alliance such as corporate services' rationalisations, the review of community services and "start well", and the reconfiguration of pathways through lead provider arrangements impact adversely on patient services, particularly fragile ones, and the strategic viability of the Trust
	Integration 2	Local population health and wellbeing deteriorates, due to the impact of the pandemic, because of a lack of available investment in, or focus on ongoing care and prevention work, and due to unsuccessful collaboration with local sector health and social care partners, resulting in continued high demand for services which is insufficiently met

Risk scores (I (Impact) L (Likelihood) S (Score))

Risk	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**			**Target**
	I	**L**	**S**	**I**	**L**	**S**	**I**	**L**	**S**	**I**	**L**	**S**	
Integration 1	4	3	12	4	3	12							8
Integration 2	4	3	12	4	3	12							8

Controls and assurances

Key controls	**Assurances**
Participation in NCL governance meetings by Executives, regular communication with executive counterparts at other organisations, good liaison through the NEDs to other Trusts. Shared Chair with UCLH. Chair, CEO and MD on the provider alliance board.	• 2nd tier – Strong engagement by all Directors in NCL Boards • 2nd tier – WH Director of Workforce is the NCL Workforce Lead • 2nd tier – WH Chief Executive is the NCL Out of Hospital Gold lead • 2nd tier – the Chief Operating Officer and Director of Strategy are on the NCL Operational Implementation Group

Key controls	Assurances
	• 2nd tier – the Medical Director is the Chief Medical Officer of the NCL Integrated Care System (ICS) and clinical lead for the NCL Provider Alliance
Review of Pathology services being undertaken with NCL colleagues and NWLP before a decision is taken on which network is joined	• 2nd tier – regular reporting to each private Trust Board meeting • 1st tier – standing item at executive team meeting
Participation and influence in clinical networks by senior clinicians	• 2nd tier – WH has the lead surgeon for general surgery for this work 2nd tier – named leads for each acute network
Participation in NCL pathway boards	• 2nd tier – Community Diagnostic Hub Board (Director of Strategy present) 2nd tier – Diagnostic Board – (Director of Strategy present)
Oncology services strategy – collaboration with UCLH	• Conversations have been held with UCLH regarding a proposed model and they are also helping with staffing capacity through a locum appointment. We have also just recruited to several other posts • 1st tier – Cancer Board – meeting roughly quarterly • Clear clinical cancer lead in place • 1st tier - Regular project group for cancer set up now meeting at least monthly 2nd tier – UCLH / Whittington Clinical Collaboration board meets every 2 months
Orthopaedic hub – collaboration with UCLH	• 1st tier – Monthly report to Transformation Programme Board • 1st tier – TMG monthly • 2nd tier – UCLH and WH Clinical Collaboration Board
Implement locality leadership working plans through close liaison with Islington and Haringey councils	• 1st tier – 3 Islington Leadership teams in place, and a single leadership team in Haringey in place and meeting monthly • 3rd tier – Monthly Borough Partnership Boards attended by CEO and Dir Strategy • 3rd tier – Monthly Haringey, Start Well, Live Well, Age Well and Place Boards Place board chaired by the Director of Strategy and service leads attend other boards • 3rd tier – Islington and Haringey Overview & Scrutiny Committees meet ad hoc to consider any issues

Key controls	Assurances
Community services review – anticipatory care / urgent response / streams of work, we are leading on the virtual ward	• 2nd tier - Project progress as per plan reported to Integrated Forum on monthly basis.
Start well review – CN and CFO are key leads on the review workstreams, Director of Strategy leads an adhoc review meeting of all the documentation.	• 1st tier – Internal start well review meetings • 1st tier – TMG
Progress Anchor Institution work – Director of Strategy leading on am action plan around the key areas of employment, procurement, buildings, environment, partnerships. Participation in various groups in Haringey and Islington – to progress local employment, engage in regeneration schemes, support the green agenda, promote LLW,	• 1st tier - Integrated forum monthly review • 1st tier – national anchor institution learning network (Q1 2021/22) • 2nd tier – Haringey and Islington borough partnership monthly • 2nd tier – Haringey inequalities working group monthly • 2nd tier – Islington Health and Social care academy *quarterly* • 2nd tier – Islington London Living Wage working group *two weekly* • 2nd tier – Quarterly report to the Trust Board on anchor institution scoring
Our anchor institution action plan is monitored and reported quarterly to board.	• 1st tier – Integrated forum – monthly meeting • 2nd tier – TMG • 2nd tier – F&BD • 2nd tier – Quarterly score review at Board meeting
Progress appointments to Primary Care Network additional roles	• 1st tier – Integrated forum – monthly meeting • 2nd tier – TMG • 2nd tier – F&BD

