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, 25 November 2022** from **9.15am to 10.55am** in rooms A1 and A2 on the ground floor of the Whittington Education Centre, Highgate Hill, London N19 5NF & via video conferencing arrangements

Item	Time	Title	Presenter	Action
		Standing agenda items		
1.	*915*	Welcome, apologies, declarations of interest	Trust Chair	Note
2.	*916*	30 September 2022 public Board meeting minutes, action log, matters arising	Trust Chair	Approve
3.	*920*	Chair's report	Trust Chair	Note
4.	*925*	Chief Executive's report	Chief Executive	Note
		Quality		
5.	*935*	Quality Assurance Committee Chair's report	Committee Chair	Note
6.	*945*	Freedom to Speak Up Guardian report	Guardian	Note
7.	*955*	Annual Medical Appraisal and Revalidation report	Medical Director	Note
8.	*1000*	Patient experience story	Chief Nurse & Director of Allied Health Professionals	Discuss
		Performance		
9.	*1020*	Integrated performance report	Director of Strategy and Corporate Affairs	Discuss
10.	*1030*	Finance, capital expenditure and cost improvement report	Chief Finance Officer	Discuss
		Governance		
11.	*1040*	Q3 Board Assurance Framework and Q2 delivery of corporate objectives	Director of Strategy and Corporate Affairs	Approve
12.	*1045*	Workforce Assurance Committee Chair's report	Committee Chair	Note
13.	*1050*	Questions to the Board on agenda items	Trust Chair	Note
14.	*1055*	Any other urgent business	Trust Chair	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 30 September 2022

Present:	
Baroness Julia Neuberger	Non-Executive Director and Trust Chair
Dr Junaid Bajwa	Non-Executive Director
Helen Brown	Chief Executive
Kevin Curnow	Chief Finance Officer
Dr Clare Dollery	Medical Director
Professor Naomi Fulop	Non-Executive Director
Amanda Gibbon	Non-Executive Director
Chinyama Okunuga	Chief Operating Officer
Tony Rice	Non-Executive Director
Baroness Glenys Thornton	Non-Executive Director
Rob Vincent CBE	Non-Executive Director
Sarah Wilding	Chief Nurse & Director of Allied Health Professionals
In attendance:	
Norma French	Director of Workforce
Jonathan Gardner	Director of Strategy & Corporate Affairs
Tina Jegede	Joint Director of Inclusion and Nurse Lead, Islington Care Homes
Helen Kent	Assistant Director Learning & Organisational Development (item 2)
Tawanda Maposa	Interim Chief Information Officer
Marcia Marrast-Lewis	Assistant Trust Secretary
Dale-Charlotte Moore	Deputy Chief Operating Officer
Gemma Mullan	Teacher, Supported internships programme, Ambitious about Autism (item 2)
Swarnjit Singh	Joint Director of Inclusion and Trust Secretary

No.	**Item**
1.	**Welcome, apologies and declarations of interest**
1.1	The Chair extended a warm welcome to everyone present and was especially pleased to formally welcome both Chinyama Okunuga and Sarah Wilding to their first Board meeting at Whittington Health.
1.2	Apologies for absence were received from Sarah Humphrey, Medical Director for Integrated Care. Naomi Fulop declared that she was a Non - Executive Director for COVID - Bereaved Families for Justice and would be a core participant in the inquiry represented by solicitors.

2.	**Staff story – Ambitious about Autism**
2.1	Sarah Wilding introduced Gemma Mullan, a teacher and co-ordinator of the Supported Internship Programme, delivered at the Trust by Ambitious About Autism, a national charity for autistic children and young people. Gemma Mullan launched a short film about a recent graduate, Jake, who spent eighteen months on an internship programme at Whittington Health. She explained that Jake secured his first full-time post in the medical records department in July.
2.2	In the film, Jake explained that he had tried for some time to secure an apprenticeship, and that his determination paid off and he had secured a placement at the Trust. During his apprenticeship, he worked in the paediatric, orthopaedic, imaging and pharmacy departments. The placements helped him to develop a range of job skills and gave him good exposure to working in teams in a busy environment. At the end of the internship, he successfully obtained a job as a health records administrator in the medical records department. Jake expressed his pride with the completion of the programme and in securing a full-time job, for which he is paid a monthly salary. He was also proud of the fact that he was making a positive contribution to his local community.
2.3	During discussion, the following points arose: • Amanda Gibbon asked whether Jake required any adjustments or additional help in his work environment. Gemma Mullan explained that the department had access to an onsite team, on a five-day a week basis. The team consisted of teachers and co-ordinators as well as two job coaches, who would assist apprentices in learning and managing tasks. The coaches were also able to suggest any reasonable adjustments that were required. • Ongoing support was also available through the partnership model, working with Project Search, a transition to work programme for young adults with a learning disability or autism spectrum conditions, or both and a support employment partner, Kaleidoscope Saver, who offered follow-on support for the interns, though job coaches and funded through access to work. • Clare Dollery asked Jake if he had any reflections on the interview process. In reply, Gemma Mullan stated that Jake had the opportunity to access coaching and was therefore able to practice extensively for interviews, which had built his confidence. She noted that there were interns who were not as confident, or whose verbal communication skills were not as good, who would benefit from more accessible recruitment practices, such as work trials, rather than traditional interview processes. Gemma Mullan also confirmed that all interns required support to go through the online application process. • Swarnjit Singh paid tribute to Gemma Mullan and her team who provided clear, demonstrable evidence of the positive work in place to help tackle health inequalities for local disabled people. He suggested that the challenge for the organisation was to increase the number of successful internship placements in this programme, as well as

	increasing the number of apprenticeships available in a broad range of NHS professions for local people **The Board thanked Gemma Mullan and the Ambitious about Autism team for their work. The Chair also noted her thanks to Jake for his inspirational recording.**
3.	**Minutes of the previous meeting**
3.1	The minutes of the meeting held on 22 July 2022 were approved as an accurate record. The updated action log was noted.
4.	**Chair's report**
4.1	The Chair thanked staff who had worked through the long bank holiday weekend which marked the funeral of the late Queen Elizabeth II. The Chair requested that a note of thanks should be conveyed on behalf of the Trust Board to those that worked during the weekend.
4.2	The Chair also highlighted the visit on 7 September to the Trust's maternity services by Emily Thornberry, MP for Islington South and Finsbury, and Catherine West, MP for Hornsey and Wood Green. The MPs had welcomed the opportunity to learn about our plans as part of our maternity and neonatal transformation programme and gave Whittington Health their full support. **The Trust Board noted the report and agreed that a note of thanks should be sent to staff who worked through the Bank Holiday weekend.**
5.	**Chief Executive's report**
5.1	Helen Brown summarised her report. She formally welcomed Chinyama Okunuga who was completing her first week with the Trust, and she noted that Sarah Wilding, the Chief Nurse was also attending her first formal Trust Board in public.
5.2	Helen Brown acknowledged the hard work of the staff over the summer period, which had been busy and challenging. Operational pressures had remained high during September. She highlighted the continued work to progress elective recovery in outpatients and surgery. Helen Brown also apprised the Board on the work taking place to refine preparations for winter and to optimise flow through the hospital. Plans were developed on the basis that the full extent of the Trust's bed base would be utilised over the winter period.
5.3	Helen Brown highlighted the excellent performance of the diabetes team in the National Diabetes Audit. She also thanked staffed involved in the different activities as part of the "Caring for the those who care" month in September. During the last week, the focus had been on compassionate culture and restorative justice. and Helen Brown reiterated the importance of caring for the workforce and supporting the wellbeing of staff, particularly in challenging times.

5.4	As part of a verbal update on the latest position regarding Covid-19, Sarah Wilding reported that Covid-19 infection rates had increased nationally and that there were three inpatients that were Covid-19 positive and 11 post-infections. There were no patients in the intensive support unit and none that required oxygen support. Norma French reported that the level of staff absence peaked at 5% over the summer period. The staff absence rate at the start of September was 3.6%.
5.5	In relation to flu and covid vaccinations, Norma French advised that the opening of the staff vaccination clinic at the Trust had been delayed but staff could access vaccinations at the Hornsey Centre in the meantime. A hard launch of the campaign for winter flu jabs and Covid-19 vaccines for staff would take place on 10 October. Weekly monitoring and reporting would be undertaken to provide regular updates on the uptake of both vaccines.
5.6	Junaid Bajwa enquired about the current level of system working particularly around the management of operational pressures in primary care, versus the pressures of acute and community care, and whether any steps were being taken to boost resilience across the local health and social care system for the winter period. Helen Brown explained that a significant amount of work had been undertaken at a system level to harmonise effective collaboration. There were pressure points at every level, so all processes were constantly reviewed and prioritised to meet the demands and needs of the patients. She assured the Board that the North Central London sector was a very active and collaborative health economy with considerable joint working. The Chair echoed this view and reported that the North Central London Integrated Care Board had emphasised the need for providers to support each other over winter.
5.7	Chinyama Okunuga added that Operational Pressures Escalations Level (OPEL) at the Trust remained under review and would be looked at in conjunction with OPEL statuses across the local system to help determine the better use of mutual aid, if appropriate. **The Trust Board noted the Chief Executive's report**.
6.	**Quality Assurance Committee Chair's report**
6.1	Naomi Fulop presented the report which highlighted items discussed at the Committee's meeting held on 14 September 2022. The Committee took significant assurance from several items, notably the quarterly learning from deaths report, which highlighted the process of identification and recording of deaths but also the learning shared. Naomi Fulop drew attention to the pressure ulcer report considered at the meeting, which was an area of focus for the Trust. She explained that, while progress had been made in the reduction and measurement of the incidence of pressure ulcers at the Trust, the target of a 10% reduction had not been met. It was therefore agreed that a further progress report would be submitted to the Committee for review.

6.2	Naomi Fulop also highlighted a presentation received from Orthodontic and Community Dental services who were the winners of the Quality Improvement celebration event. The team had established a new pathway which involved giving advice remotely and had significantly reduced waiting times.
6.3	The Committee agreed its top three risks were workforce and sickness absence, the fragility of elective recovery and the delivery of elements of the capital expenditure programme which could potentially impact on the delivery of patient care.
6.4	Tina Jegede highlighted the need to ensure that pressure ulcers from care homes were reviewed to ensure that numbers were not double counted. Sarah Wilding provided assurance that the Tissue Viability Nurse and team routinely reviewed data on pressure ulcers. She also confirmed that there was an increase in the incidence of pressure ulcers across all NHS providers in London. She explained that the Trust would look at opportunities to work with the Tissue Viability Team to increase their resources. The Chair agreed that the reduction of pressure ulcers was an important element of high-quality care, and that the Board would welcome a progress update being brought to it through the Quality Assurance Committee in due course. **The Trust noted the report agreeing that a follow up report on pressure ulcer management at the Trust would be submitted to the Quality Assurance Committee and the Board.**
7.	**Audit & Risk Committee Chair's report**
7.1	Rob Vincent summarised the report, which outlined discussions held at two meetings held on 18 July and 20 September. The Committee took good assurance on many of the items discussed, including the counter-fraud assurance report, which had reported three attempts of fraud had been made on the Trust, all of which had been successfully avoided. The Committee also discussed consultant job planning, which had been an issue following an internal audit review, which had identified problems with the job planning process, particularly during the pandemic. Significant progress had been made and over 66% job plans had been completed.
7.2	Rob Vincent confirmed that the Committee had signed off a number of internal audit reports, with the exception of consultants that worked in private practice, as the Trust was yet to receive assurance that the consultants had declared their interest in accordance with standards of business conduct, where appropriate. Rob Vincent noted that the Committee had expressed concern that the process was adding more pressure on the Medical Director and the Associate Medical Director for Revalidation & Appraisal and sought assurance that appropriate resources were in place to carry out the work. Clare Dollery confirmed that good progress had been made with consultant job plans, and that significant work and resource would be carried out to address the issues with private

	practice declarations, which was at least partly a technical problem with the current software in place.
7.3	Rob Vincent confirmed the appointment of new internal auditors, RSM, who had taken over from Grant Thornton earlier in the year. RSM were slightly behind with their audit plan but were confident that they would make the necessary progress in good time. In the meantime, the Audit Committee would informally review reports ahead of the next meeting. where the reports would then be signed off. **The Trust Board noted the report and noted the improvements made in respect of the consultant job planning process.**
8.	**Integrated performance report**
8.1	Jonathan Gardener presented the report which was produced with inputs from clinical, operational and corporate teams. He advised that the report was also written with statistical process control (SPC) methodology, which was intended to help bring further understanding of performance against metrics.
8.2	Jonathan Gardner drew the Board's attention to the following areas: • Emergency Department (ED) four hours' waiting times over the summer period had been challenging and performance against the 4-hour access standard was 73.1%. There was a noticeable downward trend and pressures across the system were running high. There were 34 12-hour trolley breaches in August and high numbers of ambulance waits. • Cancer – performance against the faster diagnosis standard was 61.4% against a target of 73%, the 62-day performance was at 28.6%. There were concerns in gynaecological and colorectal cancers and work was progressing in both areas to reduce waiting times. • While two-week breast symptom activity was low in July 2022, the faster diagnosis standard for breast cancer was achieved. • At the end of August 2022, there were 479 patients who had waited more than 52 weeks for treatment. It was expected that the target for no patients waiting for more than 78 weeks would be met. • During August, elective recovery activity levels were at 98% against a target of 104% of 2019/20 activity; day case and elective activity was running at 129% mainly due to high levels of activity in endoscopy services. • A good improvement had been made in the number of days to hire, which reduced from 100 in July to 84.1 in August, against the target of 63 days. • The compliance against mandatory training was 84.3% in August 2022, a drop of 2.7% compared to the previous month, against a target of 90%.
8.3	In relation to cancer standards, Clare Dollery confirmed that a task and finish group was in place for breast cancer services within the Cancer Alliance Network. The Group would look at a number of different

	pathways and models around the country to help, including a single point of access approach.
8.4	Amanda Gibbon observed that 12.5% of patients left the accident and emergency department without being seen and sought assurance on steps being taken to determine the level of harm experienced in such cases. Clare Dollery agreed that such data would be helpful. In the meantime, there were clinical pathways in place for patients that did re-present and that they would be seen by more senior staff. However, it was noted that, as patients could leave emergency care at any time, the earlier they left the more difficult it was to follow-up. Jonathan Gardner reflected that there could be steps to take if the pathway was known as some patients did go through to the urgent care centre. The Chair agreed and noted that many patients attended the emergency department when they had failed to secure an appointment with their general practitioner.
8.5	Junaid Bajwa noted that cancer standards had been below target for a very long time and wondered if this was connected to capacity or diagnostic issues. He queried whether there were processes that could be done differently, that might improve the Trust's position. In reply, Dale-Charlotte Moore confirmed that Whittington Health had benchmarked well compared with North Middlesex and the Royal Free relating to July for breast cancer performance.
8.6	Rob Vincent highlighted the continued struggle with elective waiting lists and wondered if there was any modelling that could be carried out to reduce lists to 2019/20 levels. Jonathan Gardner confirmed that work on the Trust's recovery trajectory had taken place. Chinyama Okunuga reported that internal targets for community services' waiting times would be established over the next few weeks.
8.7	Naomi Fulop drew attention to the community backlog and noted that there were no targets in place for community waiting times. Although some improvement had been made, waiting lists were still significantly long. She suggested that more information was needed in relation to the trajectory, to plan and take appropriate steps.
8.8	Amanda Gibbon queried whether staff would move from service areas to assist with the upcoming vaccination campaigns. Sarah Wilding explained that support was in place from the Occupational Health team to administer the Covid-19 and flu vaccinations together. Additionally, senior nurses had committed to spending some clinical time in the vaccination centres. **The Trust Board noted the report.**
9.	**Finance, capital expenditure and cost improvement report**
9.1	Kevin Curnow took the report as read. He drew Board members' attention to the following areas: • There were a number of escalation beds open above the funded level

	• Additional staffing costs had been required in emergency care pathways • The Trust recorded a deficit of £5.13m at the end of August, which was £1.95m worse than plan. • Non-delivery of savings on the Cost Improvement Programmes (CIP) meant we were approximately £1.7m off target.
9.2	Kevin Curnow clarified that the Trust's ambition remained to deliver a breakeven position on 31 March 2023. He reported that an external resource had been commissioned from Kingsgate to help identify further savings. Kevin Curnow also discussed potential solutions for intensive treatment unit (ITU) space, either through securing additional funding for the level of staff needed due to increased patient acuity or by exploring the possibility of using ITU services differently with system partners, or a combination of the two.
9.3	Kevin Curnow summarised the Trust's capital position. He stated that Trust had spent £4.31m out of its capital allocation of £30m as of the 31st of August 2022. It was therefore unlikely that the Trust would spend the entirety of its allocation and capital expenditure for the year would need to be reforecast. The Chair queried whether the capital underspend would impact any system working or capital limits and asked that the Board be kept updated on discussions with system colleagues. Kevin Curnow explained that previously a three-year allocation had been agreed with the Department of Health and Social Care by the North Central London system. It was unclear whether there would be a claw back on unspent allocations. He envisaged an increase in capital expenditure from November, as it was expected that project managers would be in place by then to take forward projects. **The Trust Board noted the report requesting that regular updates on the capital position was brought to the Board for assurance.**
10.	**Cost of living and supporting staff financial wellbeing**
10.1	Norma French presented the report and stressed that the need to support the financial wellbeing of staff had never been stronger, especially in the wake of the recent mini budget, high inflation and increases in the Bank of England's base rate. Norma French confirmed that Whittington Health was a London living wage employer. She reported that a review of all the internal and external benefits that were available across the organisation had been undertaken and were provided to staff through a financial hub on the intranet. In addition, a Cost-of-Living Group had been established over the summer period and would continue to engage with staff.
10.2	The Chair reported that there was a willingness at system level to take action to help staff across North Central London. Amanda Gibbon confirmed that some excellent practical support was being provided to staff at the Royal Free and suggested that the Trust could offer more in the way of practical support, e.g., second hand clothing and school uniforms. Tony Rice highlighted the importance of staff taking proper breaks and noted the

	need for additional advice on fuel poverty concerns – an area which the Citizens' Advice Bureau had reported a significant increase of queries. He recommended that the Cost-of-Living Group look into this with a view of ascertaining the impact of increased fuel costs across the board.
10.3	Junaid Bajwa noted the linkages to anchor institution activities taking place locally. He suggested that contact should be made with the money saving expert, Martyn Lewis, to attend the Trust to give staff the benefit of his expertise. Naomi Fulop wondered if there was a role for the Charity to secure donations of non-taxable items that would help staff through the crisis.
10.4	Helen Brown noted that University College London Partners had published a helpful green guide on financial savings which would augment the financial wellbeing hub's signposting to different initiatives designed to save money. She agreed that the executive team would reflect further and see what other actions might be taken to support staff.
10.5	Jonathan Gardner advised that Camden and Islington Councils had produced leaflets for local residents on support during the cost-of-living crisis and the Trust would use these to help support patients and staff too. **The Trust Board noted the report and agreed that Martyn Lewis be approached to give advice to staff at the Trust.**
11.	**Charitable Funds' Committee Chair's report**
11.1	Tony Rice took the report as read. He highlighted the successful $250k donation to the Michael Palin Centre but noted that the growth in investment income would be impacted with current economic conditions and volatility of stock markets.
11.2	Glenys Thornton noted that a few staff members had entered the London Marathon and would be raising money for the Charity. She stated that there was still time to sponsor any one of the runners and encouraged Board members to do so. **The Trust Board noted the report and agreed that details of how to sponsor staff running in the London Marathon be circulated.**
12.	**Strategic projects update**
12.1	Jonathan Gardener updated the Board with progress on key projects at the Trust by highlighting the following: • Phase 1 of the Maternity and Neonatal building project was delayed due to slow procurement processes; however, it was expected that planning permission would be granted either at the end of October or in early November. The phase 2 business case for this project would be submitted to the Finance & Business Development Committee in November. • The Wood Green Community hub plans were progressing well, but the

	capital cost had increased. • The Community Diagnostic Centre had been opened and phase 2 work had begun. The formal launch of the Centre was expected to take place in October by the Secretary of State • Deloitte LLP had been commissioned to support the Trust with the development of a business case for a new Electronic Patient Record system. The business case was expected to be ready for approval in December. **The Trust Board noted the report.**
13.	**Questions from the public**
13.1 13.2	The Chair advised that several questions had been received which would be responded to separately. Mr Richards sought assurance that the use of technology would not disadvantage patients. Jonathan Gardner explained that the Innovation and Digital Assurance Committee had oversight of delivery of the Digital strategy and, one of the key aims was to ensure that information was effectively communicated to all patients irrespective of their technical resources or ability to access digital platforms. The Trust would continue to communicate through electronic means and also offer hard copy letter appointments.
14.	**Any other business**
14.1	The Chair, on behalf of the Board congratulated Huda Mohammed, Specialist Midwife, who received NHS England's Gold Chief Midwifery Officer award for her local, regional and national work and expertise in female genital mutilation and acknowledged her extraordinary commitment to vulnerable women in our local community.

Action log, 30 September 2022 Public Board meeting

Agenda item	Action	Lead(s)	Progress
Chair's report	Thank all staff who worked over the Bank Holiday weekend	Chief Executive	Completed
Quality Assurance Committee Chair's report	Submit a follow up report on pressure ulcer management to the Quality Assurance Committee and the Board	Chief Nurse and Director of Allied Health Professionals	A report on pressure ulcer management will be next reported to Quality Assurance Committee in January
Integrated performance report	Provide refresher training on Statistical Process Control for Board members	Director of Strategy and Corporate Affairs	Non-Executive Directors have been asked for interest and a date will be arranged in due course
Finance report	Continue to keep the Board apprised of discussions with system colleagues on capital expenditure plans	Chief Finance Officer	A verbal update will be provided at the November Part II Board meeting
Cost of Living for staff	Contact Martyn Lewis and review any additional actions and support that could be provided	Director of Workforce	Completed - Martin Lewis has been invited to speak to staff (and this has also raised with national NHS colleagues) - a response is awaited. Contact has also been made with Islington's Citizen's Advice Bureau to procure some support for staff. In addition, learning from colleagues at the Royal Free, we are currently working through the logistics to establish a clothes swap facility for staff.
Charitable Funds Committee Chair's report	Circulate to Board members details of how to sponsor staff running in the London Marathon	Trust Secretary	Completed
Any other business	Congratulate Huda Mohammed on her Gold Chief Midwifery Officer award from NHS England	Chief Executive	Completed

Meeting title	**Trust Board – public meeting**	**Date: 25 November 2022**
Report title	**Chair's report**	**Agenda item: 3**
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 Inclusion and Trust Secretary, and Julia Neuberger	
Executive summary	This report provides a summary of activity since the last Board meeting held in public on 30 September 2022	
Purpose	Noting	
Recommendation	Board members are asked to note the report.	
Board Assurance Framework	All entries	
Report history	Report to each Board meeting held in public	
Appendices	None	

Chair's report

This report updates Board members on recent activities.

Covid-19

First, I would like to thank our staff for their dedication and hard work in continuing to manage the high demand for services, to make preparations for winter and to continue to provide both Covid-19 and winter influenza vaccinations to our local residents and to staff colleagues. The health, wellbeing and retention of our staff is of paramount importance to Whittington Health, and, on behalf of the Board, I wanted to acknowledge the incredible pressures and fatigue staff have faced from the pandemic and from other factors, such as cost of living pressures.

Wood Green Community Diagnostic Centre

I am delighted to report that, on 25 October, the then Secretary of State for Health and Social Care, Therese Coffey, formally opened the Community Diagnostic Centre in the Wood Green shopping centre. The centre is an excellent initiative and is already making a positive impact by making it easier for people to access healthcare appointments for diagnostic tests.

October 2022 Board meeting and Annual General Meeting

The Board of Whittington Health held a private meeting on 28 October. The principal items discussed were updates on fire remediation and the private finance initiative building, an update on pathology services, an electronic patient record programme, a report of the meeting of the Innovation and Digital Assurance Committee, the integrated performance report and a financial and capital expenditure report.

I am pleased that the Trust also held its annual general meeting on 28 October in the recently re-opened Whittington Education Centre. The meeting included a review of achievements in the last financial year along with future plans.

Black History Month
On 3 October, along with Glenys Thornton, our Non-Executive Director lead for inclusion, I enjoyed speaking at the launch of the Trust's race equality network's Black History Month celebrations. I wanted to thank Father Adetola Badejo, who is a chaplain at Whittington Health and also chairs our staff race equity and nationality network, for his hard work in organising the celebration and all the other activities which took place over the month.

Corporate induction
On 14 November, I attended and met new joiners to Whittington Health at the monthly corporate induction.

University College London Health Alliance and North Central London Integrated Care Board
I have been attending regular meetings of the North Central London Integrated Care Board and frequent meetings with colleagues in the University College London Health Alliance.

Consultant recruitment panels
I am very grateful to Non-Executive Director colleagues for taking part in recruitment and selection panels for consultant posts, as follows:

Post title	Non-Executive Director	Selection panel date
Consultant in obstetrics & gynaecology and perinatal mental health	Amanda Gibbon	29 September
Consultant in obstetrics & gynaecology infection control and termination of pregnancy	Rob Vincent	6 October
Clinical Director, Dental services	Amanda Gibbon	27 October
Consultant, acute & general medicine with special interest	Tony Rice	1 November
Consultant geriatrician with special interest in surgical liaison	Tony Rice	1 November

Remuneration Committee
On 8 November, I chaired the Trust's Remuneration Committee meeting, which included reports covering the 2022/2023 annual pay increase recommendation for very senior managers and the implementation of a Recycling of the Employers' Pension Contributions policy, in line with guidance issued by the Secretary of State for Health and Social Care.

Remembrance service
On 11 November, a short Remembrance Day service was held in the upper atrium, including a two minute's silence to mark the eleventh hour of the eleventh day of the eleventh month - the Armistice moment - and to honour the sacrifices made by our servicemen and women. Both Helen Brown and I participated in reading short pieces, and the event was very moving.

Meeting title	**Trust Board – public meeting**	**Date: 25 November 2022**
Report title	**Chief Executive's report**	**Agenda item: 4**
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 30 September 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

Secretary of State

The Rt. Hon. Steve Barclay MP was re-appointed as the Secretary of State for Health and Social Care following Rishi Sunak MP becoming Prime Minister. He previously held this position between June and September 2022. On 16 November, the Secretary of State delivered the keynote speech at the NHS Providers' annual conference and exhibition[1]. In it he outlined priorities for the months ahead as supporting the NHS workforce, particularly through more staff for NHS 111 and 999 services, a continued focus on recovery plans for elective, urgent and emergency care, tackling delayed hospital discharges and improving access to primary care services. The speech confirmed that the £500m discharge fund previously highlighted by the government would be released shortly. In addition, the Secretary of State also acknowledged the importance of capital investment in the NHS. Details of other health and social Ministers and parliamentary under-secretaries can be found via this link: His Majesty's Government: Department of Health and Social Care - MPs and Lords - UK Parliament

Autumn Statement

On 17 November, the Chancellor of the Exchequer announced the details of the Autumn Statement. The announcement of an additional £3billion funding for the NHS for each of the next two financial years was welcomed. Other measures highlighted which will impact NHS organisations included a freeze on income tax thresholds for many income taxpayers and a lowering of the threshold for a 45% income tax rate to £125k and an increase in tax credits in line with inflation.

Commons Health and Social Care Select Committee

Steve Brine MP, a former junior Health Minister, was selected as the Chair of the Commons Health and Social Care Select Committee. He has indicated that prevention, cancer, mental health and workforce will be the Committee's priority areas.

NHS England new emergency care and deputy chief operating officer

At a national level, Amanda Pritchard, NHS Chief Executive, announced two important developments in the senior team. First, Sarah-Jane Marsh, Chief Executive of Birmingham Women's and Children's NHS Foundation Trust, was appointed as the new National Director of Urgent and Emergency Care and as Deputy Chief Operating Officer. Secondly, Professor Tim Briggs, programme lead for the national "getting it right first time" (GIRFT) programme has been appointed to a new role as National Director for Clinical Improvement and Elective Recovery.

Industrial action

At the time of writing this report, it is clear that, following the outcome of their ballots, industrial action will be taken by some NHS unions who are in dispute over the 2022/23 pay award. On 1 November, Mike Prentice, National Director for Emergency, Planning and Incident Response, and Navina Evans, Chief Workforce

[1] Health and Social Care Secretary: NHS Providers Conference - GOV.UK (www.gov.uk)

Officer, sent a joint letter to NHS leaders advising on the actions to take in preparedness for industrial action. These included ensuring minimal disruptions to patient care and emergency services and to maintain constructive relationships with trade unions and staff side representatives. The communication asked local Integrated Care Boards to help to co-ordinate planning for, and the management of. any industrial action.

NHS Providers
Julian Hartley, Chief Executive at The Leeds Teaching Hospitals NHS Trust has been appointed as the next Chief Executive of NHS Providers, the membership body representing every NHS hospital, mental health, community and ambulance service in England. Julian will take up his new position from 1 February 2023.

Start Well
Locally, the Trust remains well engaged with the North Central London Integrated Care System's Start Well[2] initiative which aims to ensure that the best care is available for pregnant women, babies, children, young people and their families. On 14 November, executive team members received an update on progress from the Programme Director.

COVID-19 and winter influenza vaccinations
As part of the autumn booster campaign taking place across Whittington Health's sites, every member of staff has been encouraged to have a Covid-19 booster and winter influenza vaccination to help protect themselves, patients and their colleagues. As at 16 November, The current vaccination rates are shown in the table below as at 16 November and provide a benchmark against national and local vaccination rates:

	Covid-19 vaccination	Flu vaccination
National	42.3%	39.7%
London	34.9%	31%
North Central London	36.9%	31.9%
Whittington Health	29.8%	27.9%

The Executive team has been considering what further steps we can take to improve uptake as a key part of our work to ensure we are in the best possible position to deliver care over what is undoubtedly going to be a challenging winter period, with indications that flu prevalence is expected to be high this year.

Deputy Chief Executive and Chief Information Officer appointments
I wanted to report on two appointments to Whittington Health's senior team. First, Kevin Curnow, our Chief Finance Officer, has also been appointed to the role of Deputy Chief Executive Officer.

[2] Start Well: Ensuring the best care for pregnant women and people, babies, children, young people, and their families - North Central London Integrated Care System (nclhealthandcare.org.uk)

Kevin is an experienced member of the executive team. In addition to his current responsibilities of Finance, Estates and Procurement, Kevin will deputise for Helen Brown, Chief Executive. In her absence, he will provide leadership, chair meetings and take any decisions required by the role of Accountable Officer for the trust.

Secondly, I am pleased to welcome Hugo Mathias who has joined us as Chief Information Officer (CIO) having previously worked as a CIO in other NHS Trusts for five years as well as in the private sector. He has a wealth of experience and has overseen the implementation of many projects.

With a background in analytics and healthcare planning, Hugo has developed early models in risk profiling patients, capacity models for new hospital builds and software solutions for collaboration and commissioning tools.

I also want to take this opportunity to thank Tawanda Maposa for so ably stepping into the acting CIO role and who will continue to work in key roles and projects within the information management and technology directorate.

Operational update
On 16 November, staff from across the Trust met for a clinical summit as preparing for winter. Issues covered included a review of clinical risks in the ambulance service and emergency department and how risk can be distributed more evenly across the hospital and system, the winter bed plan and clinical model, and initiatives such as the virtual ward, criteria-led discharges and the importance of the COVID and Flu vaccination programme.

Congratulations to the Whittington diabetes team
Over 100 trusts from across England and Wales submitted data to 2020/2021 National Diabetes Audit. The Whittington team were ranked number one in, and number four in, two of the categories in type two diabetes care. I want to congratulate the diabetes team on this outcome. They have worked incredibly hard

to provide high quality diabetes services through the pandemic, continuing to provide diabetes clinics in addition to inpatient work and adopting remote or blended ways of working. This commitment has clearly paid off with these excellent results for our patients.

Medicines safety
This year's World Patient Safety Day was held on 17 September with a theme of 'Medication Without Harm'. To mark this, our Pharmacy team provided advice about ways to support staff on medication safety throughout the month. Key information and advice provided covered the safe storage of medicines, controlled drugs, medicines management audits, and how to get support from the pharmacy overnight.

Cost of living
As part of engagement activities taking place to support the health and wellbeing and resilience of staff, Whittington Health is holding four events on the impact of the current cost of living crisis. The purpose of these listening events was to understand the challenges staff face at this difficult time and to use the feedback to inform future support.

Health Care Assistant recruitment
On 15 November, the nursing recruitment team held a Health Care Assistant recruitment event. There was good engagement with local people who were interested in pursuing a career in the NHS. The event was very successful, from approximatley 90 attendees, 42 job offers were made on the day with further job interviews taking place before the end of the week.

Community Matron for sickle cell disease awarded the Queen's Nurse award
I am very pleased to congratulate Matty Asante-Owusu, a Community Matron for complex patients with sickle cell, who was recently awarded the Queen's Nurse award, in recognition of her demonstrating an exceptional commitment to patient care and nursing practice.

Prestigious award for our Orthopaedic team.
The Whittington Health Orthopaedic department won the Hospital of the Year Award as voted for by orthopaedic trainees on the Percival Pott rotation.

Meeting title	**Trust Board – public meeting**	**Date: 25 November 2022**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 5**
Committee Chair	Naomi Fulop, Non-Executive Director	
Executive director leads	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals, and Clare Dollery, Medical Director	
Report author	Swarnjit Singh, Joint Director of Inclusion and Trust Secretary	
Executive summary	The Quality Assurance Committee met on 9 November 2022 and was able to take significant or reasonable assurance from the following items considered: • Surgery & Cancer Integrated Clinical Service unit presentation – ward round proforma • Chair's assurance report, Quality Governance Committee • Elective recovery update • Board Assurance Framework – Quality Entries • Risk Register (Quality and COVID-19 risks) • Quarter one, 2022/23 Learning from deaths report • Quarter two, 2022/23 Quality report • 2021/22 Medicines Optimisation annual report • Quarter two, 2022/23 Maternity Transformation Board report • Bi-annual adults and children's safeguarding report • Nursing and Midwifery Establishment review • Victoria ward action plan • Lone working in mortuary report • Serious Incidents • Patient experience strategy Following discussion, the following three key risks were identified to be reported to the Trust Board: • continuing workforce pressures due to capacity and workloads • the increasing complexity of patients allied to the challenges in discharging patients • the challenge to adequately staffing flex beds opened in response to increased patient demand	

Purpose	Approval
Recommendations	Board members are asked to i. note the Chair's assurance report for the meeting held on 9 November 2022, in particular the Prevention of Future Deaths' notice following a Coroner's inquest and the Never Event declared on 27 October 2022 for a wrong side block; ii. note the recommendation to increase in the total score for the Board Assurance Framework entry, Quality 1 from 12 to 16; and iii. approve the approach to staffing as set out as indicated in the refreshed Birthright Plus calculations (see appendix 5)
BAF	Quality strategic objective entries
Appendices	1. Q1 2022/23 Learning from deaths report 2. 2021/22 Medicines Optimisation annual report 3. Bi-annual nursing and midwifery establishment review 4. Bi-annual adult and children's safeguarding report 5. Maternity service Board report

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	9 November 2022

Summary of assurance:

1. The Committee confirms to the Trust Board that it took either significant or reasonable assurance from the following agenda items:

Surgery & Cancer Integrated Clinical Service unit presentation – ward round proforma

Dr Max Wills delivered a presentation regarding a quality improvement project for the Intensive Treatment Unit (ITU) ward round proforma. Committee members learnt that there were generally low levels of satisfaction with the proforma in use in 2021. A new was developed in 2021 in response to survey findings and, as part of continuous improvement, a resurvey took place in 2022 and resulted in further medication of the proforma.

Survey responses demonstrated good engagement by junior doctors and consultants. Positive feedback was received on the comprehensiveness of the proforma, it being systematic in nature and of good quality. Going forward, plans included the streamlining of some sections and the removal of auto-pull data.

Chair's assurance report, Quality Governance Committee

The Committee noted the report which detailed discussions from the meeting held on 25 October 2022 where significant or reasonable assurance was taken from the majority of items discussed. The Medical Director drew Committee members' attention to the following areas where limited assurance was taken:

- **Adult and children safeguarding** – training compliance for level 2 safeguarding training increased to 79% at the end of September 2022, however, there remained challenges in staff engagement with training and the rollout of liberty protection standards in the face of current operational pressures
- **Health and safety** – two national patient safety alerts remained active and were being taken forward by the estates and facilities team. The first alert concerned the promulgation of a Food policy for the Trust which was due to be approved at the next meeting of the Health & Safety Committee. The second alert related to anti-barricade doors at Simmons House. A purchase order had been approved this week to enable the works to progress and liaison with colleagues at Camden & Islington NHS Foundation Trust was taking place as this was a shared facility
- **Responses to complaints** - performance in quarter two was 47% against a target of 80%. While this was an improvement from quarter one, it remained well below target

Elective recovery update

The Committee discussed activity performance as of 30 October 2022 and noted the following:

- Elective/day case surgery – 2,097 cases over the preceding four weeks which represented 114% of 2019/20 activity
- Outpatients – there had been 12,219 first appointments (97% of 2019/20 activity) and 11,446 follow ups (92% of 2019/20 activity)
- Long waiters had increased. There had been an increase of 93 patients compared with four weeks previously so that there were now 679 patients who had waited over 52 weeks since referral for treatment
- Diagnostics - unvalidated performance in October was 86.2%
- Community activity – there was a total of 43,952 contacts in October and 4,292 appointments remained unoutcomed on the system
- Community long waiters – the number of people who had waited longer than 52 weeks had increased by 9 cases to 161. Of these long waiters, 66% related to mental health in the Children and Young People Integrated Clinical Service Unit
- Cancer faster diagnosis standards (FDS) – performance against the 28 days FDS was 59.7% in August 2022 and 61.4% for July 2022. 35 patients had waited longer than 104 days and 107 patients had been waiting for 62 days or more

Assurance was provided to Committee members that the clinical summit scheduled for next week would be a real help in looking at the urgent and emergency care pathway and winter pressures. It was noted that staffing challenges in community services continued to adversely impact on some services. In addition, the Committee agreed that the position on mental health waits in the North Central London sector remained significantly challenging as services were overwhelmed at the moment. The Committee was able to take good assurance that the Wood Green Community Diagnostic Centre would make a positive impact on local people's health and on waiting times.

Board Assurance Framework (BAF) – Quality entries
The Committee discussed the BAF and agreed a recommendation to change the likelihood score for the entry Quality 1 from 3 to 4, giving a total score of 16 for this risk. The rationale for the change included significant overcrowding in the Emergency Department, general operational pressures across all services including staffing pressures and the fact that there had been an Opel 4 status in place for a number of weeks.

Risk Register (Quality and COVID-19 risks)
The Committee noted the progress being achieved in the review and prioritisation of risk register entries so that key risks were clearly identified and related to mitigating work taking place. During discussion of risk entries, the Committee was apprised that work was being taken forward by the estates and facilities team to either provide chiller cabinets or to review the ventilation in ward drug rooms. The Committee agreed that the Director of Environment be asked to attend all its meetings going forward.

Quarter one, 2022/23 Learning from deaths report
The Committee considered the report and noted that, during the period 1 April to 30 June 2022, there were 105 adult inpatient deaths reported at Whittington Health. During quarter one, 22 adult structured judgement reviews were requested and 14 had been completed and presented at departmental mortality meetings. Committee members were informed that there was one patient death in

quarter one which had been evaluated to be more than likely to be avoidable. The learning from this patient highlighted the need to promptly intervene surgically in patients with incipient large bowel obstruction and clearly counsel patients. The Committee also took assurance that the Summary Hospital-level Mortality Indicator (SHMI) for the data period April 2021 to March 2022 at Whittington Health was 0.91. Since the report was issued, the SHMI had fallen to 0.88, just above the threshold to be in the 15 NHS trusts who nationally had better than expected mortality rates.

Separately, the Committee was updated on the receipt of a Prevention of Future Deaths' (PFD) notice following a Coroner's inquest. The case involved an elderly patient who was not escalated and there was a lack of information that the patient was taking anti-coagulation medicine. The Coroner had asked why a mortality review had not been completed and the reasons for this not taking place were being investigated and was not assured that the clinician had reflected the treatment choices available. The PFD notice and a report on this case would be brought to a future Committee meeting.

Quarter two, 2022/23 Quality report

The Committee welcomed a detailed report and was able to take good assurance from the quarterly Quality report and noted the following issues:

- Positive initial feedback from the quality assurance visit to the cervical screening service. Further actions being taken in this area included the recruitment of a Colposcopy Consultant and additional administrative staff and also insourcing arrangements to help bring colposcopy waiting times down
- Good work being taken forward as part of the Better Never Stops initiative including positive feedback received as part of a review of Teignmouth Road. During quarter three, there had been weekly walk arounds in maternity services to help prepare for an inspection by the Care Quality Commission
- Focussed work continuing to take place as part of the Pressure Ulcer Improvement plan, despite vacancies and sickness absence levels in the team
- Clinical harm reviews were progressing well, and no harm had been identified in the cancer pathway
- The level of incidents reported remained below pre-Covid average levels. However, a high proportion involved abusive behaviour and needed intervention by security staff. The Trust had recently agreed a revised Violence and aggression policy and a significant amount of work had also taken place with staff in community services regarding the reporting of violence and aggression and racial incidents from patients

Committee members were also updated on:

- Work taking place to tackle the backlog of incidents which met the Duty of Candour requirements. It was noted that more than a third of the outstanding Duty of Candour incidents were pressure ulcers and actions to address this were also included in the Pressure Ulcer Improvement plan being led by the Deputy Chief Nurse
- Additional resource and support being provided to the Patient Experience Team at this time

- In August 2022, the Trust was notified of negative outlier status for the National Neonatal Audit Programme (NNAP). The outlier status refers to the audit standard for *Deferred cord clamping*, and for which results were three standard deviations from the expected measure. Assurance was given that the Trust has undertaken a QI project including the following measures with a very significant improvement in practice measured by a further audit:
    - Publication of a guideline on Optimal Cord management
    - Intensive training of obstetric and neonatal staff including a presentation at perinatal meeting, and simulation exercises.
    - Consideration of purchase of LifeStart neonatal resuscitation trolley NNAP have been informed of the progress.

2021/22 Medicines Optimisation annual report
The Committee took good assurance from the annual report presented by the Chief Pharmacist. In particular, they welcomed the key achievements outlined, including the automation of audits, the continued embedment of a patient safety culture, including the sharing of learning in the Spotlight on Safety internal publication, an increase in VTE risk assessment compliance to 95%, a positive external quality assurance inspection of Pharmacy Aseptic Services and the successful roll out of new treatments for use in sickle cell disease.

Quarter two, 2022/23 Maternity Transformation Board report
Committee members also took assurance from a report presented by the Interim Director of Midwifery which highlighted work being undertaken in the maternity unit. Updates included:

- The Trust had successfully implemented the seven immediate and essential actions included in the Ockenden report
- The progress being achieved against the 13 recommendations made following the external assurance visit, was being monitored by the Maternity and Neonatal Transformation Programme Board
- Good progress had been achieved in meeting the requirements of the 10 Maternity Incentive Scheme standards and arrangements were in hand to address three of the standards
- The upgrade of the Birth Centre was due to start in this financial year
- There was good evidence of sharing learning from serious incidents to help ensure a learning culture and approach in order to prevent future incidents

Committee members welcomed the successful recruitment of 25 new midwives who would be starting with Whittington Health by the end of the year. However, they noted that 5 applicants had withdrawn from the recruitment process and that there had also been four resignations. During discussion, Committee members were informed that the reasons for the withdrawals and resignations were being looked into – some reflected pay levels, and others were due to a relocation elsewhere in England. Glenys Thornton welcomed the detailed report and also fed back on a visit to the maternity service at Liverpool Women's NHS Foundation Trust.

Bi-annual adults and children's safeguarding report
The Committee received and reviewed the summary of adult and children's safeguarding activity undertaken in the six-month period from September 2021 to April 2022. Key points they were apprised of included the following:

- There continued to be an increase in both the numbers of referrals of adult cases and also their complexity
- Members of the safeguarding team were regularly involved in complex adult safeguarding discussion to help ensure safe discharges took place
- Concerns about the importance of following specialist care plans for residents in care homes was raised with both local Safeguarding Adults Boards and a training session for care home managers was delivered in partnership with the Trust's community matron for care homes to highlight the difficulties care homes faced in managing increasingly complex residents
- There had also been a similar increase in the complexity of children's safeguarding cases during the period with higher incidences of mental health, substance misuse and domestic abuse and also an increase in pre-birth referrals. The influence of social media was identified as a primary contributory cause of many of the adolescent mental health cases being seen
- Whittington Health continued to have robust arrangements in place to share the learning which arose from Local Safeguarding Practice Reviews. A significant point of learning concerned multi agency discharge planning from acute hospitals for children admitted with suspected non-accidental injuries. To help in this area, a North Central London working group would be established to look at safe and effective discharge planning alongside our partner agencies.

Nursing and Midwifery Establishment review
The Assistant Chief Nurse presented the report which assessed whether staffing levels were compliant with national workforce safeguards' guidance which incorporated the National Quality Board standards. The Committee noted that the safer staffing and skill mixes were carried undertaken in September and October 2022 for the following clinical areas: inpatient adult and paediatric wards, Simmons House, Emergency Department, neo-natal intensive care unit, theatres and recovery, day treatment centre and midwifery services. The Committee also noted that work was in progress to complete comprehensive reviews of staffing levels in community services (health visiting, school nursing, district nursing, children and adult community nursing) and ambulatory acute services.

The Committee welcomed the conclusions of safe staffing review and noted that, where increased investment in staff had been identified and supported by the Chief Nurse, it would be incorporated as part of respective business plans for integrated clinical service units. Furthermore, it was noted that separate staffing reviews were taking place to support both the additional "flex" beds put in place and an additional winter pressure ward.

Victoria ward action plan
The Committee was able to take good assurance from an update on progress with the implementation of the different elements of the Victoria ward action plan, including increased recruitment and retention, staff wellbeing, visible leadership, discharge performance and nursing quality indicators. The Committee welcomed the work taking place to help improve culture at monthly ward meetings and through listening events with the Freedom to Speak Up Guardian. Both the Committee Chair and Amanda Gibbon welcomed the improvements being made and stated they would undertake a visit to the ward in due course.

	Lone working in mortuary report The Committee received assurance from a report and risk assessment presented by the Chief Pharmacist on the strengthened lone working arrangements in the mortuary which included a standard operating procedure which took into account arrangements for upgraded CCTV and swipe card access. The Committee noted that the Human Tissue Authority had approved both the risk assessment and standard operating procedure and had agreed works put in place as part of its corrective and preventative action plan. **Serious Incidents** The Committee received an overview of Serious Incidents declared during August and September 2022 and noted the following: • Two Serious Incidents were declared during this period. The first case related to the death of a patient with dysphagia who was fed orally and aspirated. The second case involved the delayed escalation to the critical care unit of a patient who presented at the Emergency Department following a drug overdose • A Never Event was declared on 27 October. This case concerned a who patient came in for shoulder surgery which required the use of an interscalene block. A wrong side block occurred and an investigation is under way. The patient has no lasting physical effects and has completed their surgery. • An exceptional meeting with the Chief Nurse and Medical Director was being held to support the Integrated Clinical Service units to work through the backlog of serios incident investigations **Patient experience strategy** The Committee discussed the draft patient experience strategy and fed back suggestions for inclusion in the next iteration. These included an increased perspective and feedback from our diverse patient community, particularly from disabled people, carers, and also on tackling health inequalities.
2.	**Present:** Professor Naomi Fulop, Non-Executive Director (Committee Chair) Dr Clare Dollery, Medical Director Amanda Gibbon, Non-Executive Director (Vice Chair) Baroness Glenys Thornton, Non-Executive Director Chinyama Okunuga, Chief Operating Officer Sarah Wilding, Chief Nurse & Director of Allied Health Professionals **In attendance:** Deborah Clatworthy, Deputy Chief Nurse Isabelle Cornet, Interim Director of Midwifery Tina Jegede, Joint Director of Inclusion and Lead Nurse, Islington Care Homes Kat Nolan-Cullen, Compliance and Quality Improvement Manager Pauline Francis, Matron, Victoria ward Karen Miller, Head of Children's Safeguarding

	Clarissa Murdoch, Associate Medical Director, Quality Improvement & Clinical Effectiveness Marielle Perraut, Assistant Chief Nurse Theresa Renwick, Head of Adult Safeguarding Stuart Richardson, Chief Pharmacist Swarnjit Singh, Joint Director of Inclusion and Trust Secretary Carolyn Stewart, Executive Assistant to the Chief Nurse Dr Max Wills, Critical Care **Apologies:** Erum Jamall, Clinical Director, Children & Young People Integrated Clinical Service Unit Gillian Lewis, Associate Director, Quality Governance Paula Ryeland, Interim Head of Patient Experience

Meeting title	**Quality Assurance Committee**	**Date: 09/11/22**
Report title	**Quarterly Learning from Deaths (LfD) Report** Q1, 1 April to 30 June 2022	**Agenda item:**
Executive director lead	Dr Clare Dollery, Executive Medical Director	
Report authors	Dr Clare Dollery, Executive Lead for Learning from Deaths. Vicki Pantelli, Acting Business Manager to Medical Director Ruby Carr, Project Lead for Mortality	
Executive summary	During Quarter 1, 1 April to 30 June 2022 there were 105 adult inpatient deaths reported at Whittington Health (WH) versus 115 in Q4. 22 adult structured judgement reviews (SJRs) were requested for Quarter 1 and 14 of these have been completed and presented at department mortality meetings. There was one death this quarter evaluated to be more than 50:50 likely to be avoidable. The learning from this patient focused on the need to promptly intervene surgically in patients with large bowel obstruction. Patients needed to be counselled carefully about early intervention if they presented non-electively with obstruction. The Summary Hospital-level Mortality Indicator (SHMI) for the data period April 2021 to March 2022 at Whittington Health is 0.91. An overarching Mortality Review Group meeting took place on 11 August 2022. The meeting reviewed the learning from death reports and considered the mortality review process as a whole including a review of the Learning from Deaths Policy.	
Purpose:	The paper summarises the key learning points and actions identified in the mortality reviews completed for Q1, 1 April to 30 June 2022.	
Recommendation(s)	Members are invited to: • Recognise the assurances highlighted for the robust process implemented to strengthen governance and improved care around inpatient deaths and performance in reviewing inpatient deaths which make a significant positive contribution to patient safety culture at the Trust. • Be aware of the areas where further action is being taken to improve compliance data and the sharing of learning.	
Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register	
Report history	Presented at QGC on 25/10/22	
Appendices	Appendix 1: NHS England Trust Mortality Dashboard	

Quarterly Learning from Deaths Report
Quarter 1, 2022/23: 1 April to 30 June 2022

1. Introduction

1.1 This report summarises the key learning identified in the mortality reviews completed for Quarter 1 of 2022/23. This report describes:

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

2. Background

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

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

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

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

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

3. Mortality review Quarter 1, 2022/23

3.1 During Quarter 1, 2022/23 there were 105 adult inpatient deaths reported at Whittington Health versus 115 in Q4.

3.2 During Quarter 1, 2022/23 there were 0 paediatric deaths reported at Whittington Health.

3.3 Table 1 shows the distribution of deaths by departments/teams.

Table 1: *Death by Department/Team*

Department/Team	Number of deaths
Acute Admissions Unit (Mary Seacole North and South)	16
Cavell	12
Cloudesley	9
Meyrick	13
Critical Care Unit	14
Nightingale	13
Coronary Care Unit	9
Victoria	10
Coyle	8
Mercers	1
Child/neonatal	0
Maternal	0
Total:	**105 Adults**

3.4 Table 2a shows the total number of mortality reviews and SJRs required and how many of these reviews are outstanding.

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

	Number of reviews required	Completed Reviews	Outstanding reviews
Adult Mortality Reviews	81	15	66
Paediatric Mortality Reviews	0	NA	NA
SJR	22	14	8

3.5 Table 2b provides a breakdown of SJRs required by department.

Table 2b: *SJRs required for each department/team*

Department	Number of SJRs	Number outstanding
Acute Admissions Unit (Mary Seacole North and South)	2	0
Cavell	1	0
Cloudesley	1	0
Meyrick	4	1
Critical Care Unit	3	0
Nightingale	4	2
Coronary Care Unit	0	0
Victoria	3	3
Coyle	4	2
Mercers	0	0

Table 3: *Reasons for deaths being assigned as requiring SJR during Quarter 1, 2022/23*

Criteria for SJR	Number of SJRs identified	Completed SJRs	Comments
Staff raised concerns about care	1	1	
Family raised concerns about quality of care	2	1	
Death of a patient with Serious mental illness	4	3	
Death in surgical patients	0	0	
Paediatric/maternal/neonatal/intra-uterine deaths	0	0	
Deaths referred to Coroner's office without proposed cause of death	0	0	
Deaths related to specific patient safety or QI work e.g. sepsis and falls	2	2	
Death of a patient with a Learning disability	2	2	
Medical Examiner concern	7	3	
Serious Incident investigations	0	0	
Unexpected Death	1	0	
Concerns raised through audit, incident reporting or other mortality indicators	0	0	
Definite COVID-19 Health Care Acquired Infection (HCAI)	2	1	
Probable COVID-19 HCAI	1	1	Part of outbreak on ward
Intermediate COVID-19 HCAI	1	0	Part of outbreak on ward
Total including Neonatal Deaths	**22**	**14**	

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

3.7 The aim of this review process is to:

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

3.8 **Update on Previous Quarter's SJRs**

- For Q1 April to June 2021, 19 out of 23 SJRs have now been completed.
- For Q2 July to September 2021, 15 out of 24 SJRs have now been completed.
- For Q3 October to December 2021, 13 out of 20 SJRs have now been completed.
- For Q4 January to March 2022, 21 out of 29 SJRs have now been completed.

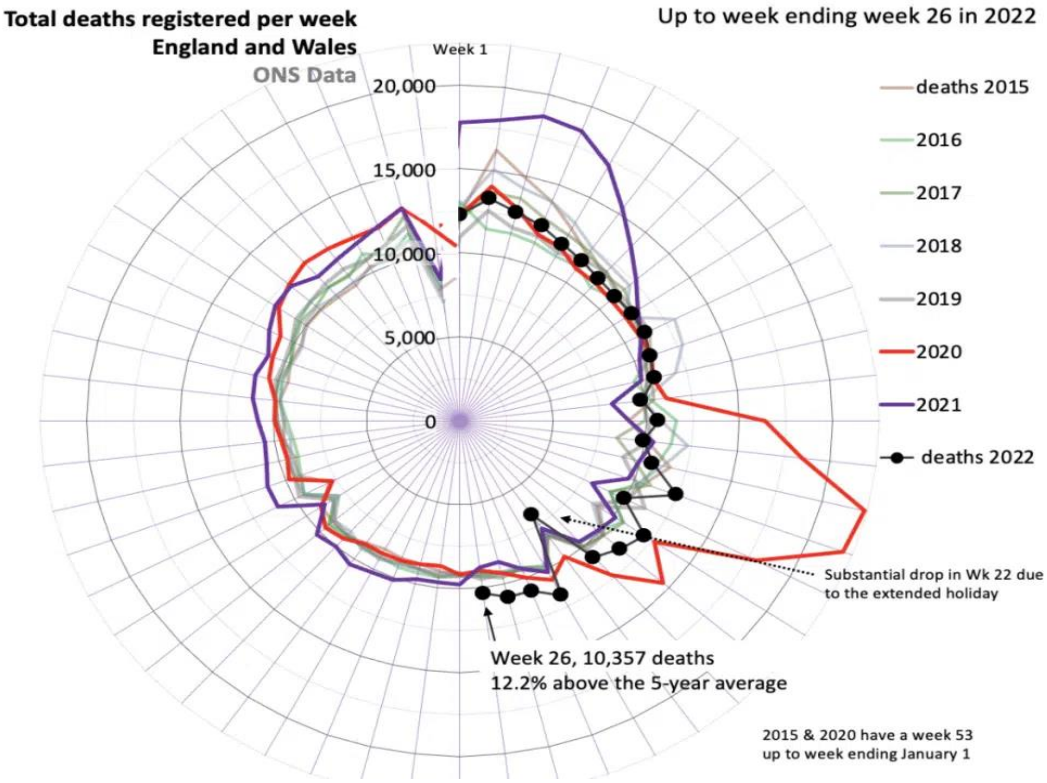
4. Mortality Dashboard

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

4.2 There were 105 inpatient adult deaths recorded in Quarter 1, 2022/23 at Whittington Health.

4.3 In week 26, ending 1 July 2022, 10,357 deaths were registered in England and Wales. This was 12.2% above the ONS 5-year average (2016 to 2019 and 2021). Of these deaths, 332 mentioned COVID-19 (2.4% of all deaths). The number of deaths was 23.3% above the five-year average in private homes (565 excess deaths), 23.3% in hospitals (403 excess deaths) and 9.7% above in care homes (162 excess deaths).

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

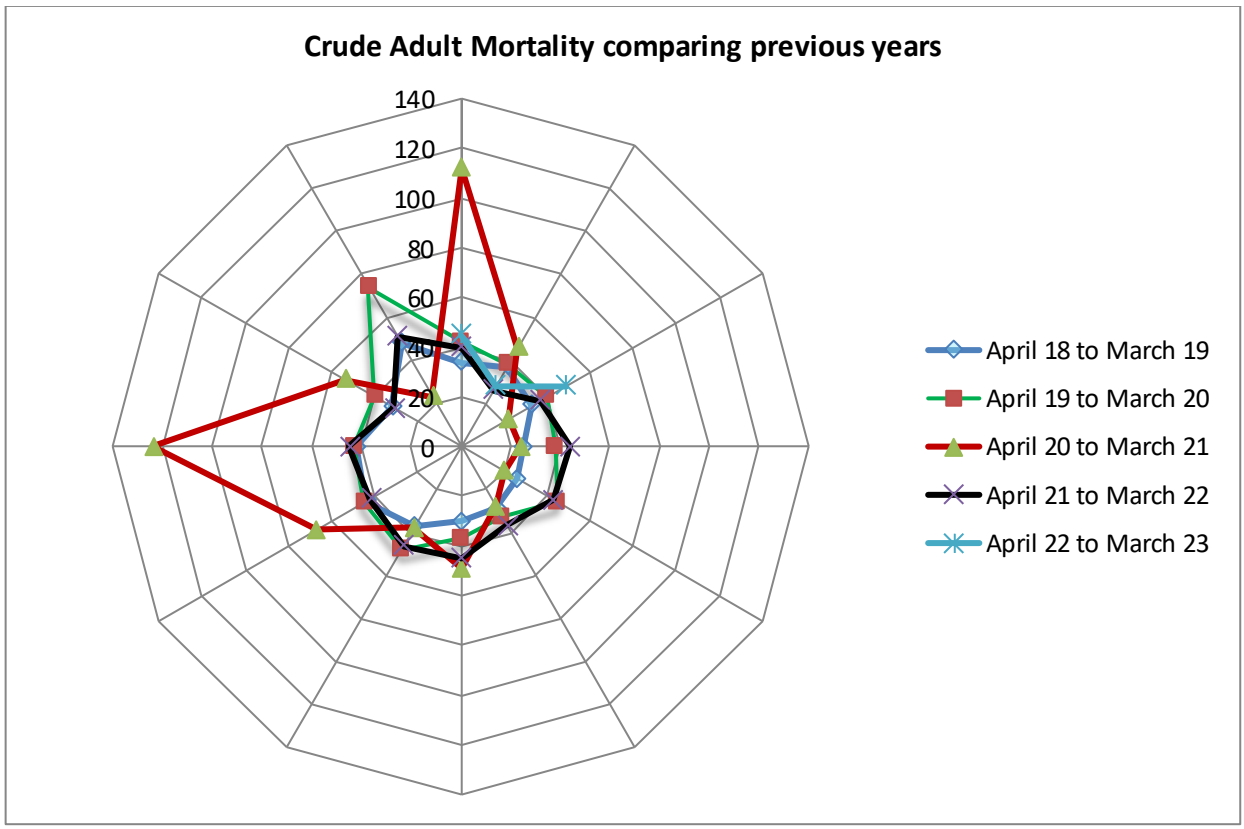


4.4 The radial graph below compares all causes of deaths (including ED deaths) in the Whittington hospital in 2018-19, 2019-20, 2020-21, 2021-22 with the year considered in this report 2022-23.

4.5 The number of deaths in Q1 2022/23 was 105 – 2 more deaths than the same quarter in the prior year.

4.6 There were 17 deaths in patients within 28 days of a positive COVID-19 test or with COVID-19 on their death certificate. This compares to 1 such death in Q1 2020/21. All of these deaths in Q1 2022/23 had pre-existing medical conditions. 3 were under 70 years of age and the remainder between 70 and 100. None of these patients had learning disabilities; none had serious mental illness and none were homeless.

Graph 2: Crude Adult Mortality comparing previous years



4.7 Table 4 reports the number of inpatient and ED deaths each month.

Table 4: Number of inpatient and ED deaths each month over the past 5 years

Month	April 18 to March 19	April 19 to March 20	April 20 to March 21	April 21 to March 22	April 22 to March 23
April	34	42	112	40	45
May	37	38	46	26	28
June	33	40	22	37	49
July	25	38	24	44	
August	26	45	20	43	
Sept	29	33	28	37	
Oct	30	37	49	45	
Nov	37	48	38	46	
Dec	44	45	67	42	
Jan	42	43	124	45	
Feb	32	40	54	31	
March	48	74	23	51	

5. Summary Hospital-level Mortality Indicator (SHMI)

5.1 The Summary Hospital-level Mortality Indicator (SHMI) for the data period April 2021 to March 2022 at Whittington Health is 0.91.

6. Themes and learning from mortality reviews Quarter 1 of 2022/2023

6.1 The importance of considering the diagnosis of necrotising fasciitis in the differential of skin infections was highlighted.

6.2 One patient's death was judged more than 50:50 avoidable – the learning focused on the need to promptly intervene surgically in patients with large bowel obstruction. Patients needed to be counselled carefully about early intervention if they presented non-electively with obstruction.

6.3 It was noted that for one patient fast track funding for a care package to facilitate the patient returning home to die only arrived once the patient had deteriorated to a point where they were too unstable to be moved. Hospital based end of life care was given to a good standard.

6.4 One review highlighted that mental health review was important for those with significant mental health issues and this was particularly important to consider in those having infrequent depot injections of their mental health medication as their mental health may deteriorate if this is overlooked.

6.5 Partial compliance with sepsis pathway was noted on one occasion– good for antibiotics within an hour but note that fluid boluses and measuring urine output are also essential early actions.

6.6 One review highlighted the difficulty of preventing COVID-19 acquisition in hospital where wards has positive and negative patients.

6.7 One review highlights the benefits of the input of the learning disabilities nurse to the care of a patient with learning disabilities and that early contact after admission was advised. The importance of accessing patient passports was also highlighted.

6.8 The benefits of a collaborative approach with the mental health liaison team were noted where a patient with significant mental illness declined a number of treatments and needed frequent reassessment of their capacity.

7. Dissemination of learning

7.1 This report is considered at the Mortality Review Group attended by the mortality leads from each specialty which allows them to disseminate onwards lessons.

7.2 Lessons from mortality reviews are included in the Trust-wide newsletter safety matters and specific cases have been the subject of patient safety forum presentations.

7.3 Teams hold mortality review meetings to discuss local cases and share wider learning between teams and jointly review cases

8. Mortality Review Group

8.1 An overarching Mortality Review Group meeting took place on 11 August 2022. The meeting reviewed the learning from death reports and considered the mortality review process as a whole including a review of the Learning from Deaths Policy.

9. Learning from Deaths Policy

It was agreed at the last Mortality Review Group that the non-mandatory criteria for the completion of SJRs would be updated as part of the learning from deaths policy review. It has been agreed that the non-mandatory criteria will align with the current quality account priorities and sepsis, diabetic ketoacidosis or a recent fall will be replaced with patients dying following treatment relating to blood transfusion. The policy is in the process of being updated and will be presented at Policy Approval Group in due course.

10. Update on Medical Examiner Service

10.1 The Lead Medical Examiner, Dr Ilana Samson, will be stepping down from the lead ME role but will continue to be part of the service as a medical examiner. Recruitment for a new lead Medical Examiner and a second Medical Examiner officer is being progressed.

11. Conclusion and recommendations

11.1 The Quality Governance Committee is asked to recognise the significant work from frontline teams and to recognise the learning from mortality reviews.

Whittington Health: Learning from Deaths Dashboard - June 2022-23

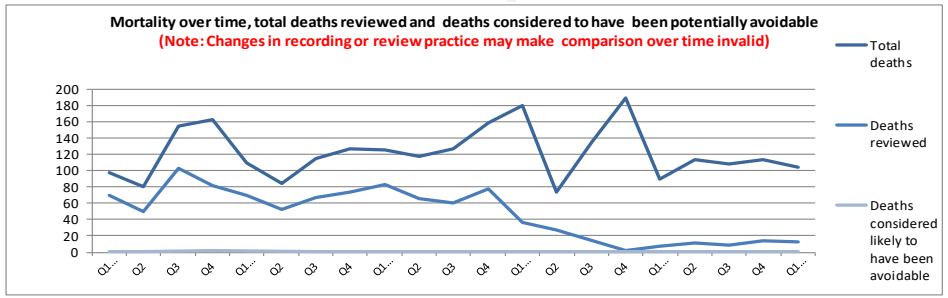
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
40	25	3	4	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
104	114	12	14	1	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
104	425	12	41	1	2

Time Series: Start date 2017-18 Q1 End date 2022-23 Q1



Total Deaths Reviewed by RCP Methodology Score

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

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	0	2	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	3	2	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	5	2	2	0	0

Whittington Health
NHS Trust

Medicines Optimisation Annual Report 2021/22

STUART RICHARDSON

Chief Pharmacist

Table of Contents

Section	Title	Page number
	Executive summary	3
1.0	Introduction	6
2.0	**Strategy, leadership and governance**	6
2.1	Strategy and leadership	6
2.2	Governance	7
3.0	**Safety**	9
3.1	Medicines Safety Group	9
3.2	Medication Incidents reported on Datix	10
3.3	NHS England Medicine Safety Improvement Programme (MedSIP)	11
3.4	NHS England Patient Safety Alerts	11
3.5	Controlled Drugs	12
3.6	Pharmacy Risk Register	14
3.7	Safety Focus and Plans for 2022/23	16
4.0	**Quality care and effectiveness**	17
4.1	Clinical Pharmacy Services	17
4.2	Antimicrobial Stewardship	22
4.3	COVID-19	22
4.4	Anticoagulation and VTE	23
4.5	Medicines Management	24
4.6	Homecare	25
4.7	Research and Audit	26
4.8	Clinical Trials	26
4.9	External Assessments	27
4.10	Patient Experience	28
5.0	**Digital Transformation**	29
6.0	**Finance**	31
7.0	**Improvement and innovation**	32
8.0	**Education, training and workforce**	34
9.0	**Whittington pharmacy community interest company**	37
10.0	**Final word**	39
	Appendix 1: Pharmacy Department Medicines Optimisation Strategy 2022 - 2025	41
	Appendix 2: Workforce, Digital and Education and Training Pharmacy Roadmaps	42

EXECUTIVE SUMMARY

The Medicines Optimisation standards specified by the Care Commission (CQC) and NHS Improvement require Trust Boards to receive an annual report to provide assurance on the use of medicines within the Trust. The Trust Drugs & Therapeutics Committee oversees medicines governance across the Organisation.