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
None currently identified		

Sustainability

Strategic objective		**Transform and deliver innovative, financially sustainable services**
Executive leads		Chief Finance Officer; Chief Operating Officer
Oversight committees		Better Value Delivery Board; Financial Performance Group; Trust Management Group; Finance and Business Development Committee; Innovation and Digital Assurance Committee
Principal risks	**Sustainability 1**	Adverse funding arrangements regionally or nationally; or failure to a) manage costs, b) reduce the run rate, c) properly fund cost pressures, due to poor internal control systems, or inability to transform services and deliver the cost improvement programme savings, or due to insufficient flexibility under a block contract along NCL system and provider alliance changes, result in an inability deliver the annual control total, a deterioration in the underlying deficit for the Trust, increased reputational risk and pressure on future investment programmes, or cancellation of key Whittington Health investment projects, and improvements in patient care and savings not being achieved
	Sustainability 2	The failure of critical estate infrastructure, or continued lack of high-quality estate capacity, due to insufficient modernisation of the estate or insufficient mitigation, results in patient harm, poorer patient experience, or reduced capacity in the hospital
	Sustainability 3	Failure by the Trust to effectively resource and implement a digital strategy focussed on improving patient care through collaborative system working and efficient, digitally enabled processes, and underpinned by a modern secure, standards-based infrastructure, will adversely impact on key transformation projects across the organisation and our ability to be a system leader

Risk scores (I (Impact) L (Likelihood) S (Score))

Risk	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**			**Target**
	I	**L**	**S**	**I**	**L**	**S**	**I**	**L**	**S**	**I**	**L**	**S**	
Sustainability 1	4	4	16	4	5	20							8
Sustainability 2	4	4	16	4	4	16							8
Sustainability 3	3	3	9	3	3	9							6

Controls and assurances

Key controls	Assurances
Create replicable better more efficient and effective pathways for the long-term including 'virtual by default' where possible and promoting self-management	• 1st tier – ICSU monthly Board meetings • 1st tier – Community Estates Programme Group – every two weeks • 1st tier – weekly monitoring of updates at TMG • 1st tier – ICSU quarterly performance reviews during 2021/22 • 2nd tier – monthly integrated performance report to Trust Board • 1st tier – fortnightly elective recovery dashboard reviewed by TMG and elective recovery targets included in the revised 2021/22 integrated performance report
Maintain financial governance controls Manage our expenditure to lower than last year's run-rate to enable investment in other services	• 1st tier – Monthly Investment Group • 1st tier – Monthly Transformation Programme Board • 1st tier – Monthly Finance report to Trust Management Group • 2nd tier - ICSU deep dives at Finance & Business Development Committee • 2nd tier – Monthly Finance report to Trust Board • 1st tier – TMG and 2nd tier – Trust Board – financial briefing on arrangements during October 2020 to March 2021 and of 2021/22 and on H2 arrangements for the last six months of the financial year
Monthly Cost Improvement Programme (CIP) delivery board	• 1st tier – Better Never Stops – Improving Value update to Executive team (weekly) and TMG (monthly) to show progress against the 2021/22 £9m CIP target • 2nd tier – Finance & Business Development Committee reviews progress at its bi-monthly meetings
Accountability Framework	• 1st tier – TMG endorsed an updated Framework in Q1 • 1st tier - Quarterly performance reviews continued in quarter one 2021/22 and targeted support provided where identified
Development of an estate plan Strong monitoring of fire safety procedures and compliance	• 2nd tier - Estate Strategic Outline Case (SOC) agreed by Trust Board November 2020 • 1st tier – Monthly Private Finance Initiative monitoring group

Key controls	Assurances
Capital programme addresses all red risks	• 1st tier – Monthly Fire safety group • 1st tier - and fire warden training with a comprehensive fire safety dashboard reported monthly to TMG; 1st tier – Monthly Health and Safety Committee • 1st tier – Capital Monitoring Group
Estate Strategy is approved Strategic Outline Case for maternity and neonatal services is approved Phase 1 business case approved Progress next stage of business cases	• 1st tier – Maternity Transformation Board monthly • 1st tier – Transformation Programme Board monthly • 2nd tier – Finance & Business Development Committee next review in the Summer for phase 2 business case
Pathology services	• 1st tier – Transformation Programme Board monthly • 2nd tier – Finance & Business Development Committee and Trust Board
Community estate transformation programme Tynemouth Road is complete Progress plans and consultation for Wood Green community hub	• 1st tier – Integrated Forum monthly review • 1st tier - Monthly summary report to Transformation Programme Board • 1st tier – Community Estates Programme Group every two weeks • 2nd tier - Trust Board agreed empty sites as surplus to requirements • 3rd tier – Overview & Scrutiny Committee and consultation (completed)
Facilitate Trust's Agile working policy	• 1st tier - Monthly report to Transformation Programme Board
Deliver maternity and neonatal transformation programme five workstreams meeting weekly – Ockenden, Culture, IT, Estates, Continuity of Carer	• 1st tier – Monthly Maternity Transformation Programme Board • 1st tier – Monthly Transformation Programme Board
Develop, resource and implement a revised Digital strategy	• 2nd tier – Implementation of approved Digital strategy is overseen by the the Innovation and Digital Assurance Committee