This report summarises the activities of groups and committees responsible for the management of medicines at Whittington Health NHS Trust and describes developments throughout the 2021-2022 year.

As a result of the COVID-19 pandemic and subsequent recovery, the NHS has been exposed to unprecedented pressures and has rapidly evolved to provide care in new and innovative ways. Consequently, additional focus continues to be placed on the safe and effective use of medications during this period. The Whittington Health NHS Trust Pharmacy team has risen to the challenge and have successfully worked locally and also across the North Central London (NCL) health system to ensure high standards of medicines management continues to be met, whilst also taking on new and expanded roles linked to the provision of COVID-19 therapies and associated programmes. This has meant that a risk-based approach has been taken to prioritise workload and balance business as usual with COVID related priorities throughout the year.

The Drugs & Therapeutics Committee (D&TC) has overseen the Trusts formulary throughout the year and has ensured the timely addition of all relevant NICE Technology Appraised medicines to the formulary. The group continues to work closely with the Joint Formulary Committee for to ensure that prescribing is aligned across the Integrated Care System A significant increase in clinical trial activity was facilitated during the year in support of research into COVID therapies and treatment pathways.

Core medicines related policies and guidelines ratified by D&TC were reviewed and updated as required throughout the year.

The Medicines Safety Group (MSG) continues to review medication related incidents across the Organisation, identifying trends and supporting risk reduction. All NHS England Patient Safety Alerts are reviewed, and their action overseen by the group. All COVID vaccine related incidents noted across the Trust including the Local Mass Vaccination Centre were fed into the NCL Vaccine Programme to support sector wide learning. A thematic approach to medication safety has been agreed and will continue in 2022/23. The trust had a positive engagement call with the CQC in year focussing on Medicines Safety throughout COVID. The team were commended by the Regional Aseptics Quality Assurance team for improvements and support to the COVID programme following an external inspection in year.

Incident reporting has fluctuated throughout the year subsequent to competing COVID related priorities. The total number of medicine incidents reported has reduced again this year compared with last year (13%). The number of incidents rated as moderate upwards remained similar to prior years but as a proportion of all medication incidents has increased from 1 to 1.5%. This mirrors a reduction in incident reporting in general across

the organisation. Significant focus will be given to increasing the reporting of medication safety related incidents in 2022/23. The majority of incidents were classed as ‘Near miss’, ‘No harm’ or ‘Low Harm’ indicating that staff are more open to reporting medicines related incidents, which subsequently encourages learning from incidents and the proactive implementation of safeguards. Key learning from incidents is disseminated through the publications Medicines Matters and Spotlight on Safety throughout the year.

Work has continued in the year to implement ‘Tendable’ an enhanced digital auditing tool in line with Internal Audit and CQC recommendations to undertake Safe and Secure Handling of Medicines audits and Controlled Drug audits within the organisation. This will enable robust ownership and oversight of audit outcomes and targeted action planning. Utilisation of the tool within the organisation already ensures a consistent approach to governance related activity. The development of a new role - Lead Nurse for Medicines Management - which will be recruited to early in 2022 will support embedding of robust medicines management across the organisation.

Risks relating to medicines are managed through the MSG and Pharmacy Risk Register. The top risks are reviewed regularly at the Divisional Board meeting and ICSU Quarterly Performance Reviews. All risks are under constant review and are being actively managed. Updates on mitigations in place are noted within the risk register. Implementation of temperature-controlled cabinets, enhanced security and storage arrangements for medicines across the trust continue and intend to complete in 2022/23.

Optimising the safe and effective use of medicines is a key component of the Digital Pharmacy programme. Whilst initial work with System C was paused last year, significant progress has been made in support of readiness for upgrade of the existing Electronic Prescribing and Medicines Administration (EPMA) Solution CareFlow Medicines Management (CMM) v8 SP1 which was launched in June 2022. A new anticoagulant electronic health record system was successfully implemented in Q4 enhancing patient care and safety within this service through improved interoperability with Trust and GP systems. VTE risk assessment compliance has significantly improved across the organisation following close working with IMT and enhancement of digital processes. Whittington Health were the first Trust in North Central London to go-live with the NHS Discharge Medicines Service (DMS) which involves suitable patients that meet pre-set criteria being referred to their nominated community pharmacy digitally utilising our EPMA solution. This is a National Medication Safety priority and will facilitate safer transfer of care across boundaries. It will become a CQUIN in 2022/23.

Medicine’s expenditure overall saw a 15% increase year on year, with a 12.5% increase non-cancer PbR excluded drug expenditure and a 25% increase in cancer related PbR expenditure. This increase has been driven through increased activity year on year as the trust supports recovery post COVID and following developments within Cancer Services.
In support of local partnership working and developing a cross sector workforce, we hosted 4 Preregistration Trainee Pharmacy Technicians (PTPTs) on a cross sector programme of training with a local Mental Health Trust and GP Federations. We had one trainee pharmacist complete a cross sector Foundation Year training programme with

Haringey Federation. We will continue to develop cross sector roles and rotations in 2022/23.

Whittington Pharmacy CIC (WPCIC), a Wholly Owned Subsidiary of Whittington Health NHS Trust, completed its fifth year of trading with a positive financial position, clean audit opinion and continued to demonstrate agility in the provision of medicines to patients during COVID and financial sustainability.

The optimisation of medicines use throughout COVID19 at Whittington Health NHS Trust continues to be a success this year and has seen significant enhancement in partnership working both internally and externally across the Integrated Care System. We will be refreshing our pharmacy and medicines optimisation plans in support of the learning and with a view to the future and living with COVID in 2022/23.

1.0 INTRODUCTION

Medicines management encompasses a range of activities intended to improve the way that medicines are selected, procured, prescribed, dispensed and administered.

This report summarises the activities of groups and committees responsible for the management of medicines at Whittington Health and describes developments throughout the 2021/2022 year and plans for 2022/23.

2.0 STRATEGY, LEADERSHIP AND GOVERNANCE

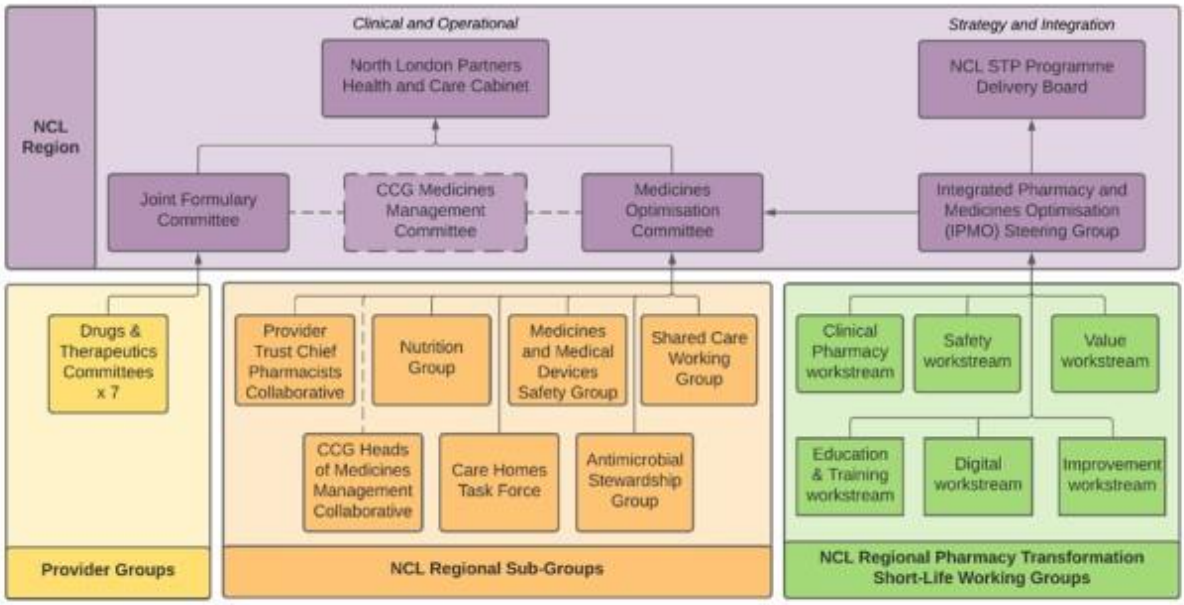
2.1 STRATEGY AND LEADERSHIP

The Executive Lead for Medicines Optimisation (MO) at Whittington Health NHS Trust is the Medical Director. The Chief Pharmacist in conjunction with the Chief Nurse & Director of AHPs and their corresponding teams work closely to support the MO agenda across the organisation and implementation of the Pharmacy and Medicines Optimisation Strategy (Appendix 1). This strategy outlines key areas of focus for the current and future 3-5 years aligned to the trust objectives and will be further refined over the next year to align with the development of the ICS and NCL wide Improving Pharmacy and Medicines Optimisation agenda.

The NCL Medicines Optimisation Network (MON) has a 'Vision to improve the health and wellbeing of people living in NCL, through the best use of medicines and pharmacy'. Two principal committees sit within the network: the Joint Formulary Committee (JFC) and the Medicines Optimisation Committee (MOC). To support integrated working across the region, these Committees include healthcare professional representation from primary care, provider Trusts (secondary care, tertiary care and mental health) and commissioning organisations. This arrangement provides the NCL MON with cohesive strategic medicines optimisation leadership across the sector ensuring the strategic direction and implementation of a co-ordinated ICS wide IPMO strategy in response to the NHSE 2019 Long Term Plan and People Plan.

The MOC has established sub-groups to lead on specific programmes of work, including Shared Care, Guidelines & Pathways and the IPMO transformation domains. Short Life Working Groups (SLWG) are created as needed, including the COVID-19 NCL Pharmacy Cell to address regional issues and deliver a regular update to NHS London throughout the pandemic. The figure below provides a summary of medicines related Committees, Sub-Groups and Short Life Working Groups across the NCL footprint, highlighting the relationship between the MOC and each of these. The Trust is well represented at all levels throughout the MON

Figure 1: Schematic of the Committees and Working Groups across the NCL within NCL forming the Medicines Optimisation Network



2.2 GOVERNANCE

Locally, the Whittington Health Drug and Therapeutics Committee (DTC) provide multi-disciplinary leadership to ensure appropriate management of medicines and the continuous improvement in the safe use of therapies within the organisation. This includes both acute and community settings.

The DTC meet every 2 months to consider new drugs applications, Patient Group Directions (PGD), medicines-related guidelines, ratification of treatments approved by NCL JFC and NICE, and any other issues concerning medicines management in the Trust. Several Trust groups report to DTC (see organogram below).

Increase the perspectives and feedback we receive from our diverse patient community The DTC also work collaboratively with the North Central London Medicines Optimisation Network (NCL MON), particularly with the NCL Joint Formulary Committee and the NCL Medicines Optimisation Committee. This collaborative work with NCL MON includes for example: local implementation of JFC and MOC decisions; sharing of information about local use of drugs or previous DTC decisions which may support JFC evaluations; review of draft JFC and MOC documents and gathering of local experts' opinion; maintenance of NetFormulary (NCL formulary platform).

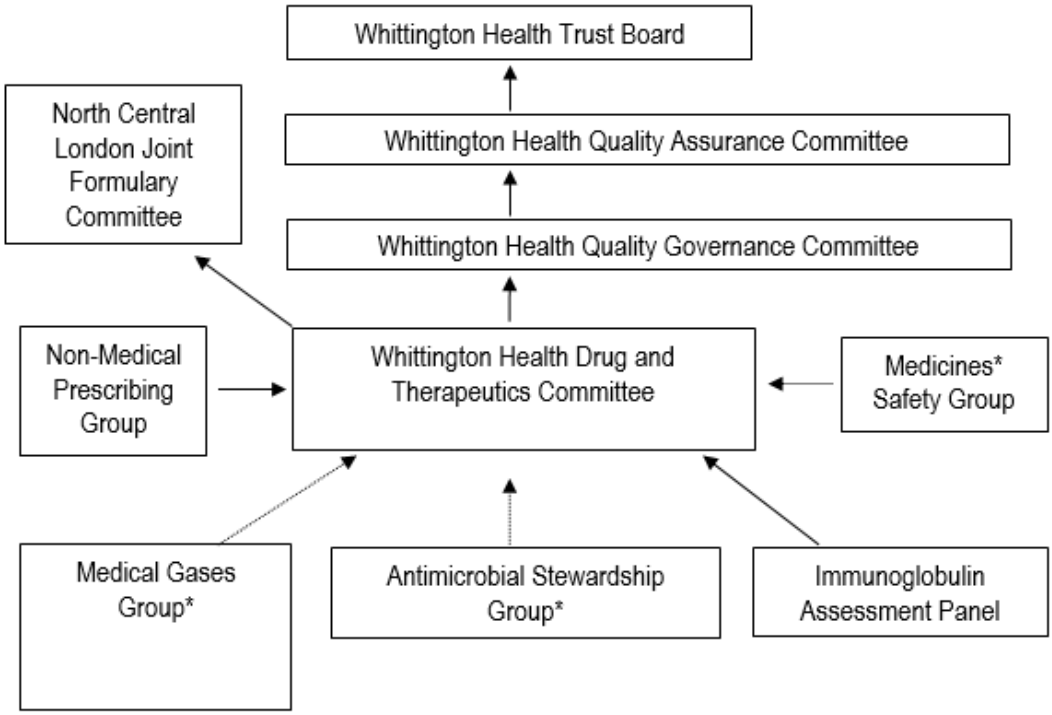


Figure 2. DTC reporting organogram.

*Note additional reporting arrangements:

- The Medical Gases Group formally reports to the Health & Safety Committee, with patient safety related aspects escalated via the DTC. The MGG will provide a report twice a year to the DTC.
- The Medicines Safety Group formally reports to the Drugs & Therapeutics Committee, but also reports twice a year to the Patient Safety Committee.
- The Antimicrobial Stewardship Group formally reports to the Infection Prevention and Control Committee but shares quarterly reports with the DTC.

DTC in 2021/22:

- 6 regular meetings held; 1 ad-hoc meeting to discuss Medicines Policy.
- 23 documents reviewed and approved among medicines-related guidelines, PGDs and medicines policy. For example, this included approval of a PGD, with supporting guideline, for the supply of aspirin to pregnant women at risk of pre-eclampsia, to ensure alignment with NICE guidance and increased access to treatment by patients.
- 60 NCL JFC and 36 NICE treatments ratified and added to the WH formulary (pending further actions if relevant). This included crizanlizumab, a new agent approved by NICE for preventing recurrent sickle cell crises in patients aged 16 or over, which will have significant impact on our patient population (Whittington Health is a haemoglobinopathy specialised centre). A new guideline was also produced to support the implementation.
- 108 requests for ‘one-off’ use of non-formulary drugs were reviewed, 80 approved.

- Oversight of controlled drugs usage, medicines management audits, antimicrobial stewardship, drug budget and cost pressures and COVID-19 vaccination.

The DTC continued to be instrumental for the internal approval of COVID-19 treatments and vaccination. As new evidence emerged and national guidance was updated, guidelines, PGDs and other supporting documents were rapidly produced/reviewed and approved by DTC, ensuring patients had access to the most cost-effective, evidence-based treatments and vaccination.

3.0 SAFETY

3.1 MEDICINES SAFETY GROUP

The Medicines Safety Group (MSG) meets every two months and reports into the Drugs and Therapeutics Committee (DTC) and Patient Safety Group (PSG). The MSG consists of representatives of different staff groups and services and is chaired by the Deputy Chief Nurse.

Standing items on the agenda include review of medication incidents reported on Datix, report on medication incidents referred to the Serious Incident Executive Advisory Group (SIEAG), MHRA and company drug alerts and NHS England Patient Safety Alerts.

Themed meetings have been carried out during 2021/22 – themes have included, controlled drugs, medications and Parkinson's Disease, the switch to enoxaparin for VTE prophylaxis, gentamicin prescribing and the new NHS steroid emergency card. Focusing on key themes has enabled a more targeted approach to medicine safety, that reflect the wider patient safety agenda for WH. As a result of this focus, there have been Trust wide initiatives to try and improve the safety around some of these higher risk areas.

During Q1 of 2021, the Trust focused on a CD awareness week which highlighted some of the key learning points relating to the safe handling, prescribing and administration of CDs. This was a truly multidisciplinary, multi modal approach and involved the delivery of digital and in person teaching sessions, engagement from Metropolitan Police colleagues and the launch of an intranet hub for controlled drugs to support staff with some of the more frequently encountered issues when handling CDs.

Another key piece of work linked to the MSG focus areas saw the delivery of a Trust wide educational event linked to the provision of Parkinson Disease medications. This was delivered through the organisations Patient Safety Forum in collaboration with specialist nursing and pharmacy colleagues.

As the Trust's Medicines Safety Officer (MSO) is a core member of the MSG, they will proactively link in with the Trust's patient safety team and aim to develop collaborative, cross cutting educational events linked to medication safety.

3.2 MEDICATION INCIDENTS REPORTED ON DATIX

The Medicines Safety Officer (MSO) sends monthly reports to the Clinical Directors and Risk Managers of the Integrated Clinical Service Units (ICSUs) and presents a bi-monthly combined summary to the MSG for discussion: this reports themes and trends.
Medication incidents reported yearly since 2018/19:

Year	Number of medication incidents reported	Number of incidents causing moderate or greater harm
2018/19	623	7
2019/20	627	8
2020/21	604	7
2021/22	525	8

The last two years have seen a decrease in medication incidents reporting – this is possibly due to the change in usual hospital activity during the COVID pandemic. This is mirrored in an overall reduction in incidents reported across the Trust.

Benchmarking medication incident reporting against other organisations would suggest that there is opportunity to increase incident reporting of medication related incidents in support of further learning and enhancing the safety culture. This will be a focus in 2022/23.

Incidents involving the administration of drugs continue to be the most frequently reported type of incident, followed by controlled drugs, omitted doses, and then prescribing and dispensing incidents.

With regards to the staff group, the highest reporters of medication incidents are hospital nursing staff followed by pharmacy staff and district nursing staff.
The Emergency and Integrated Medicine ICSU reports the greatest number of medication incidents.

Learning from incidents

All medication safety incidents are reviewed by the MSO and trend identification and subsequent learning is shared throughout the organisation in the following ways:

1. Articles in ‘Medicines Matter’. This is a quarterly Pharmacy publication that is sent to all staff and available on the intranet.
2. Articles in Spotlight on Safety. This is a bi-monthly publication produced by the Risk Department and available on the intranet.
3. Presentations to the monthly Patient Safety Forum (PSF). This is chaired by the Medical Director for Patient Safety. Topics in 21/22 have included:
    - Controlled drugs incidents – presented by the police CD liaison officer

- The introduction and use of the new steroid emergency card
- Parkinson's disease medication – 'get it on time campaign'
- An adult asthma case focussing on omission of medicines

4. Learning within and supported by pharmacy

    - Regular clinical pharmacy teaching sessions and weekly pharmacy team meetings
    - The Pharmacy Department 'medicines safety message of the week'
        - Pharmacy team leads report and discuss medication incidents to their ICSU Quality & Safety Meetings.
        - Feedback to ward staff via the ward pharmacy network.
        - Feedback to the local Medicines Safety Officer & MDSO network – this includes community colleagues as well as other local hospitals.

5. Individual feedback is also carried out via Datix by the MSO during investigation of incidents.

3.3 NHS ENGLAND MEDICINE SAFETY IMPROVEMENT PROGRAMME (MEDSIP)

The WH Pharmacy team aim to incorporate the key themes of the MedSIP plan into the local medicines' safety agenda. The key ambitions of the MedSIP programme are as follows:

- to reduce medicine administration errors in care homes by 50% by March 2024.

- to reduce harm from opioid medicines by reducing high dose prescribing (>120mg oral Morphine equivalent), for non-cancer pain by 50%, by March 2024.
- to reduce harm by reducing the prescription and supply of oral methotrexate 10mg by 50%, by October 2021.

In 21/22, the Pharmacy team have produced focused activity on opioid usage in the Trust and have delivered specialist teaching in conjunction with the Acute Pain service at the Trust. Additionally, the MedSIP work also links to key areas of the NHS Long Term Plan which include the safe use of anticoagulants. The WH Pharmacy team have senior specialist pharmacists working in anticoagulation who lead on this work for the Trust. The team also support colleagues across NCL, with a particular focus on the education and development of Primary Care Pharmacy teams who may not be as familiar with some of the medications now being commonly used in NCL.

3.4 NHS ENGLAND PATIENT SAFETY ALERTS (PSA)

The MSG and MSO work with the Trust Compliance Officer to develop action plans and ensure completion dates are adhered to. Details of all PSAs can be found on Datix. The

PSA alerts relating to medication in 21/22 are detailed below. All the alerts have been actioned by Pharmacy teams.

Alert Reference	Alert Title	Date Issued
NatPSA/2021/004/MHRA	Recall of Co-codamol 30/500 Effervescent Tablets, Batch 1K10121, Zentiva Pharma UK Ltd due to precautionary risk of causing overdose	June 2021
NatPSA/2021/007/PHE	Potent synthetic opioids implicated in increase in drug overdoses	August 2021
NatPSA/2021/008/NHSPS	Elimination of bottles of liquefied phenol 80%	August 2021
NatPSA/2022/001/UKHSA	Potential contamination of Alimentum and Elecare infant formula food products	March 2022

3.5 CONTROLLED DRUGS

The Pharmacy Department has responsibility for the governance surrounding the safe and secure handling of Controlled Drugs within the Trust to fulfil current UK legislation such as the Misuse of Drugs Act 1971 and Controlled Drugs (Supervision of Management and Use) Regulations 2013 DOH.
The governance arrangements in place currently include:

- Quarterly audits on all wards and departments in Whittington Hospital using the Tendable app as a way of ensuring accessibility to all staff and standardised practice.
- CD incidents are reported on Datix.

- CD Datix incidents are escalated to the Chief Pharmacist/Deputy Chief Pharmacist and reviewed by the Medicines Governance & Clinical Support Pharmacist and Medication Safety Officer.
- 72-hour reports are completed with any incidents of concern and taken to SIEAG this can include escalating to our allocated Police CD Liaison Officer for further advice. The incident is reported directly to NHS England Controlled Drug Division, Chief Pharmacist and Trust Controlled Drug Accountable Officer (CDAO).
- Local Intelligence Network (LIN) reports occur every financial quarter and are submitted to the NHS England CD Officer.

- Regular reviews are undertaken of our ordering and prescribing of CD's using ADIOS (Abusable Drugs Investigational Software) to identify any areas of above normal activity relating to CDs.
- Controlled Drug Policy (MP9) as part of Trust Medicine Policy has been updated to incorporate learning from Quarterly CD Audits in support of improved compliance, to reflect changes to our e-prescribing system and provides clear governance with CD reporting in response to incidents.
- Trust CDAO in place supported by the Chief Pharmacist, Deputy Chief Pharmacist, Medicines Governance & Clinical Support Pharmacist and Medication Safety Officer.

	2020/21	**2021/22**
Total number of CD incidents	113	124
No. of moderate to high-risk incidents	10	12

Figure 3: Breakdown of the CD incidents for 2021/22 by patient harm and risk rating

One case from the moderate to high-risk incidents of 2021/22 involved an unaccounted loss of Controlled Drugs. This incident was taken to the Serious Incidents Advisory Executive Group (SIEAG) following thorough investigation and reported to the Local Intelligence Network.

Due to the strict governance around controlled drugs, these incidents are routinely reported and escalated where appropriate to SIEAG. CD Audits occur at least every three months. All CD incidents are recorded on Datix where appropriate. All incidents are reviewed by the Medicines Safety Officer, Medicines Governance & Clinical Support Pharmacist, Deputy Chief Pharmacist. External communication with NHSE occurs via the Local Intelligence Network for shared learning across the sector and country.

3.6 PHARMACY RISK REGISTER

The Pharmacy Risk Register (PRR) is a subsection of the ACW ICSU risk register. Whilst the risk register predominantly incorporates risks associated with the delivery of pharmacy services, it also contains several risks associated with medicines management that are not necessarily specific to pharmacy.

The content of the pharmacy risk register is the responsibility of the Chief Pharmacist. The Chief Pharmacist delegates responsibility for the daily ongoing review of the PRR to the Medicines Governance & Clinical Support Pharmacist.

The PRR is formally reviewed once a month. All new risks are approved at the Quality and Risk Meeting and ICSU Board. Risks scoring above are 15 are noted at the ACW ICSU Board meeting and at ICSU Quarterly Performance Reviews.
At the end of 2021/22, there were 10 risks on the PRR graded as per the table below. 4 remain open and 6 have closed.

Risk	**Consequence**	**Progress and mitigations as at 31st March 2022**	**Current Risk rating**
OPEN			
Aseptic services chemotherapy isolator nearing end of life.	If isolator is not replaced this would significantly disrupt chemotherapy provision for patients	Capital bid for new Isolator, awaiting outcome at time of report.	12
HeliconHeart collective risk including: - Lack of interoperability requiring manual entry of information on Medway and ICE - Not auditable	Manual entry of information increases risk of error, which could lead to wrong dosing instructions to patients and increased risk to patient safety	Majority of initial risks mitigated with change to DAWN software, however, still lacks interoperability with ICE. Pathology scoping options for new/updated software to replace ICE.	3
Medicines shortage during COVID-19 for anaesthetics and end of life medications due to high demand	Omission of medicines due to unavailability may result in patient harm	Risk increased in year in view of increasing frequency of formal Medicines Shortage Notifications and challenges associated with contract changes. Close liaison with central medicines procurement services in place along with mutual aid agreements where appropriate.	16
Risk of duplicated prescribing on CAS cards and CMM	This can potentially cause duplicated or omitted medication administration during the patient stay causing patient harm	ED being scoped for implementation of CMM. Hardware infrastructure required to support implementation being worked up with PMO and	12

		ED team.	
CAS Alert NHSE/I-2020/003 Covid-19 Response – Oxygen Supply and Fire Safety	Number of oxygen cylinders and fire safety risk to patients and staff	Work ongoing to establish Ward and clinic stock levels for medical gas cylinders and ensuring all associated storage facilities and notices are in place.	10
Medical Gas Governance	Existing positions of governance arrangements in place	Awaiting draft for review and approval – escalated to Director of Environment	12
Trust wide compliance with the revised Royal Pharmaceutical Society Guidelines for the Safe and Secure Handling of Medicines	Includes swipe card access POD Cabinets Emergency Drug Cupboard	Swipe card access being implemented POD cabinets purchased following approval from Capital. Timeframe to completion dependent on installation on wards EDC Omnicell purchased- with view to use by end of 2022	12
Temperature Monitoring of Fridges used for Medicine storage	Temperature not adequately monitored for fridges with Kelsius	Under review discussing potential options to ensure reliable temperature monitoring of fridges	12
Medicine Storage and Handling	CQC and internal demonstrate need for continual monitoring at ward level of medicines storage and handling	Implementation of the medicines management audit on Tendable to facilitate monitoring.	6
High ambient temperatures of ward/unit treatments rooms	Temperatures fluctuate at ward level, high temperatures pose risk to medication integrity	Temperature controlled cabinets purchased, awaiting timeframe to completion dependent on installation on wards. In interim Temperature monitoring SOP in place, and medications reviewed weekly by Pharmacy team during extreme temperatures	16
CLOSED			
Non-complaint electrical and heating services within pharmacy department.	Funding for environment modifications approved and implemented. Refurbishment of selected office spaces.		12
Non-compliance with Quality Assurance requirements within Pharmacy Aseptics	CAPA in place and progressed. Further inspection in year – noted good progress. Deficiencies as at July		3

Suite - External Quality Assurance Audit noted 4 major, 8 moderate and 10 minor deficiencies	2021 reduced to 2 moderate and 6 minor.	
Reduction in income through NHSE contract associated with chemotherapy drugs	Risk closed following successful negotiation with NHSE for a fee per item model.	6
If NHSE reduce financial support afforded to Whittington Pharmacy CIC currently through a gain share agreement then financial viability of WPCIC jeopardised	Confirmation received from Income team that gain share arrangements remain in situ with NHSE and therefore the initial outlay of the CIC has been funded and ongoing costs are within the trusts baseline.	6
Windows and doors within the pharmacy store are not fit for purpose and result in a security risk for the safe storage of medicines	New metal door in place. New Alarm in place. Security gate repaired. Lights and camera in place.	8
Network failure and JAC	Upgraded to CMM June 2022- no longer an issue.	4
Trust not meeting NHS DM+D standards with JAC	Upgrade to CMM occurred in June 2022- now compliant with DM+D	5
Unclear prescriptions in out patients	Upgrade to CMM issue resolved	9
Faulty MAC Reports	Issue resolved with the EPMA upgrade	12
Electronic Prescribing and Medicines Administration System - Delay in System C implementation	Resolved CMM upgraded June 2022	10

All risks are kept under constant review and are being actively managed. Updates on mitigations in place are noted within the risk register.

3.7 SAFETY FOCUS AND PLANS FOR 22/23

- Support the National Patient Safety Day Autumn 2022/23 – this year's theme is medicines as per WHO 'Medication Without Harm' initiative.
- Develop effective working relationship with newly appointed medicines safety nurse.
- Completion and implementation of National Patient Safety Alert regarding inadvertent oral administration of potassium permanganate – due October 2022.
- Continue to contribute to Spotlight on Safety and Medicines Matter publications.
- Continue to support the Associate Medical Director for Patient Safety in organising topics and presenters for the Patient Safety Forum (PSF).

- Review membership of MSG with the aim of expanding to include nurse ward managers and junior doctors.
- Continued membership of the London MSO Group – recently re-started after COVID and maternity leave breaks.
- Continue to work with ICSU Risk Managers to support medication incident investigations.
- Review and standardise practice for medication provision over community services.
-

4.0 QUALITY CARE AND EFFECTIVENESS

The clinical needs of the patients seen at Whittington Health are becoming more complex. Polypharmacy, deprescribing and antimicrobial resistance are among the main challenges that face patients and their clinical teams. All these areas involve the use of medications and Pharmacy teams are best placed to support these patients with high quality and effective care. Some of the key clinical pharmacy areas for Whittington Health areas are discussed in more detail in later sections of this report.

As a result of these healthcare challenges, the role of the Pharmacy team has, in recent years, expanded. This has meant that the workforce is now able to take on higher level clinical responsibilities and form an integral part of the patient's healthcare journey.

Pharmacists are now responsible for the clinical management of patients in an autonomous manner and work directly with specialist nursing and medical colleagues and the wider health and social care team to optimise the patient's medication and their clinical outcomes. Pharmacists are now supported to become non-medical prescribers and advanced practitioners, with the Whittington Pharmacy department having specialist prescribers in Rheumatology, Elderly Care, Paediatrics and Cancer Services, with a plan to develop further roles in key clinical areas that support the needs of the local population of Whittington Health.

This shift in roles and responsibilities has impacted more technical members of the pharmacy team and Pharmacy Technicians and Pharmacy Assistants are now able to take on more diverse and highly skilled roles.

The department has recently developed a Clinical Pharmacy roadmap which outlines an ambitious plan for clinical pharmacy services at Whittington Health. The roadmap incorporates key areas such as education and training, workforce development, recruitment and retention and integrated clinical service provision. The plan will ensure that Pharmacy teams are providing the best care possible to patients and working in a joined up and integrated manner.

4.1 CLINICAL PHARMACY SPECIALTIES

Emergency and Integrated Medicine (EIM) ICSU

Key achievements in 2021/22 and priorities for 2022/23:

- In 21/22, the Pharmacy team working within Emergency and Integrated Medicine (EIM) has been successfully merged. Originally there were two separate teams - Emergency Medicine and Integrated Medicine which had two separate leads. Benefits of merging the pharmacy teams and having one overarching lead is that pharmacy now aligns with the Trust's ICSU pathway. This has helped to achieve better integration of the pharmacy services provided to the ICSU.

- New roles have been developed within the EIM team to optimise patient's medications and their clinical outcomes.
    - A Band 8a Biologics and Homecare Pharmacist role has been created to optimise the use of biologic drugs and enhance patient care with plans to provide a pharmacist led clinic in gastroenterology utilising independent prescribing skills.
    - A band 7 Emergency and Acute Medicine Pharmacist has been created which will focus on working in the SDEC area looking at polypharmacy, deprescribing and discharging patients safely into the community. The role will also look to improve ward services to the Emergency Department and SDEC unit on the weekends thereby introducing a 7-day pharmacy service across Emergency and Acute Services.

- Close collaboration with NCL and Trust MDT:
    - The EIM team works closely with multidisciplinary teams and other specialist pharmacists across North Central London (NCL) to share best practice and provide expert clinical and pharmaceutical input. This includes pharmacist representatives on the NCL Cardiovascular Disease & Stroke Prevention Network, NCL Respiratory Network and NCL Sustainability and lower carbon footprint inhalers group
    - Pharmacists working as part of core NCL working groups for cost improvement measures. i.e., Pharmacist representation at the NCL Edoxaban Working Group which is looking at implementation of edoxaban as a first line oral anticoagulant for Atrial Fibrillation and also reviewing and updating the NCL DOAC guidelines.
    - Joint work with multidisciplinary teams within the trust. There is pharmacist representation on the Sickle Cell Working Group which is helping to improve management of sickle cell patients at Whittington. Furthermore, a CD Task and Finishing Group was implemented and the EIM pharmacy team are leading on this to review CD incidents within the EIM ICSU and produce action plans.
    - The EIM Pharmacy team has worked closely with the multidisciplinary team to develop new guidelines such as the paracetamol (SNAP) protocol and alcohol withdrawal guidelines. Ferinject trust guidelines are also in development. PGDs have also been reviewed and new PGDs such as Plenvu (bowel cleansing preparation) are being developed following NCL JFC approval.

Surgery and Cancer ICSU

Surgery

Key achievements in 2021/22:

- Collaboration with MDT for new/updated clinical speciality guidelines and Patient Group Directions.
- Support to Dental Clinics preparation for CQC visit in relation to safe medicines management.
- Provision of clinical support to Pharmacy Procurement team in managing medicines shortages across surgical and critical care services, sourcing alternatives to ensure safe patient care is maintained (e.g., PCA CADD cassettes, remifentanil, diamorphine, IV fluids, tocilizumab/sarilumab).
- Introduction of new drug preparations for improved patient care (e.g., new strength morphine CADD cassette enabling subcutaneous PCA for sickle cell patients).
- Changes to the way resuscitation drugs are stored in paediatric areas maintaining patient safety and reducing drug acquisition costs, in collaboration with hospital resuscitation team.
- Implementation of updated online Parenteral Nutrition Ordering System.

Key priorities for 2022/23:

- Re-introduction of financial expenditure reporting for medicines at ICSU level.
- Improving patient and medicines safety in Theatres and Obstetric Theatres with implementation of ready to use, tamperproof emergency drugs.
- Reviewing pharmacy staffing levels and skill mix in surgical pharmacy team to ensure pharmacy service provision adequately supports the ICSU's priorities and national standards (e.g. GPICS).

Cancer

Key achievements in 2021/22:

- Successful implementation of Chemocare V6, an upgraded Chemotherapy prescribing solution.
- Positive External Regional Quality Assurance inspection of Pharmacy Aseptic Services.
- Facilitated timely access to new treatments ensuring all new protocols for systemic anti-cancer therapy (SACT) were built and validated for safety and clinical use.
- Led on the successful revamp of the Chemotherapy Authorisation pathway delivering a better experience for both staff and patients.
- Successful upgrade to version 3 for the reporting of the mandatory SACT dataset
- Facilitated the timely delivery of letters to cancer patients informing them of how to access COVID-19 treatments and on the appropriate vaccination schedules for their disease.

- Updated processes for the request and supply of intravenous immunoglobulin in line with the latest clinical commissioning policy and sub-regional/national guidance
- Facilitated the successful roll-out of new treatments for use in sickle-cell disease including Crizanlizumab used for preventing sickle cell crises.
- Supported the supply of nMABs for use in COVID positive patients
- Ongoing support provided to the WH:UCLH oncology collaboration team including modelling, capacity planning and monitoring of activity.

Children and Young People Services (CYP) ICSU

Key achievements in 2021/22:

- Development of JAC prescribing protocols for safer prescribing in paediatrics for newly diagnosed diabetic patients.
- Pharmacist secondary care representative at NCL Integrated Paediatric Service (IPS).
- Community paediatrics - new processes around ordering, storage and discarding for medicines management stock control and improved audit trail.
- Enhanced FP10 cost management with monthly reports on expenditure highlighting high-cost areas and non-formulary prescribing.
- Pharmacy support to new guidelines and supply issues (e.g., intranasal fentanyl guideline/ omeprazole guidance).
- Pharmacy led extended Palivizumab clinic reflecting NHSE and Joint Committee on Vaccination and Immunisation (JCVI) guidance.
- Pharmacist representative on WH CYP Learning Disabilities group (STOMP/ STAMP initiative).
- Adapting pharmacy service to changes within paediatric services – new Paediatric Short Stay Unit (PSSU) and Children's Ambulatory Unit (CAU) - restoring Paediatrics Emergency Department to one unit.
- Introduced digital ordering of neonatal total parental nutrition (TPN).
- Provide expert advice to NCL JFC about new medicines submitted for addition to formulary.

Acute Patient Access, Clinical Support Services and Women's Health (ACW) ICSU

Women's Health

Key achievements in 2021/22:

- New Aspirin PGD and guideline reflecting NICE guidance for Hypertension in pregnancy and NHSE Saving Babies' Lives (v2) care bundle.
- Pharmacist member on maternity unit group, inputting advice and providing updates on medicines supply issues and alerts.
- Pharmacist representative on Serious Incidents (SI) group involving medication incidents.

- Education and training of community midwives around reflection of medication incidents.
- Pharmacy “advent” calendar of medicine management education for maternity teams.
- Community midwives drop-in sessions – advice, support and training.
- Pharmacist education and training in “Ockenden Cafes”.
- Provided expert advice to NCL JFC about new medicines submitted for addition to formulary.

Adult Community Services (ACS) ICSU

Key achievements for 2021/22:

- Integrated new ICSU Lead Pharmacist position into the local ACS leadership structure.
- Implemented routine community safe and secure handling of medicines audits.
- Support set up for Community Diagnostic Centre (CDC).
- Build better networks across the ICB, utilising specialist staff already in place across the ACS team to represent Whittington and its values.
- Development of new roles with integrated ways of working. This year three members of staff have now started working across acute and community.
- Supported the development of staff with independent prescribing, otherwise not available in the acute setting.
- Supported high vacancy rates and challenges in recruitment with innovative and adaptive staffing.

Key priorities for 2022/23:

- Build out further pharmacy integration with both systems and staff in:
  - Virtual ward (Hospital at home)
  - OPAT
  - Rapid Response
  - Community Heart Failure
  - Community Respiratory
  - Islington Reablement
  - ICAT, MACTT and EHCH
  - District nursing – (EPMA and centralised medication management)

- Support key developments at an NCL level, leveraging the experience and practice already completed by ACS staff. Themes that will be prominent will include, training for domiciliary care workers, NCL wide medication guidance, standardised assessments in relation to medication provision, agreement on standards for compliance aid use and support with prescribing quality initiatives.

- Further improve governance within ACS through auditing, training and process reviews.
- Support service redesign, with pharmacy part of the essential requirements throughout anticipatory care.
- Support the future phased roll out of CDC.

4.2 ANTIMICROBIAL STEWARDSHIP

Outpatient Parenteral Antimicrobial Therapy (OPAT)

A pilot Antimicrobial Stewardship (AMS) / OPAT pharmacist post was trialled between January 2022 to August 2022 to work alongside the Consultant Antimicrobial Pharmacist whose remit has expanded significantly with the rapidly changing landscape of COVID-19 and related national drivers.

The aim of the AMS/OPAT post was to provide cost savings through improved service efficiency and quality of care. The COVID pandemic has highlighted the need for an efficient OPAT service to prevent hospital admissions, reduce length of stay, optimise discharges, prevent delays in accessing treatment and reduce rate of hospital-acquired infections.

Antimicrobial Point Prevalence Audit

The trust's AMS programme was suspended during the COVID19 pandemic. The antimicrobial point prevalence audit audits and AMS round were restarted in January 2022 with the fix-term pilot AMS/OPAT pharmacist post.

4.3 COVID-19

Pharmacy continues to provide essential operational, logistical and clinical support to the Whittington Health COVID-19 vaccination programme, which includes Hornsey Central mass vaccination centre, hospital staff and patient vaccination, in-school vaccination for children, maternity clinic and care homes & housebound in the community. The Consultant Antimicrobial Pharmacist is part of the NCL Clinical and Operation COVID-19 meeting group, providing support for mutual aids and movements of vaccine supplies, running campaigns to improve access and equality, and sharing best practices and learning experiences.

There were 3 different COVID-19 type vaccines that have been made available at WH (AstraZeneca, Pfizer-BioNTech and Moderna vaccines).

COVID-19 therapies continue to be implemented in a timely way, in-line with the DHSC and NHSE published Clinical Commission Policy. The workflow system and pathways have been setup by pharmacy to provide clear governance in ensuring the COVID-19 therapies are only used for patients who would most likely benefit from the treatment and

are able to have the treatment safely. All COVID-19 treatment supplied are recorded into the national Blueteq form and GPs are informed via the discharge letter. The COVID-19 therapies that were available in 2021/22 include 2 oral therapies (Dexamethasone, Paxlovid) and 4 intravenous therapies (Remdesivir, Tocilizumab, Sarilumab, Sotrovimab). Ronapreve (casirivimab and imdevimab) was removed as a treatment option in February 2022 since it was ineffective against Omicron variant.

4.4 ANTICOAGULATION AND VTE

The anticoagulation electronic health record DAWN was implemented in February 2022. The advantage of switching to this new system included:

- Full interface with Medway via Graphnet allowing patient anticoagulation data to be uploaded to Trust systems in real time.
- Full interface with EMIS via Graphnet allowing patient anticoagulation data to be uploaded to GP systems in real time.

The Trust VTE risk assessment compliance has increased to 95% since April 2022.
This has been achieved gradually:

- In May 2021, the VTE Risk assessment compliance was 73%. Initially education and training of Junior Drs, nurses and HCP was introduced (Trust Induction) and daily ward visits were planned to raise VTE profile.
- In November and December 2021, with the cooperation of the IMT team an electronic mandatory VTE risk assessment has been created and all patient admissions are now counted for general medicine and general surgery.

Root cause analyses of hospital acquired VTE are regularly considered both for education and training purposes and for reporting to Trust board/patient safety committee as required.

The plan is to engage all the other clinical areas and integrate the electronic mandatory VTE risk assessment form for all patient admissions. The main challenges are:

- the implementation of the electronic system for a specific clinical area which uses a different health record system (e.g., Maternity Medway)
- the introduction of a VTE risk assessment mandatory form into the pre-assessment note for Day treatment Centre patients (Elective surgical patients).

4.5 MEDICINES MANAGEMENT

Medicines Management Audits

As part of the measures to provide assurances to the Trust on the appropriate safe and secure handling of medicines, the Pharmacy team have historically coordinated a regular audit programme of medicines management at ward and clinic level. This will consider key aspects of managing medications in the clinical environment. Parameters which are reviewed include, but are not limited to, condition of medications, expiry dates, physical security of medications and oxygen usage.

Over the past 12 months, the Trust has made a significant investment in how these audits are conducted with the purchase and implementation of a new piece of software, Tendable®. Tendable® is a software package that helps to demonstrate compliance with local and national standards on a variety of quality standards, not just medicines management. The software will facilitate a more proactive approach to medicines management and produce outputs that can be acted upon in a timelier manner. It will also support the generation of aggregated reports which can be used to appropriately inform future practice and demonstrate compliance to appropriate regulatory bodies.

The Pharmacy team have already implemented Tendable® for completion of the quarterly controlled drug audits and will contribute to the Trust wide implementation project being run in 22/23 to ensure adoption of the software at ward level, for completion of nurse led monthly medicines management audits. To support this and a number of other medicines management related tasks, a new role, Lead Nurse for Medicines Management, is being designed that aims to bridge the gap between the pharmacy aspects of medicines management and the practical aspects of medicines handling at ward level, by nursing staff. A key part of this role will be to support the nurse led monthly medicines management audits.

Temperature Monitoring

Temperature monitoring is a key activity that is undertaken on a daily basis in all areas where medications are stored. This ensures that medications are not being stored in an environment whereby the stability and therefore, efficacy of the medication is compromised. There are two aspects to temperature monitoring: room temperature monitoring and remote monitoring of fridge and freezer temperatures.

Room temperatures are recorded daily by ward and clinic staff using calibrated thermometers placed in all areas which store medication. The ongoing calibration and monitoring of the thermometers is coordinated by Pharmacy teams. This is a key duty that is growing in importance due to the impacts of climate change. The Trust faces an ongoing challenge to the temperatures in some treatment rooms as they will occasionally rise above the acceptable storage temperatures of medication. This risk will be mitigated through the installation of temperature-controlled drug cabinets in those clinical areas which regularly exceed the upper limits of acceptable temperatures. The cabinets will maintain ambient temperatures within the cabinet environment, below 25°C. This project

has experienced significant delays throughout 21/22 due to challenges faced within the Trust wide teams supporting this piece of work. Renewed efforts and increased Executive oversight are being placed on this project to bring it to completion in 22/23.

Fridge temperatures are currently recorded digitally using a remote monitoring system, Kelsius®. All fridges and freezers across the Trust have a Kelsius® device fitted which will send an almost live temperature feed to a digital dashboard. This allows staff members to proactively check fridge temperatures, when required. The system will also generate alerts when fridge temperatures exceed the recommend temperature limits and notify a defined list of staff to act, in order to mitigate any adverse effects on stored medication being stored in. Throughout 21/22, the Pharmacy team have faced challenges with the ongoing management of the Kelsius system. The challenges experienced centre around ownership of the system and ongoing maintenance and monitoring of the hardware required to allow the system to operate effectively. The Trust are currently reviewing how this system is used and it is likely that clinical areas with refrigerated medicines will revert to manual temperature recording, to provide an adequate level of assurance that medicines are being stored under the correct conditions. This project will be a department and Trust priority for 22/23.

4.6 HOMECARE

WH provides high-cost medicines utilised in the management of long-term conditions within predominantly Gastroenterology, Rheumatology and Dermatology and Haematology. Table 1 summarises figures as at the end of 2021/22.
This area is continuously increasing in patient volume and this activity presents a significant workload to the Pharmacy team.

COVID-19 has impacted on the homecare suppliers staffing and one supplier had to temporarily stop registering new patients. Nurse training has increasingly been delivered via virtual appointments to ensure patients receive training when starting their medication.
A pharmacy technician (0.4WTE) to support with homecare administration and undertake improvement process projects was appointed in April 2022. The purchase of homecare module used for managing the ordering, receipting and payment of invoices was also approved.

The London Procurement Partnership (LPP) framework contract has been implemented which will open opportunities to access a wider range of homecare providers without the need to undertake lengthy tenders, plus support with contract management.
A patient satisfaction survey completed in March 2022 highlighted that 90% of patients had a good or very good experience and 10% reported a poor service.

The Royal Pharmaceutical Society Homecare Audit Tool has highlighted key areas for improvement in relation to governance processes. Actions in support of this will be progressed in 2022/23.

Homecare provider	No. of patients 2021	No. of patients 2022
HC1	400	426
HC2	23	111
HC3	77	93
HC4	47	46
TOTAL	**547**	**670**

Table 1. Number of Homecare patients

4.7 CLINICAL TRIALS

The Clinical Trials (CT) Pharmacy team supports the Trust to carry out robust research, contributing to new clinical knowledge and evaluating new treatments. The Pharmacy team is responsible for the overall management of Investigational Medicinal Products (IMPs).

During 21/22, 7 new clinical trials involving IMP were opened in the Trust and supported by the CT Pharmacy team across several specialties including TB, Critical Care, and Emergency Medicine. By the end of 21/22 there were 13 IMP CT open which were supported by pharmacy.

For 22/23 other clinical trials are expected to open at WH with pharmacy input. This includes a new study to evaluate a new agent for the management of Sickle Cell crisis, which is being nationally led by one of our Haematology consultants.

4.8 RESEARCH AND AUDIT

The Pharmacy Department continues to develop and support a culture of research and publication.

Any audit, quality improvement or research project undertaken by pharmacy is registered with the Whittington Clinical Governance Department.

The table below summarises projects that were completed in the 2021/22 financial year.

Project Title	Type
Antibiotic Point Prevalent audit (Weekly)	Audit
Antibiotic consumption - Expenditure and Defined Daily Doses (FY 2021/22)	Audit
LUTS clinic prescribing (Quarterly)	Audit
Controlled drugs audits (annually)	Audit
Medicines management walk about – Adherence to RPS safe and secure	Audit

guidance	
Assessment to assess compliance to Professional Standards for Home Care Services – Implementation and delivery of safe and effective homecare services	Audit
To assess the quality of medication discharge information from Whittington Health	Audit
To assess the use of Dexamethasone for Covid infection at Whittington Health	Audit
Non-Medical Prescribers audit	Audit
To assess adherence to the TTA Prepack Policy at Whittington Health	Audit
Assessment to assess compliance to Professional Standards for Home Care Services – Governance of Homecare Services	Audit
Assessment to assess compliance to Professional Standards for Home Care Services – The patient experience	Audit
Inpatient survey to assess the patient experience of pharmacy services	Service evaluation
Research into perceptions of Leadership in different HCPs (nurses, doctors & pharmacists)	Research thesis

4.9 EXTERNAL ASSESSMENTS

External Regional Quality Assurance Audit Report of Aseptic Preparation

The aseptic preparation of medicines at WH Pharmacy was assessed on 09th June 2021 by the NHS England Regional Specialist Pharmacy Services, Pharmaceutical Quality Assurance Service. The service was assessed to be Low Risk. The team were commended for the excellent progress made to implement actions identified following the audit conducted in May 2019. Since this time, the team have been involved in supporting the trust during the COVID pandemic; provision of ready to administer doses to ICU during the first wave and supporting the vaccination effort over the last 6 months. There has been no detrimental effect to the quality of service provided with 6 additional deficiencies identified during this audit (no deficiencies identified and assessed as being Major or Significant severity).

Medicines Management Initiatives – CQC & Internal Audit

The WH Pharmacy team continue to work with various teams across the Trust to implement three large scale projects that link to recommendations from our most recent CQC inspection and internal Grant Thornton audit. These projects are:

- Implementation of temperature-controlled medication cabinets to mitigate the impact of high ambient temperatures in treatment rooms where medications are stored

- Improving security of stored medications through the installation of swipe card-controlled access pads to treatment rooms and areas where medications are stored.
- Implementation of Patient's Own Drugs (POD) bedside lockers

Unfortunately, progress with these projects has slowed during 21/22 due to staffing constraints within some of the teams who are integral to the successful implementation of the projects. The teams experiencing the difficulties are working hard to overcome these restraints, with an increased resource allocation being provided. A large amount of scoping work has already been completed which will make the implementation process much efficient, once adequate human resource has been secured for this project. Pharmacy teams continue to mitigate the effects of high treatment rooms temperatures across the organisation to ensure that patient safety is not compromised.

During 2021/22, the Pharmacy team have successfully implemented two further projects to improve access to medications and support teams access critical medications out of hours. The Emergency Drug Cabinet (EDC) has now been expanded and will be fully automated to improve the governance and safety arrangements around the handling of critical medicines, out of hours. Furthermore, the on-call Pharmacist now has the functionality to remotely dispense medications from the dispensary robot, which again, aims to reduce any delays or omissions in medicines administration.

The Trust's approach to regular medicines management audits has been further reviewed and adjusted to provide timelier completion of actions and support ward level staff retain greater ownership of the audits. The Pharmacy team have worked with senior nursing colleagues to generate a RAG rated approach to inspect medicines management procedures in clinical areas. The frequency of audits will be dictated by the results of previous audits. The newly procured software, Tendable®, will be used to support this process. One of the main benefits of Tendable® is the functionality to allow teams to produce automated output reports and action plans, which can then be used to facilitate the sharing of results across the Trust's internal Quality and Safety teams. It is also useful to demonstrate compliance with National regulatory processes (i.e. CQC). Every 6 months, a summary report of completed audits and associated action plans will be shared with the Drugs and Therapeutics Committee to comply with Trust governance processes and to provide assurance to associated groups.

4.10 PATIENT EXPERIENCE

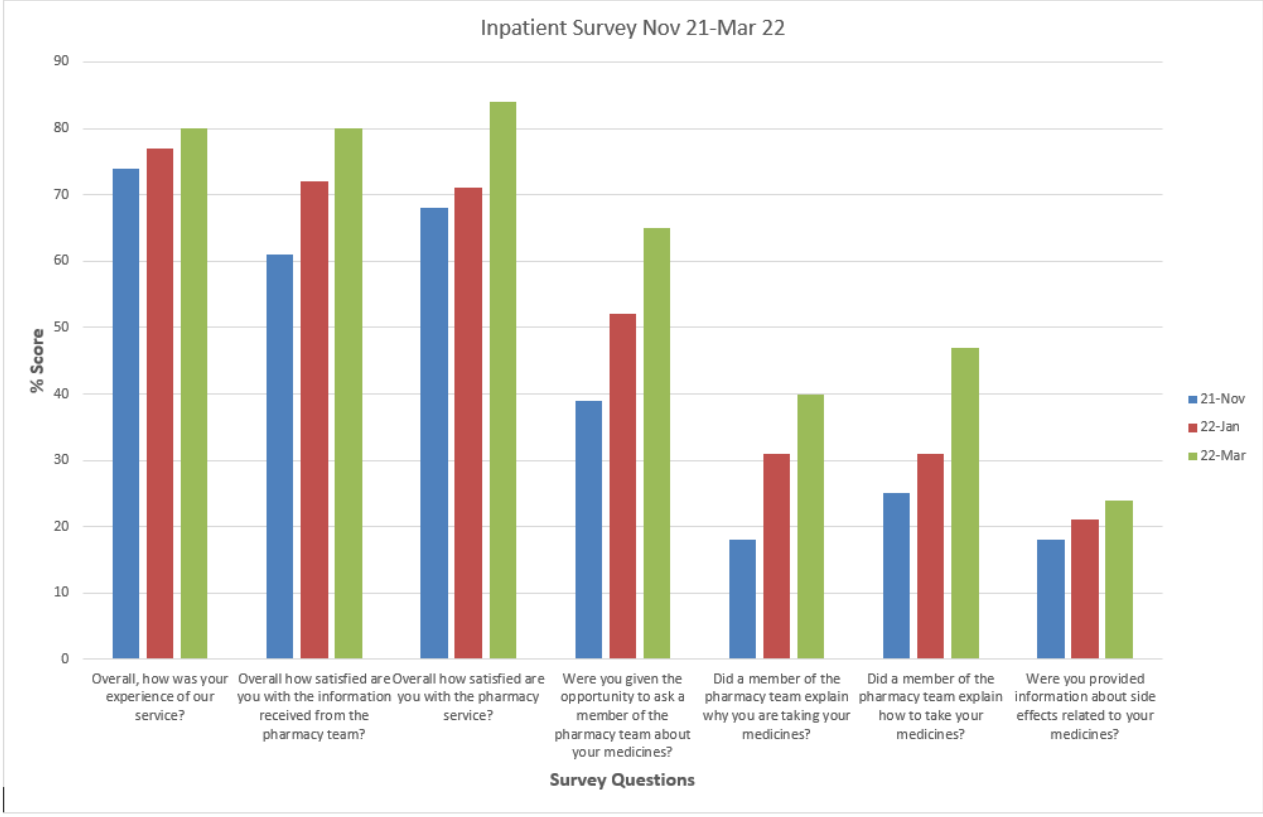
As part of the Trust wide approach to delivering the best patient experience for WH service users, the WH Pharmacy team undertake patient experience surveys on a bimonthly basis. Service users will be spoken to by a member of the Pharmacy team and asked about their experience of using the Pharmacy services at Whittington Health.

Throughout 21/22, the number of positive responses have increased with more patients receiving positive interactions with members of the pharmacy teams. Areas that show

significant increases in score focus on the physical interaction with the Pharmacy team. The table below shows the general trends of inpatient scores for the final quarter of 21/22.

Work will continue in this area for 22/23, with a greater emphasis being placed on increasing interactions with service users and ensuring patients are confident taking their medicines, at the point of discharge.

Inpatient Survey Scores and comments –Nov 21 – Mar 2022



5.0 DIGITAL TRANSFORMATION

The Pharmacy Digital team was involved in several projects throughout 21/22 which allowed the development of new digital functionalities and new electronic systems that were implemented in Q4 2021/22 and Q1 2022/23:

Electronic Prescribing and Medicines Administration (EPMA)

The Trusts EPMA system was successfully upgraded to CareFlow Medicines Management (CMM) v8 SP1 in June 2022. This means the Trust is on a fully supported system and allows us to comply with national standards on dm+d and to implement additional functionality to improve patient safety in the future. It will also allow the Trust to implement closed loop medication administration which is necessary for HiMSS level 6.

PharmOutcomes

A third-party platform, PharmOutcomes, has been integrated with the Trust's discharge system. This allows for electronic referrals to be made to community pharmacists once a patient is discharged from hospital ensuring seamless transfer of

care. The figures below are for Q1 2022 and are reflective of referrals made across 2 areas of the hospital- Care of the Older Persons and Emergency and Integrated Medicine. The plan is to introduce the system throughout the Surgical areas in August 2022.

	April 2022	**May 2022**	**June 2022**	**July 2022**
Total number of referrals made by Whittington Health	69	78	46	52
Total number of referrals accepted by Community Pharmacists	48	41	35	29

DAWN

The Trust replaced its anticoagulation prescribing and management software Helicon Health with Dawn in January 2022. The system has proved to be beneficial in making the pathway less manual and ultimately safer for patients. Phase 2 of the project will look to develop and optimise some of the interfaces between DAWN and other Trust digital systems in order to automate and streamline the process even more.

Chemocare

Successful implementation of Chemocare V6, an upgraded Chemotherapy prescribing solution.

Out of Hours (OOH) hatch

Dispensing medications to an out of hours hatch in pharmacy was introduced in April 2022. This has several cost-saving and improved patient care benefits allowing access to the majority of pharmacy stock remotely, so the on-call pharmacist does not have to come on-site. This saves time and money, and more importantly patient care is improved with less delays to administration of often critical medications.

Prescription Tracking System (PTS)

An updated version of PTS has been procured and tested. Due for implementation in the next couple of months, it will introduce several benefits to the tracking of medications across the Pharmacy pathway.

6.0 FINANCIAL PERFORMANCE

Medicines expenditure for 2021/22 is summarised in the table below:

	2021/22	2020/21	variance (£)	variance (%)
Total	£15,425,856	£13,381,679	£2,044,177	15.3%
PbR excluded (non-cancer)	£7,585,599	£6,743,808	£841,791	12.5%
Cancer (NHSE/CDF)	£2,644,071	£2,110,572	£533,499	25.3%
In tariff	£5,196,186	£4,527,299	£668,887	14.8%

2021/22 saw an increase in total medicines expenditure of over £2 million compared to 2020/21 (+15.3%). 66.3% of total drug expenditure was PbR excluded (non-cancer and cancer). This is very similar to 2020/21 (66%).

Expenditure on in-tariff drugs increased by £669k (+14.8%) from 2019/20. Generally, in-tariff expenditure increases with inflation ~4%.

Overall, the additional increase in expenditure was driven by a combination of increased hospital activity, inpatient COVID-19 related treatments and outpatient clinics working through the backlog of referrals.

In response to the COVID-19 crisis, with the stated aim of reducing the administrative burden, both the local commissioners and NHSE issued a block payment from Q1 2020-21. This remained in place throughout 2021/22. At the time of writing this report, block payment remains in place although there have been discussions to review this from Q2-Q3 2022/23.

The block payment was negotiated based on activity from month 8-10 in 2019/20 and was later uplifted for other factors. Block payment is not broken down by services. An overarching sum is received by the trust. This is monitored by the income team.

To ensure strong financial governance high-cost drug income has continued to be reported and monitored as if the payment-by-results contract was still in place.

The NHS Model Health system note that Whittington Hospital NHS Trust realised £180k in medicines savings in 2021/22 (data available up to July 22) by using less costly or biosimilar versions of a top-10 list of medicines (benchmark value of £19,453).

The pharmacy team will be focusing on the development of Service Line Reports for ICSUs and specialities in 2022/23 to further inform medicines expenditure reporting and determination of trends and cost saving opportunities. In addition, medicine cost improvement plans will be identified and shared across the NCL sector within the ‘Value and Improvement’ domain of the NCL Improving Pharmacy & Medicines Optimisation Programme.

7.0 IMPROVEMENT AND INNOVATION

7.1 ASEPTICS SERVICE PROVISION

The WH Pharmacy Cancer team have provided ongoing support to the WH:UCLH oncology collaboration team to provide a long-term solution and sustainable and safe service for local patients. This is due to the Medical Oncology service at WH struggling to recruit to staffing gaps particularly for consultants and the COVID-19 pandemic highlighting the fragility of staffing a relatively small department and the benefits of working at scale across systems.

Since 2019/20, there has been growth in activity in medical oncology. Furthermore, there is significant demand for Chemotherapy at UCLH which may be alleviated by patients having chemotherapy at WH rather than UCLH and adding a sector wide potential benefit to a closer collaboration. The team forecast up to 25% growth in medical oncology activity at WH between 2019/20 and 2022/23.

We have supported this collaboration piece at a pharmacy level with in-depth capacity planning for the aseptic unit, modelling the service based on anticipated increases in activity, reporting activity within the unit and appraising options for the future pharmacy model in response to the wider collaboration piece.

7.2 INNOVATION IN SERVICE DELIVERY – INNOVATIVE PHARMACY ROLES

Whittington Health Pharmacy department has a number of innovative roles and has made significant progress in developing and roles to support the integrated care agenda.

Cross sector roles

In order to support the NHS Long Term plan and the work force initiatives that follow it, we completed the hosting of four Preregistration Trainee Pharmacy Technician (PTPTs) on a cross sector programme of training. All four PTPTs successfully completed the programme and were employed within one of the practice settings, however we are still to develop a cross sector technician post that would take full advantage of the multisectoral training programme.

One trainee pharmacist completed a cross sector Foundation Year training programme involving a 13-week placement in Haringey GP Federation. The success of this programme resulted in the development of a band 6 pharmacist post within the federation at the end of the training year.

We continue to build on the exposure/training of our junior band 6 pharmacists to ICAT services when they undertake a rotation in Care of Older People services.

Band 7 ICS Posts

We have successfully implemented the first split posts across acute and community services. The posts have each pharmacist working half the week in area.
Within the acute side they are linked with the Care of Older People (COOP) team and provide senior ward cover and clinical leadership to the junior staff, while in the community, they take on specialist clinical roles as part of wider MDTs in either care homes or home-based reviews.

Each pharmacist has been successful in the application for independent prescribing, which, was only possible through leveraging the experience of the consultant clinical leads at each community service.

As expected with new ways of working, the structuring and feel of the roles took time to settle and is still undergoing regular review based on service requirements. Both pharmacists have become integral parts of the community teams and have started to demonstrate higher levels of clinical practice, holistic awareness and autonomy, all of which are key skills not often afforded to acute members of staff until further along in their careers.

Further areas have been identified that would support an increase in split roles which should be paramount considering the rapid expansion of integrated services. These posts have broken the ground and will continue to refine how future roles are designed.

Outpatient Parenteral Antimicrobial Therapy (OPAT) and Antimicrobial Stewardship (AMS) Pharmacist
A 6-months fixed-term pilot AMS/OPAT pharmacist post was trialled between January 2022 to August 2022 with the aim to transform and develop the Whittington OPAT service and AMS programme. This includes reducing antimicrobial wastages, reducing inappropriate use/duration of antimicrobial therapies, reduced bed blocking though optimised OPAT discharges and switching from IV to effective oral antimicrobials, and reduced hospital admissions / readmissions with more efficient follow-up of patients on IV antimicrobials or complex oral antimicrobial therapy in the community. (See also section 4.3)

COVID-19 Vaccine Programme Pharmacist

The COVID-19 vaccine programme started in December 2020. In September 2021, the COVID-19 vaccination pharmacist post was setup to help the Consultant Antimicrobial Pharmacist to run and manage the autumn vaccination programme which included the flu vaccination and the COVID-19 booster programme, as well as the Evergreen offer of the COVID-19 immunisation.

Pharmacy provided essential operational, logistical and clinical support to the Whittington Health COVID-19 vaccination programme and well as to support to the regional NCL Clinical and Operation COVID-19 group. (See also section 4.4)

7.3 MEDICINES AND SUSTAINABILITY

Sustainability is an area that has received increased attention in Pharmacy as well as Trust wide over the past year in line with supporting a Greener NHS.

In support of the NHS Long Term Plan committed to lowering the 2% of the NHS' carbon footprint from anaesthetic gases by 40%, by transforming anaesthetic practice,

the trust has eliminated the use of Desflurane, an inhaled anaesthetic known to have the most significant CO2 burden. Work is now underway in collaboration with anaesthetic colleagues and the Medical Gas Group to reduce Nitrous Oxide use across the Trust which will become a priority in 2022/23.

The pharmacy department is currently exploring ways of reducing medicines wastage through audit and review of existing processes.

At NCL level, our Respiratory Specialist Pharmacist is part of the NCL Sustainability and Lower Carbon Footprint Inhalers Group and has supported the sector wide review of inhalers with the aim to prioritise greener options and reduce carbon footprint. The outcomes of this work are expected to come to life in 22/23.

8.0 EDUCATION, TRAINING AND WORKFORCE

Undergraduate Students

As the impact of the Covid pandemic reduced we were able to re-instate some of the undergraduate placements from UCL. We prioritised 4th Year students, taking fewer students to reduce the foot fall within the pharmacy department and on wards. In response to the new GPHc Initial Education and Training Standards for pharmacists (released January 21), undergraduate placements will need to increase from a few days to 16weeks over the 4 year undergraduate course. This development will be a gradual step wise change over the next few years. Financial contribution from the HEE Education and Training tariff will support to some extent. We will be working closely with UCL and our NCL partners to formulate the vision for undergraduate placements going forward.

Trainee Pharmacists

The department takes in 5 trainee pharmacists each year, where we continue to enjoy the positive feedback we receive. Any developmental feedback obtained is used to amend the programme for coming years, enabling a fluid and dynamic review continuously. In 20/21 we trialled a 13week placement within the GP setting with Haringey GP Federation.