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
Updated Sustainability plan for the Trust to be published	A draft Sustainability plan will be presented in for feedback and agreement.	Quarter two 2022/23

Assurance definitions:	
Level 1 (1st tier)	Operational (routine local management/monitoring, performance data, executive-only committees)
Level 2 (2nd tier)	Oversight functions (Board Committees, internal compliance/self-assessment)
Level 3 (3rd tier)	Independent (external audits / regulatory reviews / inspections etc.)

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

Risk category	Risk Appetite level based on GGI matrix	Indicative risk appetite range
Quality (patient safety, experience & clinical outcomes)	Cautious	3 - 8
Finance	Cautious / Open	3 - 10
Operational performance	Cautious	3 - 8
Strategic change & innovation	Open / Seeking	6 - 15
Regulation & Compliance	Cautious	3 - 8
Workforce	Cautious	3 - 8
Reputational	Cautious / Open	3 - 10

Risk scoring matrix (Risk = Consequence x Likelihood (C x L))

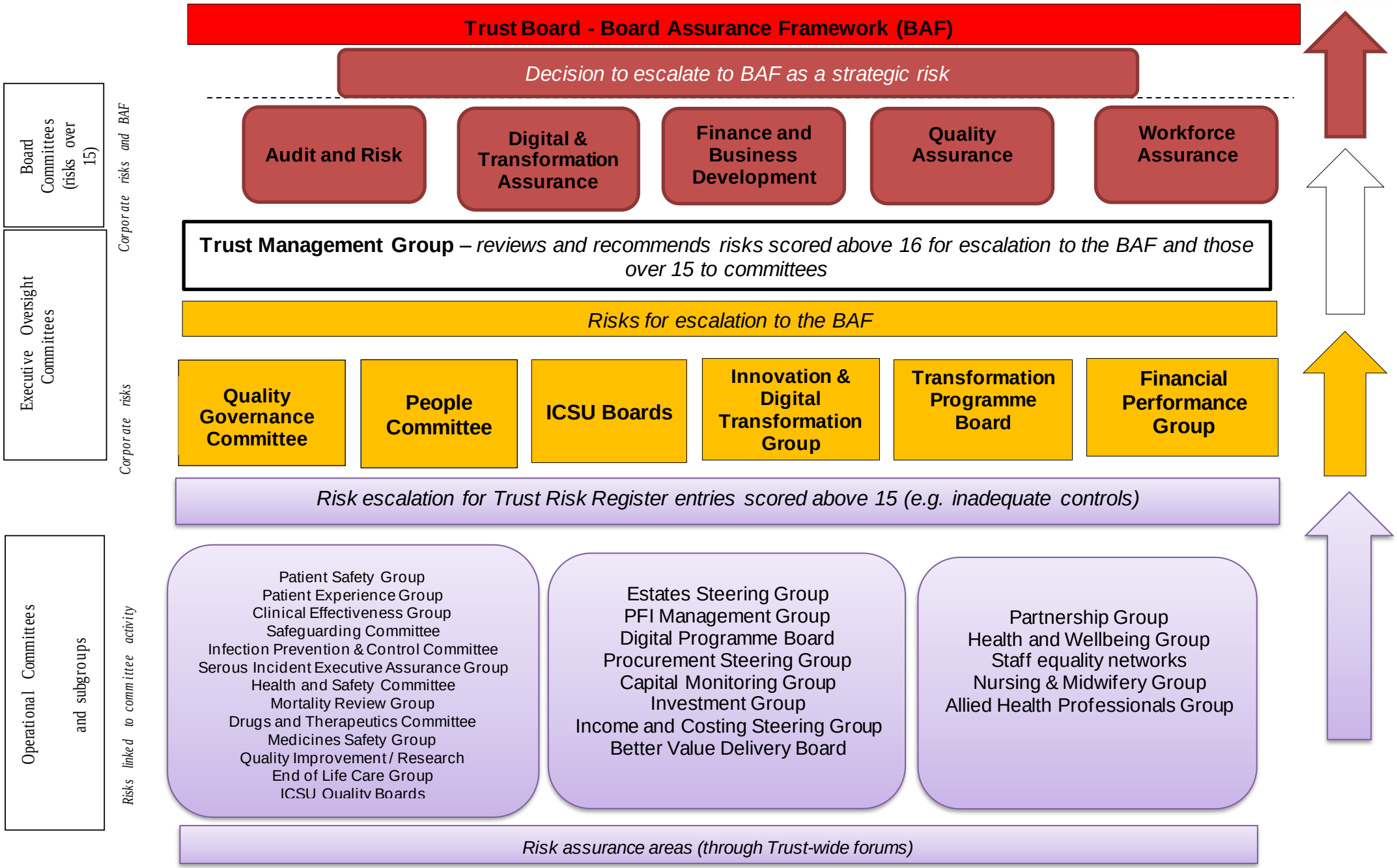
	Likelihood				
	1	2	3	4	5
Consequence	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Scores obtained from the risk matrix are assigned grades as follows:

1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-25	Extreme risk

NHS
Whittington Health
NHS Trust

Trust-wide review and escalation of strategic risks



Meeting title	**Trust Board – public meeting**	**Date: 22 July 2022**
Report title	**Strategy update**	**Agenda item: 12**
Executive director lead	Jonathan Gardner, Director of Strategy and Corporate Affairs	
Report author	Jonathan Gardner	
Executive summary	**Community Diagnostic Centre in Wood Green** We are delighted to report that the first phase of the Community Diagnostic Centre is due to open on time end of August beginning of September this year. There are still a few risks around recruiting hard to find specialists, and it is not clear yet how long CQC will take to approve the site. This development will bring much needed additional x-ray, phlebotomy, ophthalmology, and ultrasound diagnostics to the heart of Haringey. Furthermore, the London Region have approved national submission of the phase 2 business case. This is a bid for £13m capital and £7m revenue to put in an MRI and CT scanners into the basement of the shopping mall. It now goes to the national team for final approval. **Wood Green Integrated Community Health and Wellbeing Hub** The proposal is to move our community, MSK, podiatry, dental, audiology etc, from Bounds Green, Edwards Drive, St Anns and Stuart Crescent to the Wood Green Shopping City. The consultation for this exciting development has now concluded and the general view is positive. Concerns raised include parking access, ensuring the design is bright airy and spacious but private, enough drop off space and disabled parking, the safety and security in the Wood Green area, accessibility, signage and wayfinding. All of these points will be mitigated through the ongoing design work and partnership working. The consultation will then be reviewed by Haringey Healthwatch before going to the overview and scrutiny committee on the 25th July. We have finalised the rental deal with the landlords, which will now be taken through the business case process, which will be joint with NMUH, BEH, GPs, and Council. The investment is likely to be £8m partly funded through the sale of some of the properties mentioned, hopefully to the public sector via the council or GLA. The business case should come to F&BD in the autumn. **Maternity and Neonatal Programme** This continues at pace, with planning permission documents having been sent at the beginning of July. We are aiming for approval in September and phase 1 work to start as soon as possible after	

	that. Key designs are now signed off by the clinical teams. Phases 2 onwards are being reviewed to align with the best business case options. The business case is expected to come to F&BD late summer. **Borough partnership work** Our engagement with borough partnerships continues to be strong. Key developments include the continuation of inequality funds projects and development of locality ways of working in both Haringey and Islington. There is a lot of discussion at the moment about the emerging role of "accountable person for place". The current thinking is that this is likely to be the chair of each borough partnership, but further work is needed to understand the implications of this role for us as a community and acute provider of health services. The Director of Strategy continues to influence this through the system design workshops. **Provider Partnerships** We continue to work ever closer with UCLH in many clinical areas. The oncology programme is coalescing around a UCLH@ type model, but we are still working through the implications of that model for aseptic pharmacy. The UCL Health Alliance (Provider Alliance) articles were agreed by private board last month and we look forward to continuing to work on key areas of mutual benefit. **Community Review** The review of community services for NCL has now concluded. The providers are working together in workstreams to implement various recommendations. We are proud to be leading on the Children's community workstream, and the adult virtual ward workstream. This will cement our place as leaders in the community field for NCL, and hopefully will bring much needed innovation funding and support. **Start Well Review** The NCL start well review has now concluded and published the case for change. We are well placed to help come up with solutions to the issues. For example, we are discussing with other trusts the opportunity for surgical collaboration. The next step is for proposals to be thought through over the next few months at a system level. We will be part of those conversations. **Fuller Report** The Fuller Report has now been published, supported by all the ICSs. We are hopeful that strategically this will be positive for us as we already work closely with GPs, PCNs and GP federations. The report has clear recommendations for locality teams which we have been instrumental in setting up in Haringey and Islington. It also talks about the need for estate work, which we again are well placed to respond to with our Wood Green Integrated Health and Care Hub.

Purpose	Noting
Recommendation	Board members are invited to note the strategy update
BAF	BAF risk Sustainability 2
Report history	None
Appendices	None