The placement was well received by the trainee pharmacist, who was able to develop good consultation skills at a fundamental level and also practice basic physical assessment skills. The practice also benefited from an audit the trainee pharmacist conducted, looking at the quality of their warfarin prescribing, the findings of which highlighted the need for significant improvements to be made in order to promote patient safety. Feedback from the trainee and the supervisor in the practice will used to fine tune the placement for this coming year. Four of the five designated supervisors completed the educational supervisor course provided by Pro-pharmace.

Clinical Pharmacy Diplomas

The department continues to ensure that all junior pharmacists are supported in competing a Diploma in pharmacy as part of their foundation training. The UCL Diploma in General Pharmacy Practice is the preferred programme for new practitioners joining the trust with full financial and supervision support offered. However, pharmacists already enrolled onto another diploma before joining the department are partially funded and supported until completion. In 21/22, a total of fourteen pharmacists were supported on the UCl programme with further 2 pharmacists on the Queens Belfast and De Montford diplomas. Two of the practitoners will be completing a Clinically Enhanced Pharmacy Independent Prescribing course as part of their diplomas.

Apprenticeships and Pre-registration Trainee Pharmacy Technicians (PTPTs)

Much of the 2021/22 has been spent settling into our new education governance structure for level 2 and level 3 learners. We are working much better together as a team of educational and practice supervisors all engaged in fully supporting our L2 and L3 learners through whatever programme of learning they are undertaking.

Most pharmacy support staff have now been enrolled onto an appropriate competency-based programme of learning leading to a qualification recognised by GPhC. We are busy working towards all of them completing the programme in the coming months. The one level 2 learner that was put unto an apprenticeship is nearing the end of their studies, they are currently completing a final unit and will be sitting the end point assessment in a couple of months. Because of the difficulties we have been experiencing recently in recruitment to these roles we expect that most new Band 2's that we employ in the future will have to be put on to the full level 2 apprenticeship.

We aim to train up a few more senior technicians as clinical supervisors so that they can further develop themselves and at the same time support the department particularly with the training of level 2 and 3 learners.

We are still supporting one staff member with functional skills training in preparation for them undertaking a level 2 qualification later on in 2022.

In February 22 we had two PTPTs successfully completed the BTEC Level 3 Diploma in the Principles and Practice for Pharmacy Technicians, they both left the Whittington to join other NHS Trusts. In March 22 we made the difficult decision to go with a new learning provider for these L3 learners. The new PTPTs started their qualification with the University of East Anglia and are currently working towards completing the Certificate of Higher Education in Pharmacy Technician Practice using the apprenticeship framework. It was a good decision, and they are progressing well so far. Because the new qualification enables the development of pharmacy technicians who can support Medicines Optimisation on wards and be an accredited final checker at the point of completing the programme, we have to ensure that our in-house training is very robust in these areas.

Local Faculty Group (LFG)

Local Faculty Groups form part of the governance structure for the education and training of trainee pharmacists and pre-registration trainee pharmacy technicians.

During 2021/22 a total of three LFG meetings took place jointly with Camden & Islington Mental Health Trust. The meetings continue to foster an environment conducive to the development of our training programmes for the above-mentioned learners with good representation from Whittington Health practice and designated supervisors. The focus of much of the discussions at the meetings this year have centred around the implementation of the new GPhC interim learning outcomes for trainee pharmacists and the new apprenticeship programmes for trainee technicians.

Although not mandated by HEE for this year, an annual LFG report has been compiled outlining achievements and progress made with education and training agenda.

Training Programmes

There has been a real focus to promote the uptake of both internal and external training programmes during 2021/22. The compilation of a workforce development matrix adapted from other trusts within London, has led to all grades of staff being able to engage with learning programmes aligned with their PDPs.

Staff have also been supported with larger programmes of development such as:

- Prince2/Agile project management courses
- MSc in Advanced Pharmacy Practice with UCL

Non-Medical Prescribing (NMP) Qualification for Pharmacists

As of April 2022, there are 15 pharmacist independent prescribers, 8 of whom are active and a further three undertaking the IP course:

Column1	Number	Scope (or intended) of practice
Pharmacist IPs	14	Anticoagulation (x3), Bone protection (frailty) (x2), Cancer (x2), Chronic pain / MSK, General Practice, Hypertension, Critical care, Rheumatology, Paediatrics (x2)
Active Pharmacist IPs	7	Anticoagulation (x 2), Bone Protection (frailty) (x2), Chronic Pain / MSK, General Practice, Oncology, Rheumatology,

Increasing prescribing capacity and identifying opportunities for pharmacist NMPs forms part of the department's strategy. The team will focus on improving access to NMP at appropriate grades within the Pharmacist workforce, and not just restrict activity to a specialist area. This will be able to better support the needs of the wider MDT, but also that of the patients.

Work is also underway to prepare the department to support the new pharmacist undergraduate training programme that will provide newly qualified pharmacists with the required legal qualifications to prescribe, at the point of registration. The first group of trainee pharmacists will enter the workplace with this qualification in 2025. This requires extensive work to ensure appropriate and adequate supervision is in place to ensure safe practice of the future workforce.

Staff Survey

Pharmacy teams continue to complete and contribute to the NHS National Staff Survey. Results from the 21/22 survey have been analysed in detail with extensive engagement across the internal staff groups to ensure that their views are adequately represented and responses fully understood.

An action plan has been devised, in collaboration with Pharmacy team members, and is being progressed through various groups and channels that exist. The work is highly visible within the department so that staff are engaged and made aware of the on going work which will hopefully improve engagement with the 22/23 survey. Going

forward, staff wellbeing and workforce development, linked to the themes identified in the 21/22 staff survey will be a focus area for 22/23.

9.0 WHITTINGTON PHARMACY COMMUNITY INTEREST COMPANY

Whilst COVID-19 has resulted in decreased prescription activity, retail sales and Travel Health, activity has increased year on year. A new Superintendent Pharmacist was appointed in year and will commence in April 2022.

Whittington Pharmacy CIC (WPCIC) provided 69151 items to outpatients and Emergency Department (ED) attenders in 2021/22, a 34% increase on 2020/21. Retail sales for the CIC increased by 6% but are below pre COVID levels. Further work on reviewing retail offering will occur in 2022/23.

Waiting times for prescriptions have decreased year on year averaging 15mins in 2021/22 compared to 16mins in 2019/20 minutes which has helped provide a better experience for our patients.

The fourth set of annual accounts for 2020/2021 was filed at Companies house along with the Community Interest Company Report (CIC34) describing a small profit. A clean audit opinion was received. The accounts for 2022/22 are currently in progress and equally demonstrate a small profit in 2021/22 despite the challenges associated with COVID and increased costs associated with postal and couriering of medicines. All profits associated with the CIC are reinvested back into the organisation.

The COVID-19 Pandemic changed the way WPCIC has operated to help ensure that patients received their medications. Activity is increasing again.

The WPCIC has been working with the ED department to put in place a formal redirection process in support of reducing the patient burden on ED for patients that could ultimately be treated for 'minor ailments' at a Pharmacy. This will be further adapted to mirror similar Community Pharmacy initiatives across NCL.

10.0 FINAL WORD

Key achievements 2021/22

Governance

- Review of several medication related guidelines, policies, PGD and new treatments through D&TC

Medication Safety

- Continued medicines safety message of the week at the pharmacy staff meeting
- Input into Spotlight on Safety
- Learning from medication incidents presented at the Patient Safety Forum (PSF)
- Implementation of new steroid emergency card and actions as per National Patient Safety Alert
- Medicines Safety Group (MSG) – work around controlled drugs and discharge and omitted doses (both in progress)

Clinical Pharmacy Specialties

- Implementation of new roles to support Biologics & Homecare and Emergency and Acute Medicine (SDEC)
- Development and implementation of new policies and guidance in collaboration with MDT
- Support to community clinics preparation for CQC visit in relation to safe medicines management
- Introduction of new drug preparations for improved patient care (e.g., new strength morphine CADD cassette enabling subcutaneous PCA for sickle cell patients).
- Positive External Regional Quality Assurance inspection of Pharmacy Aseptic Services
- Updated processes for the request and supply of intravenous immunoglobulin in line with the latest clinical commissioning policy and sub-regional/national guidance
- Facilitated the successful roll-out of new treatments for use in sickle-cell disease including Crizanlizumab used for preventing sickle cell crises.
- Supported the supply of nMABs for use in COVID positive patients
- Pharmacy led extended Palivizumab clinic reflecting NHSE and Joint Committee on Vaccination and Immunisation (JCVI) guidance.
- Development JAC protocols for safer prescribing in paediatrics for newly diagnosed diabetic patients.
- Education and training of community midwives around reflection of medication incidents.
- Improved feedback from patient experience survey related to pharmacy services at WH.
- Trust VTE risk assessment compliance increased to 95% since April 2022
- Successful and safe Tinzaparin to Enoxaparin prophylaxis switch – manufacturer issues resolved in April 2022.

Antimicrobials and COVID-19

- New AMS/OPAT pharmacist recruited
- Restart of AMS round and antimicrobial point prevalence audit

Integration

- Implementation of two new roles working across the acute and community boundaries of care in Haringey and Islington
- Leading on workstreams of the North Central London Improving Pharmacy and Medicines Optimisation programme
- Team Lead Pharmacist appointed in support of Adult Community Services to drive medicines optimisation within this sector

Digital

- Preparations for Electronic Prescribing and Medicines Administration (EPMA) upgrade, including robust testing, creation of support material and e-learning package.
- Development of a daily medicines reconciliation report for Pharmacy to improve operational efficiency and patient safety
- Established and lead a Careflow Medicines Management EPMA user group with Trusts across the UK to share learning and collaborate
- Creation of medicines reconciliation note in Careflow (and move away from

recording in JAC) to ensure all clinical information is held in one place
- Development of a digital pharmacy prioritisation tool
- Implementation of an on-call automated pharmacy hatch and procurement of an electronic (Omnicell) Emergency Drugs Cabinet in support of timely provision of medicines 24hrs, 7 days a week
- Pharmacy technician representative for the Trust at NCL Improving Pharmacy and Medicines Optimisation (IPMO) Technician Group
- Implementation of Chemocare V6 an upgraded Chemotherapy prescribing solution
- Migration of all pharmacy notes from JAC to Careflow Medicines Management
- Implementation of Tendable for medicines related governance audits
- New anticoagulation electronic health record (DAWN) implemented

Education and Training

- All band 6 pharmacists are enrolled onto a Foundation training programme – Diploma with UCL
- All Trainees Pharmacists passed their GPhC exam to qualify as Pharmacists
- More staff than ever have been supported to undertake formal programmes of education:
- Pharmacy support staff enrolled onto appropriate competency-based programmes.
- Four PTPTs successfully completed the cross sector PTPT programme which was conducted with 3 partners: C&I MH trust, Haringey GP fed, Islington GP Fed and us.

Medical Gas

- Enhanced trust wide oxygen piping infrastructure to support the treatment of more patients requiring high levels of oxygen treatment
- Development and publication of a new Trust wide Medical Gas Policy and Medical Gas Operational Management Procedures.

Key areas of focus and plans for 2022/23

As evidenced in this report, the Pharmacy department have successfully completed a diverse range of projects that will ultimately improve how medicines are managed at WH. These range from the implementation of new innovative roles to advances in how digital technologies improve patient safety.

As the team enter 22/22, the key areas of focus are as follows:

1. Deployment of an updated Electronic Prescribing and Medicines Administration (EPMA) solution – Careflow Medicines Management (CMM) Version 8
2. Once successfully deployed, CMM will then be deployed into new areas which are currently still utilising paper medication charts.
3. Full roll out of Tendable® to support the regular safe and secure handling medicines management audits. This will be done in a phased manner, focusing on Acute areas in the first wave, with a small trial in community clinics. Once complete, a full community roll out will be commenced. The roll out of this solution will be accompanied by a full governance process to ensure appropriate oversight of medicines through the relevant Trust governance committees.
4. Review and update of the Trust's Controlled Drugs Medicine Policy to reflect updated practices and developments in technology. This will be accompanied by a Trust wide education and training programme focusing on the appropriately handling of controlled drugs

5. Implementation of specific projects to ensure the appropriate temperature maintenance of medications in clinical areas. This includes:
   - Review and update of digital solutions used to monitor treatment rooms and refrigerated medicines
   - Implementation of ambient temperature-controlled drug cabinets
6. Completion of Trust wide Estates projects to improve the handling of medications at ward level. This includes the previously discussed ambient temperature-controlled drug cabinets and the installation of swipe card access to treatment rooms and installation of patient's own drugs bedside lockers
7. Targeted initiatives to improve Trust wide reporting of medication incidents.

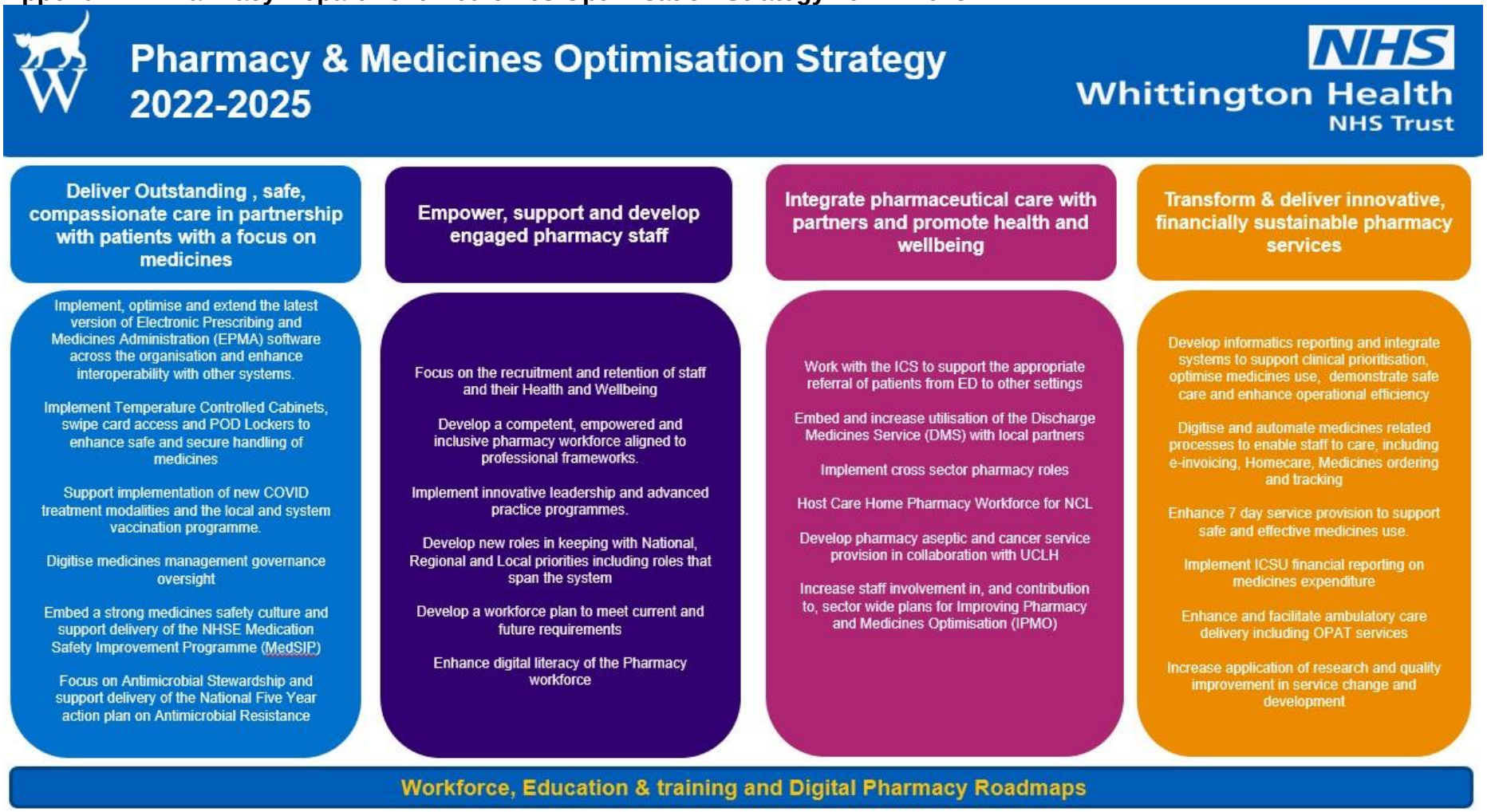
In addition to the above discrete programmes of work, the department will continue to deliver on the topics outlined in the department's strategy, as shown in Appendices 1 and 2.

Key achievements will include:

1. Ongoing development of the department's workforce strategy, with vacancies reviewed and updated to match service needs and overcome challenges faced relating to the Pharmacy Technician workforce.
2. Initial review and update of the department's weekend and bank holiday service provision to match changes in service delivery, already realised across the Trust
3. Identification and implementation of additional B7 pharmacist non-medical prescribing opportunities.
4. Full roll out of the DMS across the Trust and continued engagement with NCL on this project
5. Optimisation of digital tools to help improve efficiencies at ward level for clinical pharmacy teams (i.e. implementation of clinical prioritisation tools and investment in hardware required to support ward level working)
6. Reintroduction of Pharmacy SLR financial reporting
7. Continued engagement with the NCL IPMO programme
8. Investment in the wellbeing of Pharmacy staff.
9.

11.0 APPENDICES

Appendix 1: Pharmacy Department Medicines Optimisation Strategy 2022 - 2025



Appendix 2: Workforce, Digital and E&T Pharmacy Roadmaps

Workforce Roadmap

NHS Whittington Health NHS Trust

Theme	Focus area	Deliverable		
		1 year	3 year	5 year
Workforce	Recruitment and Retention Technician Development Support staff development Strengthening of Line Management Structure Weekend / On-call service review Consultant Pharmacist Strategy Advanced Practice Portfolios	Recruitment and Retention Group established Over recruitment in key establishment lines confirmed Line management competencies mapped and programme of training development for all line managers (incorporated into induction if applicable) Small changes made to weekend / Bank Holiday services within existing operational model Review of recruitment strategy (adverts / promotion / key text)	Improvement in retention of key areas (MMTs, B7 pharmacist) Pharmacy Technician roadmap developed Support Staff development plan in place with key areas having ATOs embedded within clinical teams MMTs no longer tied to dispensing activities All 8A and above mapped to RPS advanced practice competencies On-call service review Weekend Service review	2 additional Consultant Pharmacist posts developed in key clinical areas

Education & Training Roadmap

NHS Whittington Health NHS Trust

Theme	Focus area	Deliverable		
		1 year	3 year	5 year
Education and Training	NMP / DDP review B7 leadership and development programme Refresh and review of rotations and objectives Diploma / Advance Practice / Consultant Pathways review Identification and engagement with HEE and Integrated pilot programmes	B7 leadership programme reviewed and designed for Pharmacy department Rotations reviewed and updated focusing on opportunities within existing department structure NMP at B7 level scoped and trialled	Rotations reviewed to incorporate ICS partners NMP at B7 level fully implemented Educational roadmap designed and mapped across all staff groups within the department	Cross provider / sector rotations for all trainees

Digital Roadmap

NHS Whittington Health NHS Trust

Theme	Focus area	Deliverable		
		1 year	3 year	5 year
Digital	Increase in digital literacy across the department Optimisation and improvement in department infrastructure Increased development and use of existing digital functionality / software Clinical prioritisation Automation / AI / CLMA	Mapping of required hardware and software to suitably empower individuals to do their roles Map digital literacy currently within department and utilise Trust wide and sector wide opportunities to improve literacy Clinical Prioritisation scoped Digital dashboard designed to support basic ward level functions DMS implemented across all areas of the hospital	Clinical prioritisation implemented and utilised to support appropriate deployment of resource Digital dashboard fully designed and implemented and used both within the department and at ward level to enhance patient flow Digital tools used to monitor operational performance of department	Full implemented CLMA system

Meeting title	**Quality Assurance Committee**	**Date: 09/11/2022**
Report title	**Bi-Annual Nursing and Midwifery Establishment Review Report**	**Agenda item:**
Executive director lead	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals	
Report authors	Marielle Perraut assistant Chief Nurse Roda Mohamed, Lead Nurse for Safer Staffing	
Executive summary	• In line with National Quality Board (NQB) guidance, the Bi-Annual Nursing and Midwifery Establishment Review report outlines the Trust's response to the statutory requirements to have safe Nursing and Midwifery staffing identified across Whittington Health. • It Includes a comprehensive overview of Nursing & Midwifery staffing over 2021/22. Over the past 6 months, ESR reports that Whittington Health Nursing and Midwifery establishment represent 1797.69WTE (1256.71WTE Registered and 540.98WTE Unregistered staff) • The report presents the establishment assessment, and proposal for the establishment, of the following areas: - ○ Inpatient adult and paediatric wards (EIM, Surgery& Cancer and CYP) ○ Simmons House (CYP) ○ Emergency Department (ED) (EIM) ○ Critical Care Unit (CCU) (Surgery and Cancer) ○ Neonatal Intensive Care Unit (NICU) (CYP) ○ Theatres and Recovery (Surgery and Cancer) ○ Day Treatment Centre (Surgery and Cancer) ○ Maternity • Additionally, the quality indicators (QI) sensitive to Community nursing were considered. • Where increase investment has been identified and supported in principle by Chief Nurse, the ICSU will incorporate this as part of their business planning: ○ **Ifor Ward/CAU:** 2WTE HCA ○ **Ifor Ward: Fixed term 1 year**: 2WTE RMN (B5 and B6) and 2WTE HCA ○ **Paediatric Day care:** 1WTE RN B6 (this post was disestablished and converted to a non-clinical role) ○ **Simmons House:** 2WTE RMN (1B5 and 1B6)	

	○ **ED:** 18WTE RNs and 6WTE HCA (includes 10 RN removed from establishment during Covid 19 and offered as a CIP (narrative in report) ○ **Nightingale:** 2WTE HCA ○ **Cancer and Surgery:** 1WTE PDN ○ **Maternity:** 1.4WTE Bereavement midwife • Separate staffing reviews are awaiting approval to support the additional "flex beds" (34 in total) and an additional 20 bed winter pressure ward: ○ **Coyle** :11.6WTE (RN and HCAs) ○ **Mercers:** 4.3WTE (RN and HCAs) ○ **Victoria:** 20.8WTE (RN and HCAs) ○ **COOP:** 27.3WTE (RN and HCAs) ○ **Winter ward:** 31WTE (RN and HCAs)
Purpose:	To assure the Quality Governance Committee and the Board of Directors regarding Nursing and Midwifery safe staffing levels across Whittington Health
Recommendation	The Quality Governance Committee is asked to: (i) Review the paper content (ii) Note establishment adjustments that will be proposed within the ICSUs business planning cycle
Risk Register or Board Assurance Framework	BAF risk 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. BAF risk People 1 - Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs
Report history	1. Establishment review meetings with Chief Nurse, Deputy Chief Nurse, Assistant Chief Nurse, Safer Staffing lead nurse, Associate Directors of Nursing and Midwifery ADoN/M), Deputies and Matrons 2. Quality Governance Committee 3. Nursing and Midwifery Leadership Group (NMLG) 4. Quality Governance Committee 25/10/2022
Appendices	1. The NQB's 3 priorities 2. Pack example

Bi-Annual Nursing and Midwifery Establishment Review Report

1. INTRODUCTION

1.1 The purpose of this report is to provide assurance to the Quality Governance Committee and the Board of Directors that the Trust Nursing and Midwifery staffing levels are compliant with Developing Workforce Safeguards (NHSI, 2018), which incorporate the National Quality Board Standards (NQB, 2016), for safe Nursing and Midwifery staffing at Whittington Health.

1.2 The guidance sets out the key principles and tools that organisations should use to measure and improve their use of staffing resources to ensure safe, sustainable, and productive services. The NQB's 3 priorities that form the basis to making staffing decisions are as below and detailed in *appendix 1*

- Right staff
- Right Skills
- Right place and time

1.3 The Bi-Annual Nursing and Midwifery Establishment Reviews were undertaken throughout September and October 2022, with the overview of the outcomes of these reviews detailed within this report. The information pack included workforce and staffing data from March 2022 to August 2022

1.4 Reviews were led by the Safer Staffing Lead Nurse, Chief Nurse, Deputy Chief Nurse and Assistant Chief Nurse

1.5 Safer staffing and skill mix reviews were undertaken in September 2022 for the following clinical areas:

- Inpatient adult and paediatric wards (EIM, Surgery& Cancer and CYP)
- Simmons House (CYP)
- Emergency Department (ED) (EIM)
- Critical Care Unit (CCU) (Surgery and Cancer)
- NICU (CYP)
- Theatres and Recovery (Surgery and Cancer)
- Day Treatment Centre- DTC (Surgery and Cancer)
- Midwifery

1.6 Work is in progress to include comprehensive reviews of community services (Health Visiting, School Nursing, District Nursing and Children and Adults Community Nursing) and ambulatory acute services.

2. ESTABLISHMENT REVIEW PROCESS AND METHODOLOGY

2.1 Nursing & midwifery staff establishments are formally reviewed biannually or annually for several areas, to ensure that the nursing & midwifery workforce meets the demands of clinical care provision, delivers safe care with a positive patient

experience and aligns with Whittington Health's financial, operational and strategic objectives.

2.2 As part of the establishment review process, all ward-based areas completed a Safer Nursing Care Tool (SNCT) or Mental Health Optimal Staffing Tool (MHOST) audit for 30 days in April 2022.

The Acuity and Dependency level of each patient is assessed and recorded on SafeCare® three times daily. The validity of data entered onto SafeCare® is checked by the Matrons and verified by the Lead Nurse for safer staffing. The afternoon census is used to apply the SNCT multipliers and generate the SNCT recommended establishment.

NHS Improvement published the Developing Workforce Safeguards: "Supporting providers to deliver high quality care through safe and effective staffing" (October 2018). This guidance addresses any gaps around safe workforce planning and recommendations to ensure a consistent approach to achieve:

- Effective workforce planning
- Staff deployment by using evidence-based tools
- Governance considerations when redesigning roles/skills mix
- Responding to unplanned workforce challenges

There is a requirement that Trusts formally ensure NQB's 2016 guidance is embedded in their safe staffing governance and should ensure that the triangulated approach is used in their safe staffing processes, which include:

- evidence-based tools (SNCT, Birth rate plus, MHOST..)
- professional judgement
- outcomes based on patient need, acuity and risks

The NQB recommend the use of other quality data to inform professional judgement, including acuity and dependency tools, incident data, health roster KPIs, Workforce KPIs, quality indicators and peer/national benchmarking.

The SNCT was used to establish the optimal staffing levels for the ward-based adult and paediatric areas. ED used the ED SNCT which was implemented in 2021.

The MHOST was used for Simmons House.

In addition, National guidance was used during this establishment review as detailed below:

- Safe staffing assessment for CCU was informed by recommendations issued from the Faculty of Intensive Care Medicine and NICE.

- BirthRate Plus®, completed in 2022, was used to inform the maternity services staffing review assessment

- The Association for Perioperative Practice (AfPP) sets out minimum staffing requirement and its guidance was used to review the establishment in theatres.

- Recommendations from the British Association of Perinatal Medicine (BAPM) and the Royal College of Nursing (RCN), guided the establishment review in the Neonatal Intensive Care Unit (NICU).

- The nurse-to-patient ratios as recommended by NICE (1:8) was used where appropriate. Professional judgement was applied, having considered the specialism of each setting, acuity and quality/safety indicators.

For the purpose of this review, data was collected from Electronic Staff Record (ESR), QlikView®, HealthRoster® and SafeCare® .and were assessed against workforce and performance KPIs and targets as detailed in table below

Indicator	Target
Appraisals % Rate	>90%
Mandatory Training % Rate	>90%
Staff sickness absence %	<3.5%
Staff turnover %	<13%
Vacancy % Rate against Establishment	<10%
Average Time to Hire (Days)	<63 Days

Table 1: Workforce KPIs and Performance targets

Information for national data and benchmarking was obtained from the Model Hospital database and NHSE/I website.

The Quality Indicators (QI) sensitive to Nursing and Midwifery staffing were collated to identify potential association of performance to staffing levels.

Care Hours Per Patient per Day (CHPPD) were also reviewed.

2.3 The template for the Bi-Annual Nursing and Midwifery Establishment reviews has been updated for the review process to focus on key areas for discussion, whilst also ensuring that the requirements of the review were included (*Template example in Appendix 2*). The template was circulated to the ICSUs in advance of the meeting with pre-populated data, and they were asked to complete the relevant sections.

2.4 The discussions were undertaken in September and October 2022 with the Associate Directors of Nursing/Midwifery (ADON/M), Deputies and Matrons for some ICSUs. They were led by the Safer Staffing Lead Nurse, Chief Nurse, Deputy Chief Nurse and Assistant Chief Nurse.

2.5 Based on the data and information they provided, each ICSU was able to highlight areas of concern and showcase innovation and good practice. Requests to increase an establishment were discussed at length.
Any increase requests were based on following criteria:

1. Patient Safety
2. Increased acuity and dependency
3. Service redesign, increased footprint or expansion (including flex beds)
4. Quality (staff / patient experience/leadership)

2.6 The guiding principles for the inpatient ward establishments are outlined below:

1. RN/NA skill mix ranging from 50/50 to 90/10 (national recommendation 65/35 but varies according to speciality and acuity)
2. 21% uplift within establishment to cover annual leave, sickness and study leave allowances
3. Supervisory time for Ward Manager
4. Nurse in Charge to be supernumerary
5. Acknowledgement that operational and seasonal pressures on staffing require support which may include the increase of staffing establishment to maintain safe ratios

2.7 Discussions also included:

1. Workforce planning and opportunities to embed new roles or a repurpose of roles to meet patient and service needs: (Nursing Associates, Registered Nurse Degree Apprentices, Advanced and Specialist Nurses/Midwives, Trainee Nursing Associates)
2. International Recruitment opportunities
3. Service redesign/expansion opportunities
4. Any concerns identified (sickness, HR, recruitment, overspend) and assurance that a mitigation plan is in pace or to escalate to the panel for support.
5. Successes and celebrations that ICSUs wanted to share

3. KEY CHALLENGES

3.1 Ongoing operational pressures throughout 2022, due to increased demand and acuity, required some department reconfiguration by flexing beds (i.e., increasing beds without funded establishment on existing wards) and intermittent opening of additional beds on empty wards, including Thorogood. Summer 2022 was unprecedentedly busy with a higher demand on services and attendances to ED. This translated in increased staff deployment to support both department reconfiguration and higher staff absence levels than expected due to sickness and annual leave that is usually granted over the summer months.

3.2 Oversight of safe staffing across the Whittington Health remains a challenge due to short notice changes in staff availability, deployment, and increased establishment requirements to support services with increased acuity and creation of additional capacity. This is managed through the Trust daily site meetings and safe staffing

meetings as required to support additional staffing requirements, balancing the risk across the organisation.

3.3 Turnover rates are consistently above target of 13%. Staff turnover has been (6-month average) 16.5%. There are significant and multifactorial contributing factors, including staff relocation due to the cost of living and impact on health and wellbeing due to increased acuity and demand on acute wards (noted in EIM and CYP). It is also noted that unregistered staff are markedly affected (17.6% average) compared to registered staff (15.5%)

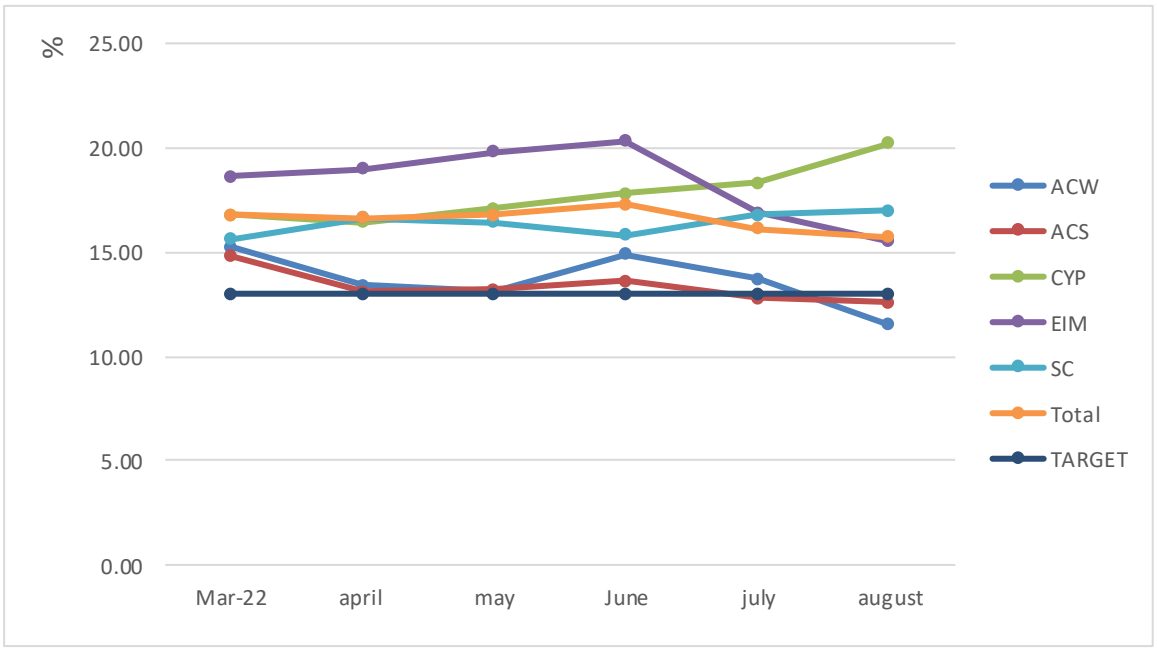


Table 2: Turnover rates by ICSU combined registered and unregistered staff March-august 2022

3.4 Staff health sickness and absence has been persistently above the Trust Target (3%) (although improving in last few months). Staffing pressures, enhanced care needs increase also impacts on staff-patient ratio in many areas.

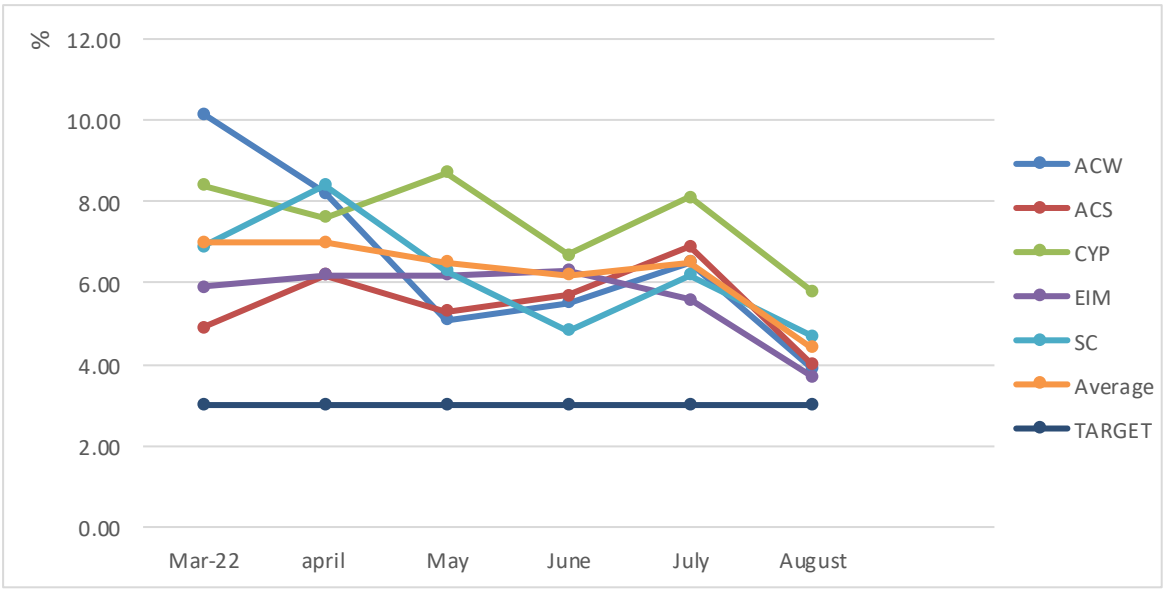


Table 3: Sickness by ICSU combined registered and unregistered staff March-august 2022

3.5 Recruitment and retention (vacancy target 13%) remains a challenge due to the impact of Covid-19, cost of living and staff health and wellbeing. The unregistered workforce is disproportionally affected, with a vacancy rate average of 18.3% compared to registered nursing which is within target of 12.53%…
Over the past year, the stability index target (where staff remain post over 12 months, set at 85%) is 80% for registered staff and 75% for unregistered colleagues

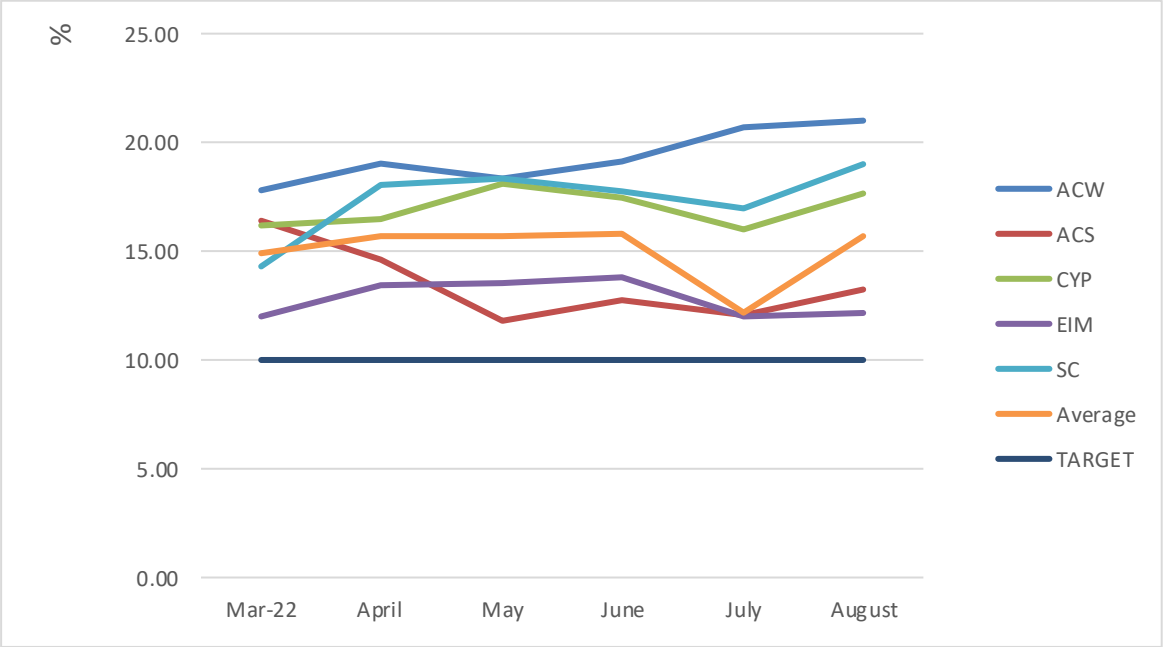


Table 3: Vacancy rates against establishments by ICSU combined registered and unregistered staff March-august 2022

3.6 Challenges in embedding preceptorship and clinical supervision across the Trust due to competing priorities and operational pressures.

4. KEY FINDINGS

4.1 The reviews demonstrated that, when Nursing and Midwifery levels are fully established with the recommended budgeted establishments, all areas will be safely staffed. Temporary staff are used, where appropriate, to cover vacancies and also to provide additional staff to maintain patient safety in the areas where the acuity and/or dependency of patients has increased.

4.2 The number of additional posts requested from the establishment reviews to provide ongoing safe staffing of areas and incorporating services expansion/increased patient acuity is under review as part of business planning. The summary of discussion and outcome from individual establishment reviews are included later in this report.

4.3 Workforce planning discussions identified wide scale support for the Nursing Associate role and international nurses within the future establishments and acknowledged the need to further embed the roles within the clinical areas where they already exist. There is recognition that clinical areas need support to enable learners and new starters to receive the appropriate level of training and time whilst meeting competing demands and increased patients' acuity and dependency.

5. ICSU REVIEWS AND ANALYSIS

5.1 Children and Young People

The ICSU has several services across both acute and community settings. This review addressed Ifor ward, Children Ambulatory Unit (CAU), Day Care, NICU and Simmons House. Further reviews at a later date will include Children Community Nurses, School Nurses and Health Visitors.

- **Funded establishment changes:**

The main topic during the discussion was the increased acuity and complexity of patients across childrens' services and Simmons House and the need for the establishment to reflect these changes.
There has been an increase in the use of temporary staffing from agency and staff undertaking extra duties.
The ADoN also raised that during Covid-19, the B6 day care RN post was disestablished and converted to a non-clinical role without consultation with nursing leadership. The team is formally requesting this is reinstated. It is an essential role that supports day care activities and planned surgery.

Any nursing budget that is considered for removal or repurpose should first be reviewed and approved by the Chief Nurse.
No concerns were raised about the NICU establishment level as part of this review

	Patient safety	Service redesign, increased footprint or expansion (including flex beds)	Increased acuity and dependency	Quality (staff and patient experience, Leadership)
IFOR /CAU 2WTW B3 HCAs	x	x	x	
IFOR (fixed term 1 year) 2WTE RMN (1 B5& 1B6) 2WTE 2WTE HCA	x		x	
Day care 1WTE B6 (this post was disestablished and converted to non-clinical role. Needs restablishing)	x		x	
Simmons House 2WTE RMN (1 B5& 1B6)	x		x	

Table 4: CYP increased establishment request criteria applied to

- **Workforce data**

Over the past 6 months, the sickness rate has averaged 7.7%. Over the last 2 months there has been an improvement across both registered and non-registered staff. It was noted that the main theme was stress related and some bereavement leave. There were suggestions during the review to consider rotation between acute care and Simmons House to diversify staff experience and maintain well-being

- **Quality and safety data**

  Complaints Themes identified around communication
  Pressure ulcers review work being undertaken in NICU
  Datix mainly around patient's self-harm and aggression towards staff

- **Safer staffing**

  It was noted that the need for enhanced care has increased and was higher than expected during the summer months
  In patient beds had been increased from 15 to 17 earlier than expected
  The team is currently reviewing the model of care on CAU to meet increased demand and improve patient safety and experience.

- **Clinical supervision/staff development**

  Development of RMNS and HCAs to support day cases

- **Workforce success and celebration**

  Successful recruitment if 9 international nurses across CYP.
  Morale has improved as establishment is improving and there is good leadership across the ICSU

- **Succession planning**

  There are some challenges in recruiting 3rd year students. The team is working with the Recruitment team to attract graduates (the cost of living is a barrier to attracting graduates)
  Currently CYP has a young ward workforce, but a mature CNS team.
  There is a review of the skills of temporary RMNs agency/bank.

- **Planning next review**

  Include CNS team in the review
  Include Heath Visitors and School Nurses
  Mandatory training and appraisal data to be discussed to ensure safe practices and career conversations are productive.

5.2 **Maternity as part of ACW**

This review was based on the Birthrate Plus report from May 2022 across inpatient and outpatients' areas.
Within maternity services the Birthrate Plus tool has been used to provide detailed calculation of workforce needed based on the needs of the resident population.

- **Funded establishment changes**

The team is actively working to repurpose vacancies to ensure adequate succession planning and offer opportunities for new enhanced roles.
Currently the team reports that the establishment is safe but have identified a need to support bereaved families to provide 7-day service and request an uplift on an existing post to have 2WTE bereavement midwives.
It is also noted that uplift should be increased to reflect added specialist courses that Midwives must undertake. This will be included in next establishment review.

	Patient safety	Service redesign, increased footprint or expansion (including flex beds)	Increased acuity and dependency	Quality (staff and patient experience, Leadership)
1.4WTE Bereavement midwife	x			x
1WTE 8C nurse consultant (Ockendon recommendation)				x

Table 4: Maternity increased establishment request criteria applied to

- **Workforce data**

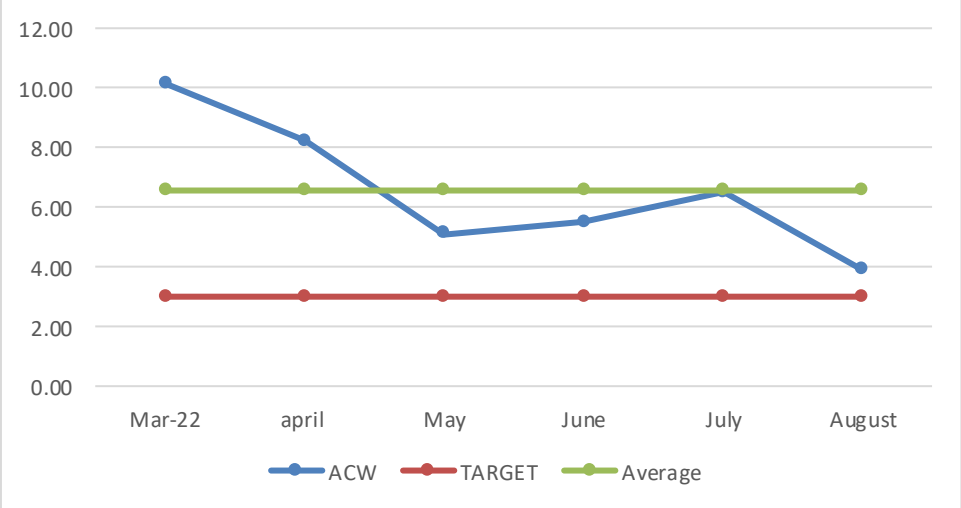


Table 5: ACW trend sickness combined registered and unregistered March-August 2022

Sickness overall remains over the 3% target, but there was a marked improvement in the previous 2 months where non- registered staff sickness level was within target (2.57%)
The team reports some long-term sickness, The main themes being Covid-19 related illness, stress and musculoskeletal complaints.

- **Safer staffing**

Plans were discussed to initiate the rotation of junior midwives from an acute to community setting if robust systems are in place.

- **Quality and safety data**

Red flags will be included in the Birthrate plus data pack to ensure accuracy. Maternity has a sitrep, but the team is planning to audit when Midwives are moved from the Birth centre due to staffing pressures. There is also a plan to introduce a sitrep audit to the community teams

Flexible working existing but need to be reviewed, to ensure parity and impact on the service.

Complaints have reduced in last few months. the themes identified are linked to delayed medication and communication.
The Ockendon report also highlighted that triage phones are not answered in a timely manner. The plan is to allocate a midwife or administrative staff to support midwives at triage
.

- **Workforce success and celebrations**
  Head of Midwifery currently undertaking CNO safer staffing fellowship
  Huda Mohamed, Specialist Midwife for FGM awarded CNO gold award
  Matron accepted to King's fund programme
  2 midwives on BAME Capital Midwife fellowship

- **Succession planning**
  High retirement rate and aging workforce
  Recruitment of 10 international Midwives starting in 2023
  Current review of preceptorship pathway and post preceptorship rotation.

- **Planning next review**
  Introduction of Roster checks and challenge session monthly.
  Outpatient services will be included in next review.
  Maternity to include when service had to divert and close in next report.

5.3 **<u>Surgery and Cancer</u>**

Inpatients areas (Mercers, Coyle,CCU), Theatres and DTC were evaluated in this establishment review.

- **Funded establishment changes**

Coyle and Mercers establishments do not meet the current establishment requirement for escalation beds currently open on those wards. A separate business case has been submitted for Executive approval and will not be included in this

report. An Enhanced Care proposal is to be submitted by EIM, which will include S&C as this is currently 50% underfunded.

DTC have not raised concerns about the current establishment. CCU's current establishment, whilst covers the 10-bed unit, does not allow for the higher number of patients that need to be isolated in cubicles due to infection control reasons (such as Covid 19). This increases the need for staff in CCU. A separate business case is being considered to review the need for funding.
Theatres is requesting a 1WTE PDN but suggested that this is a post that could support the ICSU outside Theatres.

	Patient safety	Service redesign, increased footprint, or expansion (including flex beds)	Increased acuity and dependency	Quality (staff and patient experience, Leadership)
1.1WTE B7 PDN				x

Table 6: Surgery and cancer increased establishment request criteria applied to

- **Workforce data**

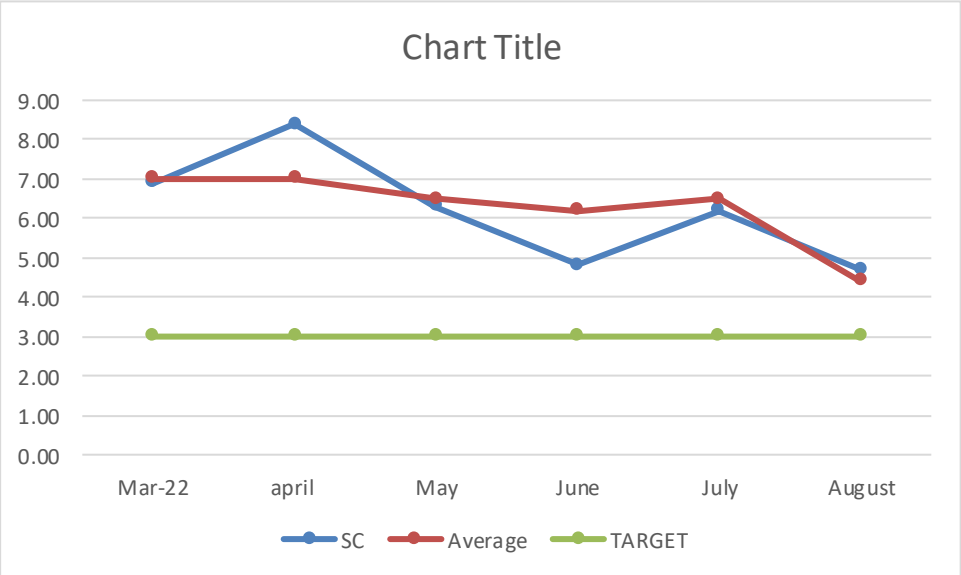


Table 7: S&C trend sickness combined registered and unregistered march-August 2022

Sickness, although above target, shows a trend of improvement across the ICSU
Some concerns were raised around flexible working and its management. Some historical arrangements with poor documentation makes this difficult to challenge.

- **Safer staffing**

The main barrier to meet roster KPI are time pressure and conflicting demands.
Considering should be given to the multiskilling of staff
Suggestion to use dual roles that encompass clinical and education to help retention of experienced staff. This is being discussed currently with Middlesex University.

- **Workforce successes and celebrations**

  There has been a reduction in pressure ulcers, particularly in CCU.

- **Succession planning**

  CCC has a clear pathway- from B5-B7
  International recruitment has been successful across the ICSU including theatres and DTC.

- **Planning next review**

  Include CNSs and cancer services in next review
  Review CNS job planning and clinical supervision

5.4 **Integrated and emergency medicine (EIM)**

The establishment review assessed the emergency floor and inpatients areas. It is to noted that Care of Older People (COOP) wards (Cloudesley, Meryick and Cavell) and Victoria ward establishments do not meet the current requirement for the escalation beds currently open in those areas. A separate business case will be submitted for Executive approval and will not be included in this report.

	Patient safety	Service redesign, increased footprint or expansion (including flex beds)	Increased acuity and dependency	Quality (staff and patient experience, Leadership)
Nightingale 2WTE HCA	x		x	
ED 18WTE RNs and 6WTE HCA including 10 CIP RN posts (10+8)	x	x	x	x

Table 8: EIM increased establishment request criteria applied to

Same Day Emergency Care (SDEC), paediatric ED, Montuschi, urgent care establishments are all meeting the staffing demand.

The adult ED establishment is not meeting the demand, caused by the increased acuity and pressure of increased attendances. 10 WTE were offered as part of the ICSU CIPS without a robust quality impact assessment and approval from the Chief Nurse.. The team is formally requesting these posts are reinstated.
Any nursing budget that is considered for removal or repurpose should first be reviewed and approved by the Chief Nurse.

Nightingale requests 2WTE HCA to increase the ratio at night. Currently there is 1 HCA on night duty, and this raises safety risk due to increased acuity, particularly

since Covid 19 pandemic, and the floor lay out which includes 9 side rooms.

- **Workforce data**

  Sickness is still above the threshold but there is an overall trend of improvement. The team reports that the main barrier to managing sickness robustly is the lack of available management time, as this time is unable to be ring-fenced due to staff shortages.
  The common themes for sickness are musculo skeletal complaints and stress.

- **Safer staffing**

  Red flags were high during the summer due to staffing shortages and the opening of escalation beds/ward.

  Roster KPIS (such as publishing rotas in advance) are not always met sue to the lack of management time, described above.

- **Planning next review**

  Include outpatient reviews
  Include endoscopy information and data
  Ensure workforce and quality KPIs are analysed and reported

7. RECOMMENDATIONS

The Nursing establishments will formally be reviewed again at the biannual review in April/May 2023. All safe staffing metrics will continue to be monitored monthly via performance meetings, safe staffing governance meetings and the integrated board reports.

The next review will also include adult community services, Health Visitors, School Nurses and all acute ambulatory settings

A review of uplifts will be conducted across establishment and should consider any variances due to specialist areas specific education requirements.

Appendix 1 - National Quality Board expectations

Nursing & Midwifery 6 monthly Establishment Review

ICSU: **Date:**

Section 1 - Update on actions from Latest Establishment Review

Please outline below the actions that were agreed as part of the last Nurse Staffing Review and provide and update regarding the progress of each action.

Action	Area/Lead	Update

Section 2 – Please identify all clinical areas within your ICSU

Area / Ward	Type of area e.g. Inpatient/ Outpatient	Days open	Hours open

Section 3 – Funded Establishment (July 2022 data)

Please review for each Ward/Service what the current budgeted establishment is and outline in comments any discrepancies or any concerns if this is not deemed to meet service need:

Please

Ward/ Department	WTE budgeted establishment RN, RNA/B4, HCA, TNA	Does this meet service needs Y/N	WTE vacancies RN, RNA/B4, HCA TNA	Budget £	YTD spend £	Variance £	Comments

complete the following information for the last 6 months as an exception report for those areas not meeting the required KPIs:
All areas within section 2 not highlighted within the exception report below are considered to meet the required parameters/KPIs and so providing the required assurance.

Ward/Dept	Average Vacancy Rate Target <10%	Average Monthly Turnover Target <12%	Average PDR Rate Target > 95%	Average Mandatory Training Rate Target >95%	Average Sickness Rate Target < 3%	Comments

Section 4 – Activity and acuity impacting on staffing

- Please comment on the numbers of Red Flag and Datix related to staffing over the previous six months identifying any themes / trends and Action Plans to address them.

Ward/Dept	Number of Red Flags	All Red Flags Resolved – Yes/No	Number of Datix relating to safe Staffing	Comments

- Please review the last 6 months information regarding CHPPD and comment on any trends noted.

Ward/Dept	CHPPD Trend over 6 months	Planned Hours	Actual Hours	% Variance	Comments

- Please review the last 6 months use of enhanced care hours

Do staff consistently use the Enhanced Care Assessment to support their decision making for both stepping up and down of enhanced care – Yes/No (highlight as appropriate)

- Consider any trends/changes in activity over the past 6 months which have impacted on nurse staffing eg: weekend/evening clinic or theatre opening, use of flex beds

Section 5 – Safe and Effective Deployment of Staff

Please complete the following information:

Ward/Dept	All Flexible workers have had FW agreement reviewed in last 12 months and uploaded to HR portal? Yes/No	Roster Lead Time compliant – Yes/No	Annual leave within agreed parameters – Yes/No	Nurse in Charge on all shifts – Yes/No

Section 6– Quality & Performance

Please review your last 6 months of quality data:

Ward/Dept	No of Falls with Harm	No of Pressure Ulcers	No of Complaints	No of Serious Incidents

Please add below:

- Friends and Family data
- Patients/visitors feedback
- Staff feedback and surveys results –

Section 7 – Workforce planning

Key questions to consider:

- What do you think your workforce needs to look like in the future to be sustainable and how will you integrate new roles?
- What numbers of CNS/ANP as an ICSU do you think you will need to recruit each year to reach your future planned skill mix?
- Is there a recognised training programme you use/plan to use?
- Is there funding agreed for training and salary cost?

Planned Staffing per ward/service

Ward/Dept	RN (Inc NAs):HCA ratio-DAY	RN (Inc NAs):HCA ratio Night	Comments

Assistant Practitioners/Nursing Associates/Registered Nurse Degree Apprenticeships (RNDA)

Ward/Area	Number of Registered Nursing Associates	Number of Apprentice Nursing Associates	Course completion date	TNA course interruptions	TNA course withdrawals	No of vacant TNA posts

Ward/Area	Number of current RNDAs	Course completion date	RNDA course interruptions	RNDA course withdrawals	No of vacant RNDA posts

Nurse Practitioners/Advanced Clinical Practitioners/Advanced Nurse Practitioners

Area	Number of CNS/ ANPs and banding	Do all meet Job Spec for role – Y/N	Clinical Supervision in last 6 months- Y/N	Development/ Changes in Nurses in Specialist Roles within last year?	Any new roles planned in next 3 years (ie: Surgical care practitioners, advanced critical care practitioners, consultant nurses/midwives- this list is not exhaustive	Comments

International recruitment

Area	Current number of international recruited nurses (IRN)	Number of added posts planned/agreed IRN in next 12 months?	Number of extra IRN to be requested	Comments

Section 8 – Succession Planning

Please provide any update on the following

- Has the age profile of your workforce recently been reviewed?
- Are there any areas of risk in key workforce groups?
- Do you have clear succession plans in place for any key workforce groups and if not what factors are impacting this?

Section 9 – workforce success and celebrations (inc. award, publications etc)

Section 10 – 6 month Action Plan going forward

Please add any additional actions not outlined in Section 1.

I confirm that the data given here is correct at the time of Annual Establishment Reviews.

Signed name:

Printed name:

Title:

Meeting title	**Quality Assurance Committee**	**Date: 9th November 2022**
Report title	Adult and Children's Safeguarding six monthly report (April - September 2022)	**Agenda item: 4.9**
Executive director lead	Sarah Wilding 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, with one month having the highest number of safeguarding adult referrals recorded. • There has been an increasing need for the safeguarding adult lead and/or safeguarding adult advisor to become involved in complex safeguarding adult discussions, especially around ensuring safe discharges. • Concerns had been identified by a team in the community regarding the ability of care home staff to follow specialist care plans for residents. This has been raised with both Safeguarding Adults Boards, and the Trust's part-time community matron for care homes and safeguarding adult lead led a training session for car home managers to discuss the difficulties care homes face in managing increasingly complex residents. • WRAP 3 compliance stands at 87% and Basic awareness of PREVENT at 90% on 30th September 2022. • Training compliance has increased with Level 1 at 88% and Level 2 at 79% at end of September 2022.	

	• Preparations for the implementation of the new Liberty Protection safeguards (LPS) to replace Deprivation of Liberty Standards (DoLs) continues. • A breakdown of figures for Q1 found 58 inpatients subject to urgent authorisations remained in hospital over 21 days. This is especially relevant when planning for the increased resource allocation which will be required to fulfil the legal obligations the Trust will become liable to meet with the implementation of the LPS legal framework. • A consultation response was submitted on behalf of the Trust for the LPS consultation process. It is anticipated the Department of Health and Social Care will provide responses to the over 650 responses nationally by the end of the year. • There has been an increase in numbers of urgent DoLS applications made over the period covered in this report. **Children & Young People** • Safeguarding training compliance has vastly improved since introduction of the Elev8 system. Level 1 training compliance is currently 88%, level 2 87% and level 3 is 81%. 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, substance misuse and domestic abuse feature in the referrals. Of note, prebirth referrals have increased. • 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. There has been an increase in men reporting themselves as victims of domestic abuse. • 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 SC'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:	Approve
Recommendation(s)	The Trust Board is asked to: (i) receive assurance that there are systems in place to protect children and vulnerable adults from abuse and neglect whilst in our care. (ii) 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; Quality Assurance Committee November 2022
Appendices	1: Biannual Integrated safeguarding report to Trust Board (April-September 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's Quality Assurance Committee for approval by the Trust Board. It covers the period from April to September 2022.The report provides assurance around the following areas:

- The adoption of national policy changes
- Responses to, and learning from, safeguarding concerns raised from internal incidents and Serious Incidents; Safeguarding Practice Reviews (SPR), 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 (SCR) 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 timely way. Nine cases are currently open to Whittington Health.

A significant point of learning for Whittington Health raised within these SCRs/SPRs is multi agency discharge planning from acute hospitals for children admitted with suspected non-accidental injuries. An North Central London (NCL) wide working group is being established to look at safe and effective discharge planning alongside our partner agencies.

Another point of learning is managing the risks of extra-familial harm for vulnerable adolescents as inpatients within Simmons House. In June 2022, an executive briefing was presented at the Haringey Partnership Board to provide reassurance that additional measures had been taken within Simmons House following absconding episodes leading to young people suffering significant harm.

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-pandemic 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 at average rates. We still experience increased adolescent mental illness. Of significance has been a dramatic increase in attendances for dog bites, some quite serious. This has been seen nationally too. It was thought the hot summer accounted for some injuries, and possibly the increased number of puppies bought during lockdown losing their appeal may have contributed.

It is also still a significant factor that children attend Emergency Department (ED) when unable to get a face-to-face appointment with a general practitioner (GP). Whilst incidences of this are better than during the pandemic, it is thought that A&E continues to be used in preference of the GP on account of speed of being seen. GPs are often referring children to ED when consulting virtually.

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 at the Whittington and nationally. The primary increase in referrals is as a result of demand for mental health services. 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. Recently it was felt that the cost of living crisis was impacting on prospective parents in respect of mental health and potential neglect.

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 complexity of safeguarding adult cases continues to increase, with careful planning being required around hospital discharges involving the safeguarding adult lead and/or safeguarding adult advisor.

3.3 Neglect is the most identified category of alleged abuse, in keeping with both local and national safeguarding adult figures.

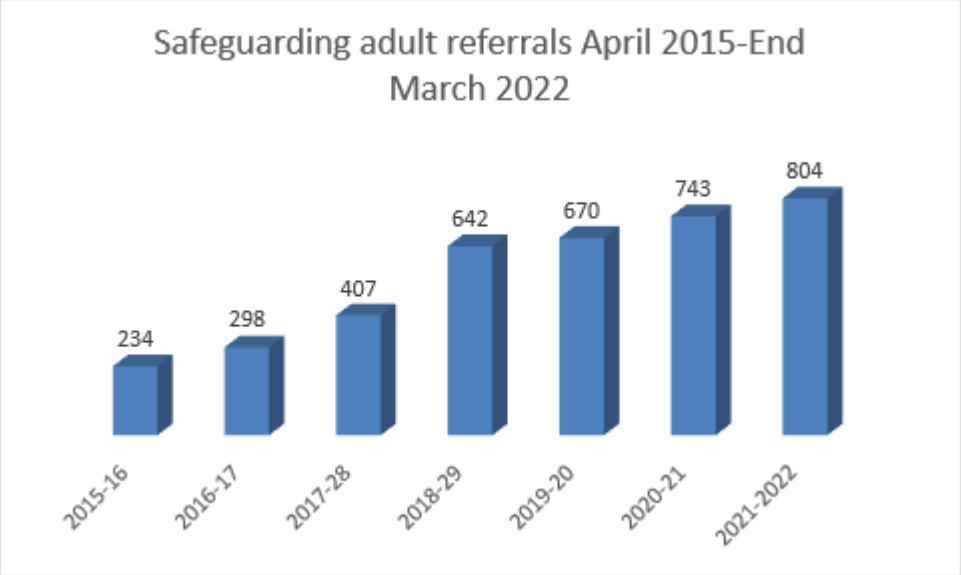
3.4 Urgent and Emergency Medicine ICSU continues to raise the most safeguarding adult concerns for the period covered in this report.

3.5 There had been a reduction in numbers of safeguarding adult referrals received from Adult Community Services. A weekly drop-in session was started in April 2022 to offer staff a forum to discuss safeguarding adult concerns. Figures have increased since this session commenced.

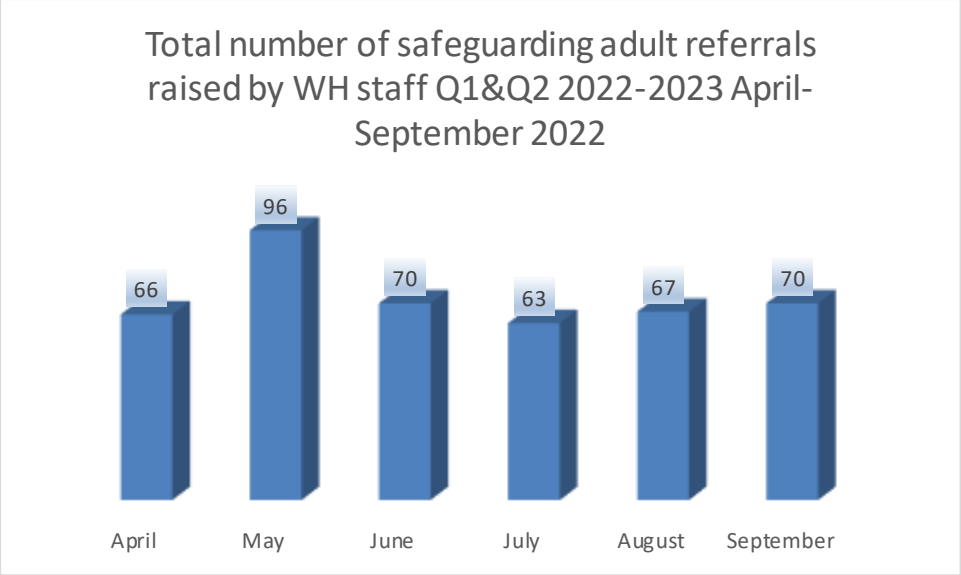
3.6 Training compliance continues to be monitored, and compliance has increased during this reporting period, with level 2 safeguarding adults at 80% on 31st March 2022.

3.7 Graphs 2-10 below show the demographics, nature of allegations, person alleged to have caused harm and location of alleged abuse for safeguarding adults.

3.8 Graph 1 below shows the figures of safeguarding adult referrals since April 2015 until April 2022, graph 2 the figures for the period covered in this report, and graph 3 the preceding two quarters (Q3&Q4 2021-2022 October 2021-April 2022).



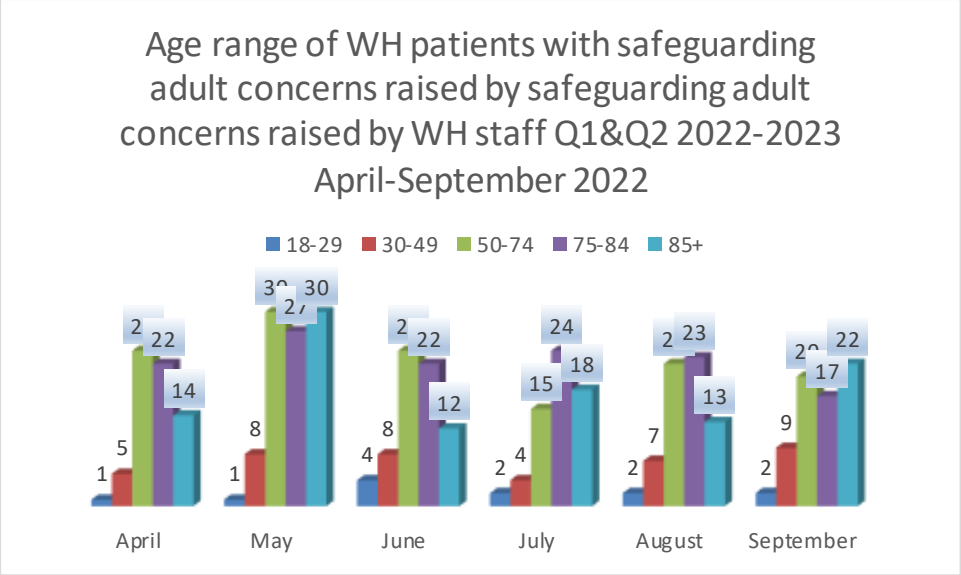
Graph 1



Graph 2

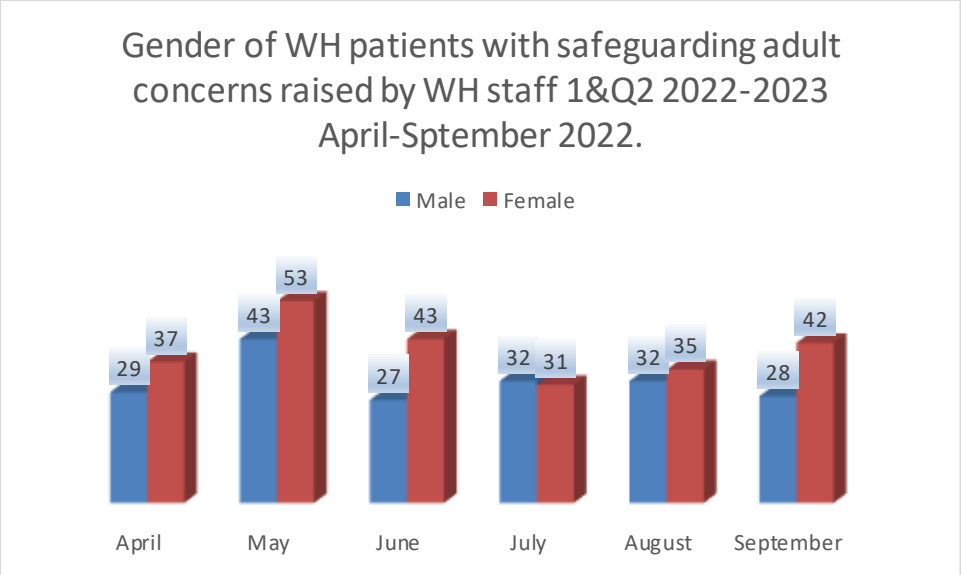
Graph 3

3.7 Graph 4 below shows those aged 50 and above are likely to have a safeguarding adult concerns raised.



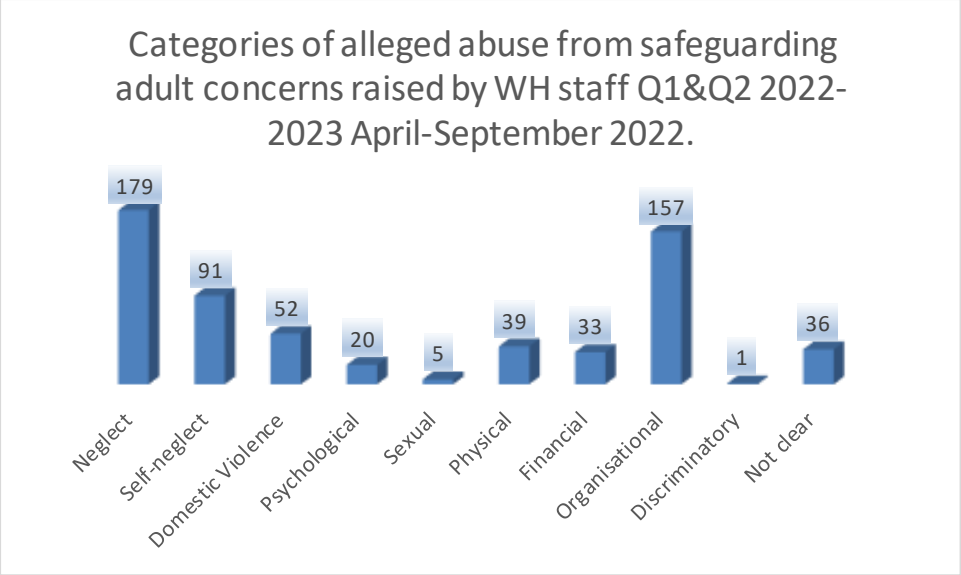
Graph 4

3.8. Graph 5 shows a distinct difference between the genders, women more likely to be identified as experiencing abuse.



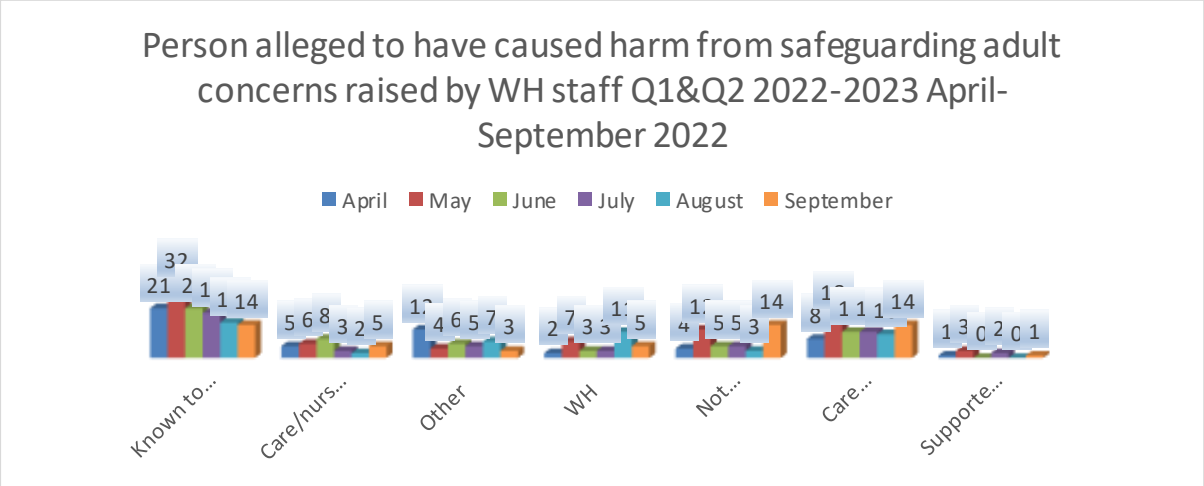
Graph 5

3.9 Graph 6 below shows neglect as the category with the most alleged abuse, with organisational abuse being a close second.



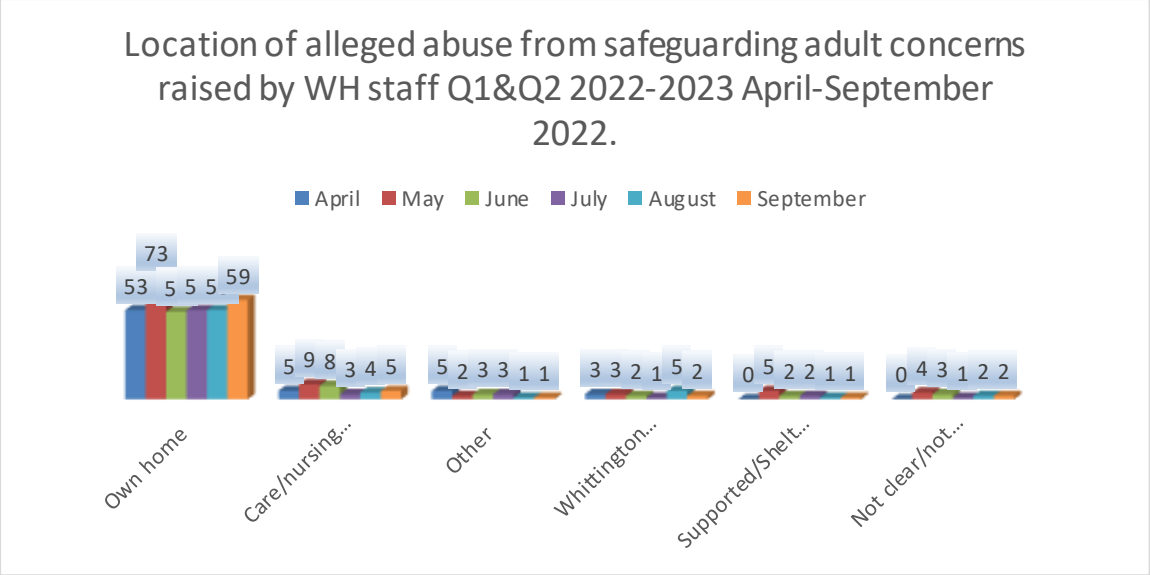
Graph 6

3.10 Table 7 below shows patient are likely to know the person alleged to have caused harm. It is important to remember these numbers refer to *allegations* of abuse.



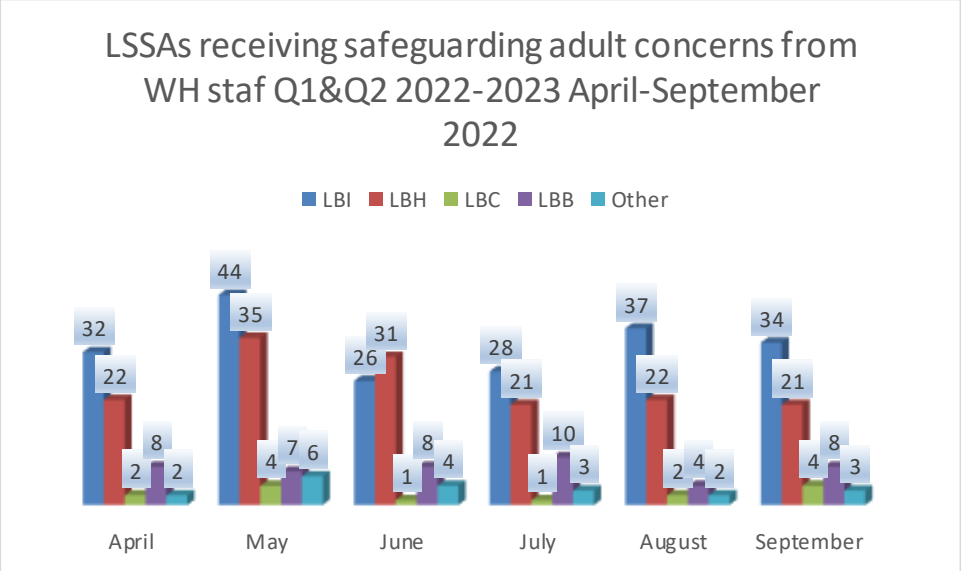
Graph 7

3.11 'Own home' was the most frequently identified location of abuse as graph 8 below shows.



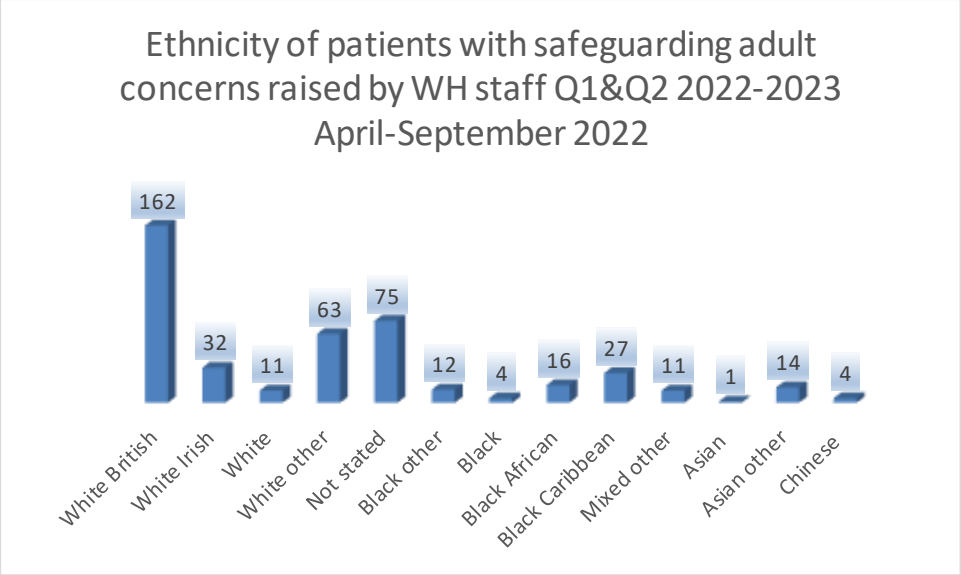
Graph 8

3.12. Graph 9 below shows the distribution of safeguarding adult concerns across local authorities.



Graph 9

3.13 Graph 10 shows the ethnic makeup of safeguarding adult referrals. Both SABs had been informed about the increase in safeguarding adult referrals received in relation to patients of Black Caribbean origin. This will continue to be monitored, and additional support for these communities are being discussed to try and understand why there has been an increase.



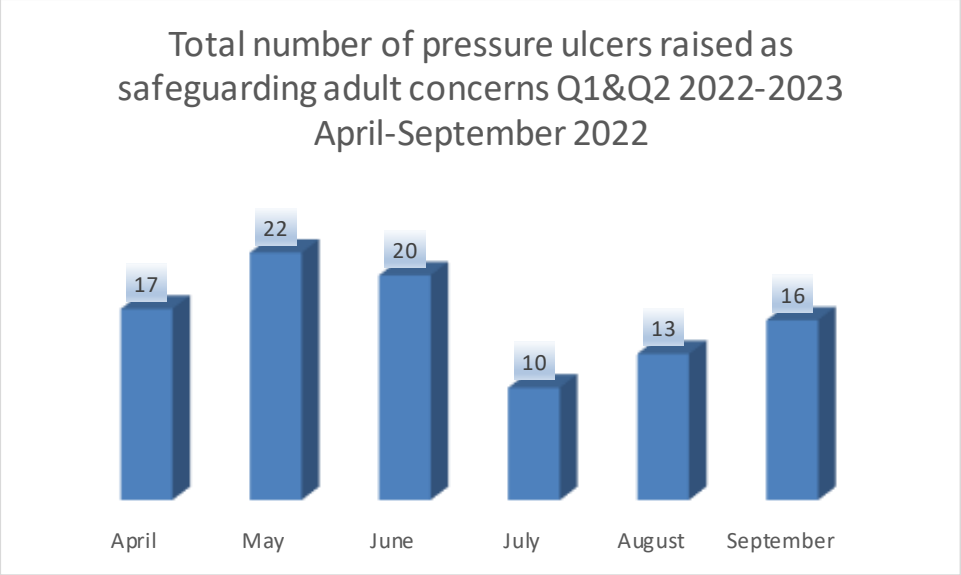
Graph 10

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

CASE EXAMPLE

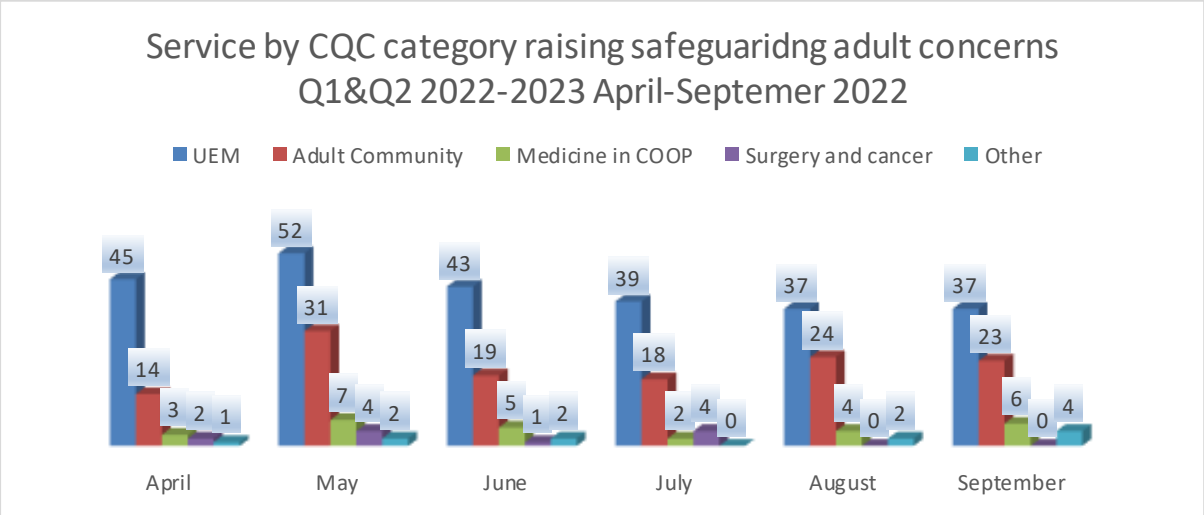
Gertrude is an 80 year old woman who has advanced dementia. During an earlier admission, it became clear there were problems between Gertrude and her husband. In her latest presentation, staff reviewed those concerns and raised another safeguarding adult concern due to the unexplained fractures. Clear communication with the safeguarding adult team in the local authority, ward staff, hospital discharge team and Trust safeguarding adult team ensured these concerns remained central to all discharge plans.

3.15 Graph 11 below shows numbers of pressure ulcers being identified as safeguarding adult concerns by Trust staff over this period, a reduction to the previous two quarters.



Graph 11

3.16 Graph 12 below shows service lines raising safeguarding adult concerns.



Graph 12

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 September 2022.Level 2 compliance is 79%. WRAP 3 compliance reached 87%.
Basic Awareness of PREVENT is recorded as 90% compliance.

6.0 Learning from Serious Incidents (SIs), Serious Case Reviews(SCR child), Safeguarding Practice Reviews (SPRs), 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/SIs 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 longstanding 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.

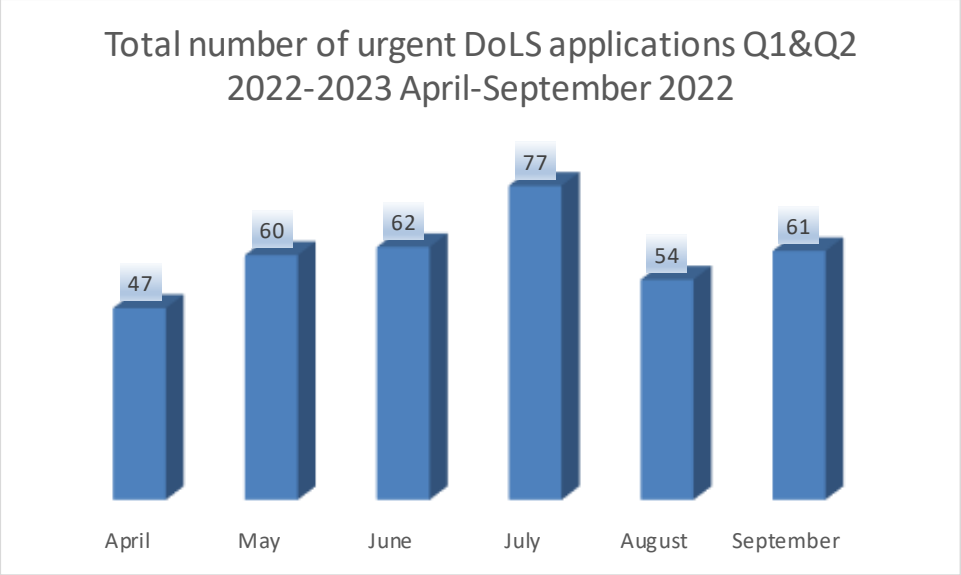
6.7 The Trust has submitted an extensive chronology for a SAR 'Liam'. The SAR author is currently looking at all of the chronologies received from a number of agencies, and the draft report is still to be produced.

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.

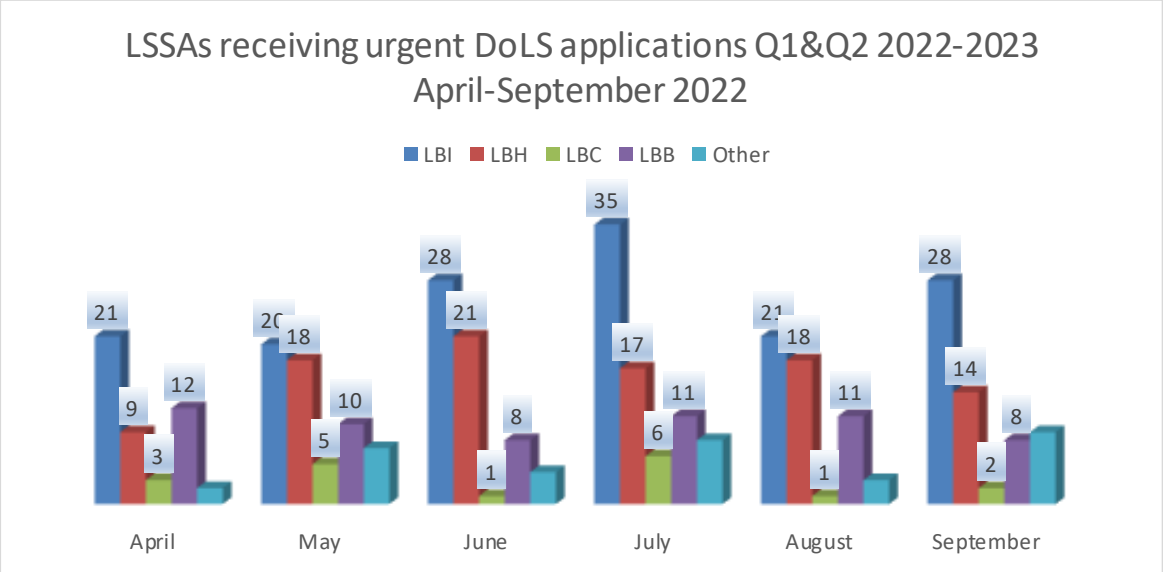
7. Deprivations of liberty safeguards

7.1. Graphs 13 and 14 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.



Graph 13



Graph 14

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**

- Give the increase in complexity of safeguarding adult referrals and involvement required to assist with discharge planning, resource allocation review in this area is required.
- Planning for implementation of the LPS framework will require involvement of the ICSUs to ensure systems are in place to fulfil statutory obligations. undertaken.
- Look to develop appropriate and relevant training for safeguarding adults to reduce the reliance on face-to-face training.
- Develop an audit programme for safeguarding adults, MCA and DoLS to assist with service development.

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: 09/11/2022**
Report title	Maternity Services Board Report	**Agenda item:4.5**
Executive director lead	Dr Clare Dollery and Sarah Wilding	
Report author	Isabelle Cornet, Director of Midwifery (Interim)	
Executive summary	This report provides a quarterly summary of the work being undertaken in the Whittington Health Maternity Unit. 1. ***Ockenden Report and Immediate and Essential Actions (IEAs)*** Whittington meets the 7 IEAs. Post the assurance visit 13 recommendations were made. Progress against the recommendations is being Monitored and the Maternity and Neonatal Transformation Programme Board. 2. ***Maternity Incentive Scheme*** There are 10 safety standards each with multiple elements. There 3 standards that currently are at risk: Safety action5: The definition of the supernumerary labour ward coordinator role has changed and Trusts across London as well as WH are concerned about being able to reach this standard due to this change. Safety action 6: Evidence of measurement of CO at 36 weeks gestation is required. The equipment for the community midwives was purchased and measuring started in August. Audits are being undertaken. Safety action 8: Training of the anaesthetic teams requires focus and is being supported by the anaesthetic clinical lead. The new trainees are being supported in ensuring they complete their training. 3. ***Care Quality Commission Standards*** The head of Midwifery is leading the work to ensure improvement as part of the 'Better Never Stops' work. 4. ***Incidents and Learning Points from Serious Incidents*** Actions include; implementation of the Birmingham symptom specific obstetric triage system; refresher training in escalation; education on SBAR and simulation training and an update of the CTG guideline. 5. ***Workforce***	

	Midwives; 25 recruited.9 have withdrawn. The reasons for this are being investigated. Obstercian:2 new consultants recruited. 4 new posts going our to advert this month. 6. ***Maternity and Neonatal Estates Programme*** Upgrade of Birth Centre and Phase 1 to start this financial year. Phase 2 design to be signed off in October. 7. ***Bids*** Successful bid of £37k to support bereavement training. **Addendum since QAC:** The Birth Rate Plus report of May 2022 recommended a WTE workforce of 184.04. The current WTE in the maternity budget is 177.81. This calculation was based on total birth numbers of 3680. The birth numbers have dropped and over the last 12 months the birth numbers are Whittington Health have been 3102. Birth Rate Plus is being used to calculate the number of staff required to care for this number of births. If this means additional staff required over the current budget of 177.81 WTE WH commits to funding these posts.
Purpose:	Assurance
Recommendation(s)	To note the report and progress toward meeting National Standards
BAF	Quality 1 and People 1
Report history	Quality Governance Committee – 25/10/22
Appendices	1: Maternity Incentive Scheme: 2: Healthcare Safety inspection Branch report

Whittington Health Maternity Services Board report
October 2022

This report provides a quarterly summary of the work being undertaken in the Whittington Health Maternity Unit.

1.0 Ockenden Report and Immediate and Essential Actions (IEAs)

1.1 In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the Secretary of State for Health and Social Care instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust. The outcome of this review was the publication of 7 Immediate and Essential Actions outlined by the initial Ockenden report (December 2020).

1.2 An assurance visit to Whittington Health maternity service was completed on 27th June 2022 measuring the Trust compliance against these 7 IEAs. The final report was sent from NHSE to the Trust on the 4th August 2022 and was presented to the Quality Assurance Committee on the 14th September 2022.

1.3 The Trust demonstrated full compliance across all of the 7 IEAs and was congratulated in the final assurance visit report.

1.4 The report identified a number of positives within the unit and 13 actions to take forward. An action plan to address these areas had been developed. Progress against this will be monitored at the Maternity and Neonatal Transformation Programme Board (M&NTP) which is chaired by the Chief Nurse.

1.5 In 2023 NHS England will publish a single delivery plan for maternity and neonatal care which will bring together actions required following the recent Kirkup investigation into East Kent Maternity and Neonatal Services; the report into maternity services at Shrewsbury and Telford NHS Foundation Trust; the NHS Long-Term Plan and Maternity Transformation Programme deliverables.

2.0 Maternity Incentive Scheme (IMS) – Year 4 (Previously Clinical Negligence Scheme for Trusts (CNST))

2.1 The scheme supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST. The scheme, developed in partnership with the national maternity safety champions, Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent OBE, rewards Trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services.

2.2 The revised Maternity Incentive Scheme guidance (Appendix 1) advises a submission date of 2nd February 2023 and includes changes to 5 of the 10 Safety Actions.

2.3 The Whittington Health (WH) submission and evidence will be presented, after commissioner sign off, to the Quality Assurance Committee on the 11th January 2023 and the Trust Board on 26th January 2023.

2.4 Work is underway in order for the Trust to be compliant at time of submission. Currently, there are three safety actions that are at risk of non-compliance. In order to mitigate the risk, the following work outlined below is underway.

Safety Actions at risk:

2.4.1 **Safety Action 5**: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

2.4.2 There are 5 required standards to meet this safety action. The Trust will be compliant at time of submission with 4. The one that is at risk of non-compliance is: "The midwifery coordinator in charge of labour ward must have supernumerary status; (defines as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service".

2.4.3 The evidence required to demonstrate the supernumerary status of the labour ward coordinator has changed. Units across London are evaluating how they will achieve compliance and are working towards establishing a shared definition of supernumerary status. This has been raised at Regional level by many London Trusts last week at the Directors Of Midwifery and Head of Midwifery meeting and the regional team will report to NHS resolution in this matter.

2.4.4 A task and Finish group will be established to identify a methodology to audit the requirement above with support from NCL and the Region.

2.4.5 **Safety Action 6:** Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

2.4.6 Saving Babies' Lives Care Bundle Version 2 (SBLCB V2) is a care bundle for reducing perinatal mortality. It consists of 5 elements of care:

- Element 1: Reducing smoking in pregnancy
- Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
- Element 3: Raising awareness of reducing fetal movement (RFM)
- Element 4: Effective fetal monitoring during labour
- Element 5: Reducing preterm birth

2.4.7 The Trust will be compliant at time of submission with 4 of the 5 elements. The one that is at risk of non-compliance is element 1: “Percentage of women where Carbon Monoxide (CO) measurement at 36 weeks is recorded”.

2.4.8 Changes were made to this element of safety action 6. The evidence required is an audit of 4 consecutive months demonstrating that 80% of our population at 36 weeks gestation has had CO monitoring. CO monitors were ordered this summer and delivered to the maternity unit in September 2022. They have been dispatched to all community midwives as well as antenatal clinic, triage and inpatient areas since the beginning of October 2022. Maternity Support Workers have been trained to conduct the screening at the same time as observation measurements in the antenatal clinic and for the doctors to document and action high readings.

2.4.9 The matron for outpatient maternity services is accountable for ensuring delivery of this safety action. Compliance with this requirement is to be monitored and reported at maternity clinical governance.

2.4.10 **Safety Action 8**: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

2.4.11 The change made to this requirement is about the reporting timeframe. It was previously from August 2021 till December 2022. It has now been changed to 12 consecutive months between August 2021 to the 5th December 2022. Looking at our data, we have chosen the period from 3rd December 2021 till the 2nd December 2022.

2.4.12 Below is an update on the Training figures. The area of focus is the training for anesthetic consultants and trainees. There has been significant progress, but additional work is required to reach the numbers (90% for PROMPT and Fetal Monitoring). This is being monitored at the Maternity and Safety Champions Meeting and the M&NTP board.

2.4.13 The Midwifery and obstetric consultant workforce will meet the required compliance by 2nd December 2022. The anaesthetic team has made good progress, however, has still a substantial number of staff to complete the training. The Director of Midwifery will liaise with the anaesthetic clinical lead to discuss the way forward in achieving the standard.

2.4.14 The Women’s Health college tutor and the clinical director will be working together to ensure the trainee obstetric staff are compliant.

Table 1: Whittington Health Maternity Mandatory Training Compliance (%)

	PROMPT June 2022	Sept 2022	20th Oct 2022	Fetal monitoring June 2022	Sept 2022	20th Oct 2022
Staff Group						
Midwives	78%	78.9%	86%	75%	53%	86%
Consultant Obstetricians	23%	69%	77%	30%	77%	100%
Obstetric staff (all other grades)	54%	62%	75%	60%	44%	53%
Anaesthetic consultants	13%	56%	75%			
Anaesthetic juniors	22%	48%	59.0%			

3.0 Care Quality Commission Standards

3.1 The Head of Midwifery is leading the programme of work to ensure a 'good to outstanding' service in maternity. This work will support the Trust's improvements in "Better Never Stops" programme and provide the staff with confidence in the quality of the services delivered. The action plan is being monitored at the Maternity Clinical Governance Meeting.

3.2 Weekly mock visits are organised with support from the medicine's safety team and Infection, Prevention and Control Team. Areas of focus include:

- Ward information boards to be updated monthly
- Review the guidelines tracker
- Develop governance boards for the clinical areas
- Set up swipe access to drugs rooms for temporary staff
- Medicine's management including controlled drug key holding and room temperatures monitoring and improvements
- Working with Pharmacy on prefilled syringes for anaesthetics
- Baby tagging business case to be presented to investment group
- Baby abduction drill planned and policy has been reviewed
- Continued focus on reducing open Datix reports
- Focus on resuscitation trolleys checks
- Focus on good house-keeping and working with Estates to follow up repairs
- Safe storage of patient notes
- Staff culture work:
  - Junior doctor and midwives buddy system
  - Multi-Disciplinary Quality Improvement Projects
  - Monthly "Ockenden" Cafes restarting from the 27th October 2022
  - Quarterly Schwartz Round specific to maternity unit staff
- Focus on mandatory training as improvement in numbers has dropped in the last month

4.0 Incidents and learning points from Serious Incidences (SIs)

4.1 The aim of reporting and investigating SIs is to ensure a learning culture and approach to healthcare in order to prevent future incidents.

Table 2: Serious Incidents

Datix Ref	Description	Target date of report completion
A80847	A baby was born at 28+ 2 weeks (premature birth) in poor condition requiring resuscitation. Baby was transferred to NICU on resuscitaire with manual ventilation and for initial stabilisation	Going to SIEAG next Friday for review.
A90188	Term admission to NICU – Hypoxic-ischaemic encephalopathy (HIE) – Therapeutic Cooling	Completion timeline to be confirmed as requesting external involvement.
A87076	Intrauterine death at 26 weeks and 5 days & ITU admission	Final report to be submitted 04/11/2022.

4.2 Themes, learning and recommendations:

- Processes and guidelines for the Maternity Assessment Unit: Implementation of BSOTS (Birmingham symptom specific obstetric triage system) or a modified BSOTs system to support staff in appropriately managing and escalating the unwell patient. This is to be led by the Intrapartum Matron.
- Develop an education package / simulation to teach identification of the critically unwell medical patient, demonstrate early useful investigations and management steps, and how to involve the ward medical teams and critical care outreach. A consultant has been identified to lead this work.
- Refresh training for escalation either when there are concerns or for a sick or deteriorating patient, for the whole Multi-Disciplinary Maternity Team. This will include ensuring all staff feel enabled to escalate to consultant on-call if necessary. This escalation process will then be widely disseminated using flow charts and SOP as appropriate.
- The team will review the Antenatal Fetal Monitoring guideline and consider including appropriate use of the centralised Cardiotocography (CTG) system using Dawes and Redman criteria. These criteria are an algorithm that uses a library of 100 000 fetal heart rate recordings. It's aim is the delivery of an automated analysis of the fetal heart rate and 20 other factors which alerts after 60 minutes of recording if not all the criteria are met. There will also be an addition to the guideline that all patients who have a CTG that does not meet Dawes Redman criteria must be reviewed in person by the obstetric registrar or consultant**.**
- A review and update of the resuscitaire and daily room safety and checking process

- Training and education package focusing on: a structured communication tool – SBAR and continual risk assessments & recognition and escalation of a deteriorating patient

5.0 Healthcare Safety Investigation Branch (HSIB) – Quarter 2 feedback

5.1 The Healthcare Safety Investigation Branch (HSIB) replace the Trust's investigations for all incidents that fit the criteria of the Each Baby Counts programme and any maternal deaths within 42 days of birth.

Regarding referrals from Whittington Health to HSIB (slides 9 and 10, Appendix 2):

- The Trust has received no Safety Recommendations for this quarter.
- No cases rejected since last Quarterly Review Meeting (QRM) (June 2022)
- The Trust has one active investigation being undertaken by HSIB at present and there were no changes recommended at the HSIB QRM on 20Th September 2022.
- The active investigation relates to an intrapartum stillbirth. This incident was subjected to a rapid MDT review that did not identify care and service delivery problems contributing to this incident. However, there are areas for learning and improvement which relate to clinical documentation.

At the QRM meeting HSIB shared "Insight and temperature check – Coincidental findings" where no concerns were identified (Slide 25, Appendix 2).

6.0 Maternity Dashboard

Table 3: Maternity Dashboard

Measure	Goal	Red flag	July	August	September
Antenatal Referrals			351	315	312
Booking Scheduled			327	278	262
Proportion of Vaginal births in a midwifery led unit			14.5 %	16.2 %	14.4 %
Induction of labour rate	< 32.1%	>41.2%	**28.4 %**	**29.5 %**	**25.4 %**
Robson Group 1 CS Rate	Nulliparous women with single cephalic pregnancy, ≥ 37 weeks gestation in spontaneous labour		2.3 %	5.3%	5.1 %
Robson	Nulliparous women with		17.5%	11.0%	10.2%

Measure	Goal	Red flag	July	August	September
Group 2 CS Rate	single cephalic pregnancy, ≥ 37 weeks gestation who either had labour induced or were delivered by caesarean section before labour				
Robson Group 2a CS Rate	As 2, induced		9.7 %	5.3 %	5.5 %
Robson Group 2b CS Rate	As 2, caesarean section before labour		7.8 %	5.7 %	4.7 %
Robson Group 3 CS Rate	Multiparous women without a previous uterine scar, with single cephalic pregnancy, ≥ 37 weeks gestation in spontaneous labour		0.8 %	0.4 %	0.4 %
Robson Group 4 CS Rate	Multiparous women without a previous uterine scar, with single cephalic pregnancy, ≥ 37 weeks gestation who either had labour induced or were delivered by caesarean section before labour		3.1 %	3.0 %	3.0 %
Robson Group 4a CS Rate	As 4, induced		0.8 %	1.1 %	0.8 %
Robson Group 4b CS Rate	As 4, caesarean section before labour		2.3 %	1.9 %	2.1 %
Robson Group 5 CS Rate	All multiparous women with at least one previous uterine scar, with single pregnancy, ≥ 37 weeks gestation.		11.7 %	11.4 %	7.6 %
Robson Group 5a CS Rate	As 5, with 1 previous CS		9.3 %	9.5 %	5.9 %
Robson Group 5b CS Rate	As 5, with more than 1 previous CS		2.3 %	1.9 %	1.7 %
Robson Group 6 CS Rate	All nulliparous women with a single breech pregnancy		1.9 %	1.1 %	2.1 %
Robson	All multiparous women		0.4 %	1.1%	2.1 %

Measure	Goal	Red flag	July	August	September
Group 7 CS Rate	with a single breech pregnancy, including women with previous uterine scars				
Robson Group 8 CS Rate	All women with multiple pregnancies, including women with previous uterine scars		2.7 %	1.9 %	0.0 %
Robson Group 9 CS Rate	All women with a single pregnancy with a transvers or oblique lie, including women with previous uterine scars.		1.2 %	0.4 %	0.0 %
Robson Group 10 CS Rate	All women with a single cephalic pregnancy < 37 weeks gestation, including women with previous scars.		3.9 %	3.8 %	0.4 %
Overall Instrumental Vaginal Delivery Rate (Ventouse or Forceps)	<12.3%	>15.5%	**14.4 %**	**14.8 %**	**18.0 %**
Failed instrumental delivery rate	N/A	N/A	2.8 %	5.0 %	4.5 %
Stillbirth rate	<3.93per 1000births after 23+6 weeks	> 4.8 per 1000 births after 23+6 weeks	**3.8**	**3.7**	**0.0**
Neonatal death rate	<1.71per 1000 live births	>1.81per 1000 live births	**0.0**	**0.0**	**0.0**
Term admissions to NICU (maternity dashboard data)	N/A		6.6 %	6.1 %	6.1 %

6.1 Antenatal referrals – From January 22 to September 22 there has been a drop in the numbers of referrals received to maternity care. It is important to note that before June 22 our Trust had a visiting policy during COVID 19 that was

much more accommodating for visitors and birth companions that the other Trusts within NCL LMNS.

6.2 The lack of administration operational support at first point of contact throughout the maternity care pathway is recognised on the maternity risk register as leading to a risk of poor data capture and poor data quality with an inaccurate recording of activity episodes.

6.3 Regarding the antenatal referrals, this translates into not all referrals and bookings being captured. The delay in processing this data also leads to women booking at other Trusts.

6.4 Administration operational support has been recruited in the past 2 weeks (October 2022) for most of the areas, except labour ward. Data quality and capture should improve in the following months.

6.5 Bookings scheduled – There is a decrease for August and September in comparison with previous months. This is most likely a result of the lack of timely triage of the antenatal referrals. This might lead to women opting to self-refer and booking elsewhere. The team are exploring whether similar changes are being seen in other north central London Units. The current rate of booking will impact on our number of births for the year.

6.6 Since April 2022, the birth centre has become consistently available to women as an option for place of birth. The dashboard reflects this as the number of women giving birth in the birth centre have doubled. As per the national recommendations it should be the default place for birth and women referred to labour ward for choice or medical reasons. The plan going forward is to work in collaboration with the MVP's and GPs to promote Whittington Health Maternity Services. Women need to be reassured that they will be consistently offered the choice of the 3 options for birth places: Home, birth centre, labour ward. The ratification of the SOP for second on call midwife for homebirth being facilitated by the inpatient areas will also support consistent access to the Birth Centre.

6.7 The induction of labour rate in September 2022 was the lowest of the year. Although our overall induction rate is below the national average the failed induction rate for both primiparous and multiparous women is above the national average. To be able to draw further conclusions an insight in the reasons for induction of labour is needed. When the induction of labour rate was compared with neonatal outcomes the number of terms admissions to NICU remained stable which provides assurance.

6.8 The metrics for caesarean section are now reported using the Robson classification:

- The highest caesarean section rate is for: Nulliparous women with single cephalic pregnancies, ≥ 37 weeks gestation who either had labour induced or were delivered by caesarean section before labour. Out of

these the ones that had their labour induced were the ones that had a higher section rate.

- The second highest caesarean section rate is for: All Multiparous women with at least one previous uterine scar, with single cephalic pregnancy, ≥ 37 weeks gestation.
- The lowest caesarean section rates (<1%) are for:
  - Multiparous women without a previous uterine scar with single cephalic pregnancy, ≥ 37 weeks gestation in spontaneous labour
  - All women with multiple pregnancies including women with previous uterine scars
  - All women with a single pregnancy with a transverse or oblique lie including women with previous uterine scars
  - All women with a single cephalic pregnancy <37 weeks gestation, including women with previous scars

6.9 The overall instrumental vaginal birth rate is the second highest of the year. Most of them were primiparous. Also, 2 were failed instrumental delivery resulting in Emergency Caesarean Section (EMCS) which is a stable number throughout the year. When we compare the overall instrumental rate with neonatal outcomes, we are reassured that the number of terms admissions to NICU remained stable.

6.10 For September 2022, 3 women sustained a 3rd degree tear. Two women were multiparous with spontaneous vaginal births and birthweights were on the 5th and the 30Th centile. The perineum was not guarded. The primigravida had risk factors for a 3rd degree tear: Female Genital Mutilation (FGM) and instrumental birth. All third degree tears are reviewed.

6.11 The term admission rate to the neonatal unit remained stable. These admissions are reviewed by the Multi-Disciplinary Team, and they were all unavoidable.

6.12 For September there were no stillbirths nor neonatal deaths.

7.0 Workforce

7.1 Midwifery:

7.1.1 Recruitment: The Trust have successfully recruited 25 new midwives who will be starting with WH by the end of the year. However, 9 staff have withdrawn from the recruitment process and 4 staff have recently resigned. A new rolling advert and programme of recruitment is being considered to start. The practice development team is investigating the reasons for withdrawal and developing an action plan.

7.1.2 Continuity of Care team: 1 team (Sunflower Team) operating in Islington that cares for women in area of higher social deprivation where Continuity of Care has been shown to greatest impact. The next team will be set up in Haringey again to support higher risk women, however this will be on hold until our recruitment is complete as directed nationally.

7.1.3 Homebirth Cover: No cover possible for every night and every weekend of the months. Interim plan for birth centre midwife to be the 2nd on call to support the community team regarding homebirth. Long Term Plan to be established.

7.2 Obstetrics:

7.2.1 The Trust recently successfully recruited 2 new obstetric consultants. The Trust were unable to appoint to a third post but will be re advertising and have an additional 4 jobs just returned from the college that are going through the Trust processes and out to advert. The Trust have also been successful in obtaining funding for an additional PA from the national team to support post - natal care and bereavement.

8.0 Maternity Digital Programme

8.1 The Programme to move from a hybrid paper and digital to digital working in maternity is reaching a crucial stage. The equipment and hardware have been purchased. The project team have spent time shadowing the teams and identified variation in working. To enable safe and effective movement to digital, 36 SOPs are in development. This will be followed by an intensive training programme to support the go-live to move to digital. This will further support the data quality in maternity and provide improved care, transparency and access to women's care plans.

9.0 Maternity and Neonatal Estates Programme

9.1 Birth Centre:

9.1.1 The work to improve the birth centre has been agreed and will be going out to tender in the next month to ensure the work is undertaken this financial year.

9.2 Phase 1:

9.2.1 The funding has been agreed and the following will be developed:

- 2x new labour ward ensuites
- New maternity entrance
- Moving staff change, bed store and linen store
- New temporary triage that is co-located with labour ward
- Essential backlog maintenance

9.3 Phase 2:

9.3.1 The development of Outline Business Case is underway and the 1:200 designs for this are being completed.

10.0 Bids

10.1 The Trust recently bid for funding from NHSE and were successful in:

Table 4: Maternity Workforce Funding from NHSE

Funding Element	Funding purpose	Allocation
Obstetric Leadership	To increase the number of PAs to support and enhance local obstetric leadership capacity	£4,750
Bereavement Provision	Universal offer to be used towards ensuring adequate numbers of staff are trained in bereavement care	£4,470
Maternity Services Support Workers	To continue the employment of dedicated resource to enhance the retention and educational development of support staff working in maternity services	£28,500
Total allocation to be paid in October 2022 (subject to the MoU return date)		**£37,720**

11.0 Complaints and Compliments

11.1 A system reporting issue with the Maternity Friends and Family Test (FFT) data has been reported from the data analytics company IQVIA since August 2022. Data captured "Don't Know" as respondent answers which is not correct. Hence, it was excluded from the reports and submissions until it is fixed. It is being investigated at present and the information analyst will update the reports when the correct data is available.

11.2 There were no new complaints reported for maternity since the 12th July 2022, and 3 complaints are outstanding.

11.3 Here are example compliments received in September:

- Wedding cake delivered to midwives on the labour ward, baby delivered at WH in 2020.
- Compliment for agency midwife who identified cord prolapse and baby delivered swiftly by emergency caesarean

12.0 Conclusions

12.1 The committee is asked to note the assurances given around national standards and MIS requirements.

12.2 The committee is asked to note the report**.**

Maternity incentive scheme – year four

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

October 2022

Contents

Introduction 4

Maternity incentive scheme year four: conditions 4

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? 8

Technical guidance for Safety action 1 10

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? 17

Technical guidance for Safety action 2 20

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? 25

Technical guidance for Safety action 3 30

Safety action 4: Can you demonstrate an effective system of clinical* workforce planning to the required standard? 35

Technical guidance for Safety action 4 38

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard? 44

Technical guidance for Safety action 5 46

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? 48

Technical guidance for Safety action 6 54

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? 56

Technical guidance for Safety action 7 58

Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4? ... 59

Technical guidance for Safety action 8 60

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? 66

Technical guidance for Safety action 9 71

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22??..... 74

Technical guidance for Safety action 10 76

FAQs for year four of the CNST maternity incentive scheme……...82

Introduction

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year four: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by 12 noon on Thursday 2 February 2023 and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
  - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
  - There are no reports covering either year 2021/22 or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before Thursday 2 February 2023.

- The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be

signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution
  Note: CCG functions will be subsumed into integrated care systems, with CCGs ceasing to exist as statutory organisations by July 2022.

- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.

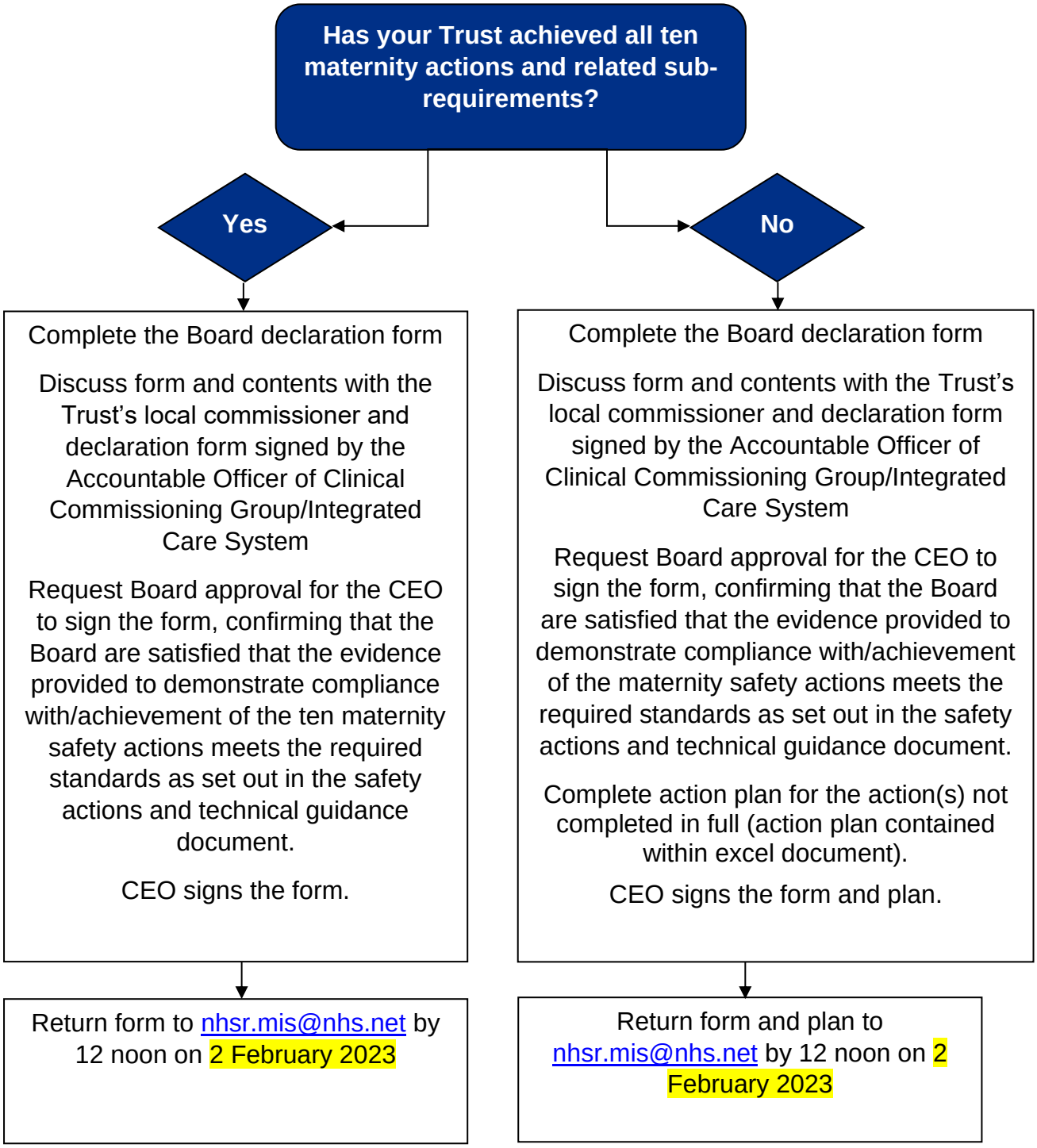
- Trusts will need to report compliance with MIS by Thursday 2 February 2023 at 12 noon using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.
- Only for a set amount of safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The declaration form will be available on the MIS webpage at a later date.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution (nhsr.mis@nhs.net) prior to the submission date.
- The Board declaration form must be sent to NHS Resolution (nhsr.mis@nhs.net) between Thursday 26 January 2023 and Thursday 2 February 2023 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within ten working days from submission date.
- Submissions and any comments/corrections received after 12 noon on Thursday 2 February 2023 will not be considered.
- Further detail on the results publication, appeals and payments process will be communicated at a later date

For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 2 February 2023 to NHS Resolution (nhsr.mis@nhs.net). The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.

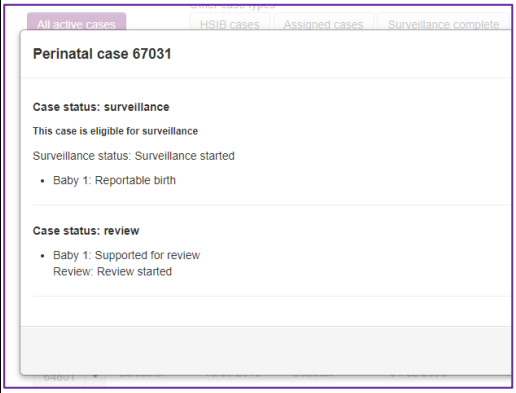

Has your Trust achieved all ten maternity actions and related sub-requirements?
Yes
No
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
CEO signs the form.
Return form to nhsr.mis@nhs.net by 12 noon on 2 February 2023
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
CEO signs the form and plan.
Return form and plan to nhsr.mis@nhs.net by 12 noon on 2 February 2023
Send any queries relating to the ten actions to NHS Resolution (nhsr.mis@nhs.net) prior to the submission date

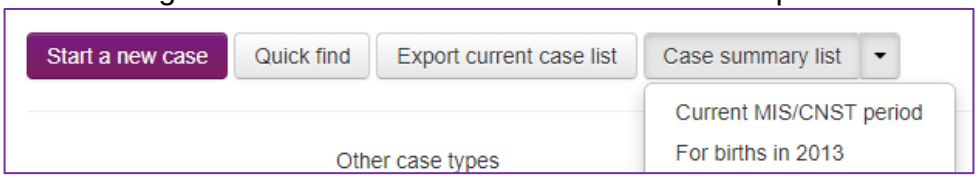
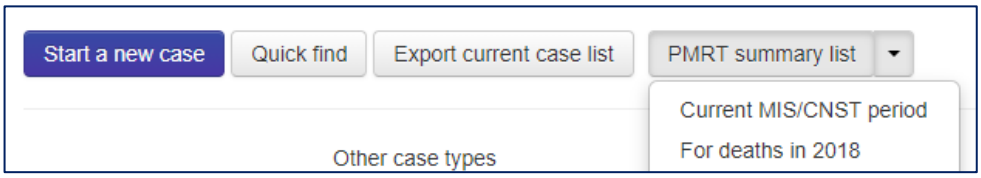
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

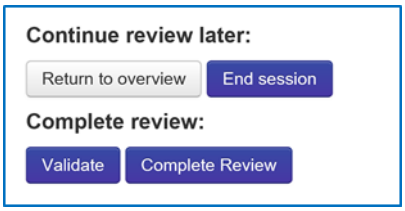
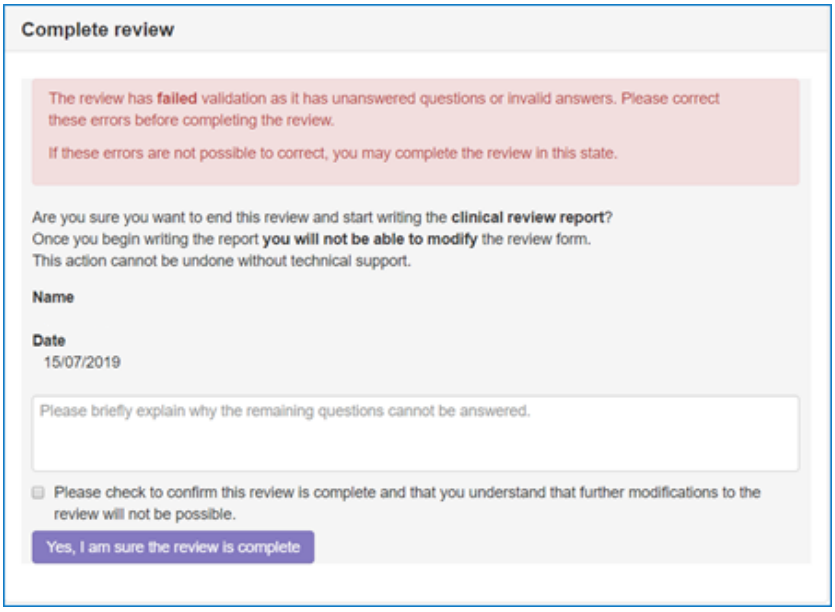
Required standard	a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust. b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death. c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

	d) Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.
Minimum evidential requirement for Trust Board	Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 1

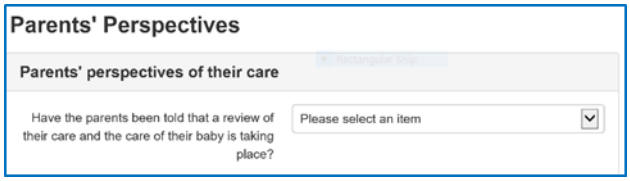
Technical guidance	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK from 6 May 2022 must be notified to MBRRACE-UK within seven working days. When a notification is complete the notification status will show whether surveillance (and review) is required for each case. This is available from the case management screen by clicking on the Case ID and selecting Notification status.  Following notification within seven working days of the perinatal death, the surveillance form, where required, must be completed within one month of the death. If at that stage post-mortem or other investigations are not available and the final cause of death is not confirmed, indicate this in the "Cause of Death/Confirmation of cause of death" section, complete the rest of the information, and close the surveillance form. Once the additional information and the final cause of death is known and confirmed as part of the PMRT review discussion, the reporter should re-open the case, update the relevant sections and close it again. You can reopen the surveillance form from the case management screen. If you need to assign the surveillance form to another Trust for additional information then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death.

What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths which will be via MBRRACE-UK. Once this single route is established MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP). At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission to CDOP. This will also be the required route for providing additional information about the death required by the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in the forthcoming months.
How can we keep a check on which of our deaths require surveillance?	There is a report under 'Case summary list' on the MBRRACE-UK case management screen entitled 'Current MIS/CNST period'.  This includes ALL deaths in the Trust which have been notified to MBRRACE-UK and shows the status of the surveillance if required. This will also indicate if surveillance is required and not started/completed.
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: •All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) •All stillbirths (from 24+0 weeks' gestation) •Neonatal death (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet safety action one.
How can we keep a check on which of our deaths are suitable for review using the PMRT and their review status?	Within the PMRT authorised users of the PMRT can generate a report for your Trust under 'PMRT summary list' entitled 'Current MIS/CNST period'. This list includes those deaths notified by your Trust which are suitable for review using the PMRT at the point when the report is generated.  This is a list of those deaths notified by your Trust which are suitable for review using the PMRT **at the point when the report is**

	generated. This report is of ALL deaths in the Trust which have been notified to MBRRACE-UK some of which (for example terminations of pregnancy) are not suitable for review using the PMRT.
What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to have been used to complete the first review session (which might be the first session of several) for that death. At a minimum all the 'factual' questions in the PMRT should be completed for the review to be regarded as started; it is not sufficient to just open the PMRT tool, this does not meet the criterion of having started a review.
What is meant by "completing a review to the point that at least a draft report has been generated"?	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'.  The tool may raise validation errors at this point. If validation errors appear you need to deal with these in one of two ways: (i) resolve them and then press the 'Complete Review' button again OR (ii) complete the text box with an explanation of why the remaining questions cannot be validated (for example, the mother's hand held notes were lost). Confirm that the review is complete by ticking the box and pressing the button **'Yes I am sure that the review is complete'**.  The report entitled 'PMRT summary list' includes the status of the review, which should be 'Writing report' or 'Review complete'.

What does multi-disciplinary review mean?	The team conducting the review should include at least one and preferably two professionals relevant to the care of the woman and her baby. Ideally the team should include a member from a relevant professional group who is external to the unit who can provide peer review as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Where a HSIB investigation has been carried out the external member could be one or more of the HSIB reviewers involved in the HSIB investigation. Further guidance about multidisciplinary review can be found on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/implementation-support
Review assignment	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided Issues with care identified are 'owned' by the Trust which identified them as are the related action plans, but a single report is generated. This ensures that when the report is discussed with the parents all aspects of the care they received can be covered; this should avoid potentially contradictory findings being conveyed and inappropriate advice being given regarding their next pregnancy.
Can the PMRT help by providing a quarterly report which can be presented to the Trust Board?	Reports for your Trust, summarising the results from completed reviews over a period, can be generated within the PMRT by authorised PMRT users for user-defined periods of time. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for your quarterly Board reports and should be discussed with your Trust maternity safety champion.
What deaths should we review outside the relevant time period for the safety action validation process?	We recommend Trusts review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process.
What should we do if our post-mortem	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results

service has a turn-around time in excess of four months?	to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing learning opportunities earlier, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker than this information from the post-mortem can be included in the original reviews.
What should we do if we do not have any eligible perinatal deaths with the relevant time period?	If you do not have any babies that have died between 6 May 2022 and 5 December 2022 then you should partner up with a Trust with which you have a referral relationship to participate in case reviews.
How does the involvement of the Healthcare Safety Investigation Branch (HSIB) in investigations impact on meeting safety action one?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB INVESTIGATION is taking place and this will be accounted for in the external validation process.
How does "assigning a review" impact on safety action 1, especially on starting a review?	It is recognised that if you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the external validation process.
We have informed parents that a local review will take place and they have been asked if they have any	In order to address any questions that parents have about their care and why their baby died, parents need to be informed that a review will take place and be given the opportunity to provide their perspective about their care and raise any questions that they have. In order that parents' perspectives and questions can be considered this information needs to be incorporated as part of the review and

reflections or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	entered into the PMRT. So if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials 
We have contacted the parents of a baby who has died and they don't wish to have any involvement in the review process, what should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of neonatal deaths parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.
Parents have not responded to our messages and therefore we are unable to discuss the review – what should we do?	As stated above, following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care, and that of their baby, will be undertaken by the Trust (as above). If this does not happen for any reason and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if causes for concern for the mother's wellbeing were raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of role of key contact, are available on the PMRT website at: materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials

	See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
Is the quarterly review of the Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for your Trust summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis of your quarterly reports to your Trust Board and should be discussed with your Trust maternity safety champion. Please note that these reports will only show summaries, issues and action plans for reviews **that have been published** therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
The scheme was paused on 23 December 2021. Trusts were asked to continue to report eligible cases to MBRRACE-UK during the pause. Will the safety action 1 standards be applied to the deaths occurring before the pause date?	Trusts were asked to continue to report eligible cases to MBRRACE-UK during MIS year 4 pause. However, Standard 1 requirements will only be validated for the period after the pause that is, from 6 May 2022 until 5 December 2022.
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK as soon as possible. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on PMRT for the maternity incentive scheme where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action, will be communicated via NHS Resolution email and will also be included in the PMRT "message of the day".

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required standard	This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. By 31st October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme. 2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022. 3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month. 4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month. 5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2) 6. July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in

	the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics: **Midwifery Continuity of carer (MCoC)** i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information).
Minimum evidential requirement for Trust Board	1) Criteria 1 will be reported to NHS Resolution as part of trusts' self-declaration using the Board declaration form. For criteria 2 to 7, the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series displays whether trusts have passed the requisite data quality thresholds.

Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England and Improvement will cross-reference self-certification of criteria 2 to 7 (inclusive) against NHS Digital data
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 2

Technical guidance	
Regarding criteria 1, we have not started a digital strategy for our maternity service. What support is available?	NHSEI will not be reviewing individual strategies. Support on how to write a strategy can be sought within your own Trust, ICS and Regional Digital Midwife Expert Reference Groups (see below for further information).
Regarding criteria 1, what is meant by having digital leadership in place?	By digital leadership, we mean that the maternity service should have at least 1 person who is dedicated towards working on the digital strategy and improving digital maturity within maternity services. The digital lead does not have to be a clinical member of staff, and could, for example, be a project manager, however they must report to or work alongside a clinician.
Regarding criteria 1, what is meant by engaging with the Digital Child Health and Maternity Programme?	By engaging with the programme, we mean that the digital lead should have made contact and be known to the Regional Digital Midwives Expert Reference group (or equivalent). For further information regarding the Expert Reference Group, please email england.digitalmaternitynhsx@nhs.net
Regarding criteria 1, our Integrated Care Board is unable to sign off our digital strategy. What are the alternative options?	If a Trust already have a pre-existing digital strategy for maternity that aligns with the What Good Looks Like Framework which has been signed off by the appropriate governance, then no further action is needed to meet this criteria. If it is not possible to obtain Integrated Care Board sign-off for new strategies, then sign-off by another appropriate governance board will be acceptable (e.g. LMNS Board).
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If your maternity service has suspended Midwifery Continuity of Carer (MCoC) pathways, in your MSDS submission you should report that women are not being placed on these pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 7i. Consequently, criteria 7ii would not be applicable to your CNST submission as it relates only to women placed on MCoC pathways, and no further action from you would be necessary. However, criteria 7iii does still apply to all maternity services, even if they have suspended MCoC pathways, as we would expect all services to report Care Professional Local Identifier data

Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? • **Proportion of babies born at term with an Apgar score <7 at 5 minutes** • **Women who had a postpartum haemorrhage of 1,500ml or more** • **Women who were current smokers at delivery** • **Women delivering vaginally who had a 3rd or 4th degree tear** • **Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section** • **Caesarean section delivery rate in Robson group 1 women** • **Caesarean section delivery rate in Robson group 2 women** • **Caesarean section delivery rate in Robson group 5 women**	No. For the purposes of the CNST assessment trusts will only be assessed on July 2022 data for these CQIMs. Due to this, trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts. NHS E&I will externally verify Trust' compliance with criteria 2 to 7.
Will my Trust fail this action if women choose not to receive continuity of carer or a Personalised Care and Support Plan?	**No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output.**

The metrics for Midwifery Continuity of Carer appear to have changed. Why is this?	In the last version, there was a metric for placement of women onto midwifery continuity of carer pathways. This has not changed and has simply been broken down into the 2 required data quality measures (see i and ii), to provide more clarity on what is required. The last version also contained a metric to demonstrate evidence of receipt of continuity of carer by women. Current national data quality levels suggest there is much further work to be done for all Trusts to achieve this. Therefore, this has been replaced with a metric (see iii) containing important elements needed to improve the overall data.
The metric for Personalised Care and Support Plans (PCSP) has changed. Why is this?	NHSEI has taken on board feedback that reporting of the PCSP metrics as given previously in this action were not sufficiently aligned to the policy or clinical practice. In addition, we were informed that, as a consequence, Maternity Information Systems had not been appropriately configured to record PCSPs in the way suggested. The replacement metric is the same as that used in last year's MIS, which Trusts successfully reported on. The only difference is that we have increased the reporting threshold from 90 to 95% for the proportion of women with the antenatal PCSP field completed ('yes' or 'no') who were booked in the month. This data still provides useful insight and will contribute towards a more refined measure for PCSPs in future.
What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS Digital specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available on NHS Digital's website: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool

For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 7?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for MIS. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics. Also note – in the last version of this action we had asked for evidence of 4 months' use of the tool which included the assessment month. This is no longer the case – any 3 consecutive months before submission of evidence to your Trust Board is sufficient.
The monthly publications and Maternity Services Dashboard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series (https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics). The scores for each data quality criteria can be found in the "Measures" file within the same publication series.
The monthly publications and national Maternity Services Dashboard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.

Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services Dashboard please contact NHS Digital at maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Required standard	a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter. c)A data recording process (electronic and/or paper based for capturing **all** term babies transferred to the neonatal unit, regardless of the length of stay, is in place. d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered. e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been

	cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis. g) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion. h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.
Minimum evidential requirement for Trust Board	Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: **Evidence for standard a) to include:** • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.
	Evidence for standard b) to include: • An audit trail is available which provides evidence that ongoing audits from year 3 of the maternity incentive scheme of the pathway of care into transitional care are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. • Audit findings are shared with the neonatal safety champion on a quarterly basis. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions.
	Evidence for standard c) to include: • Data is available (electronic and/or paper based) on all term babies transferred or admitted to the neonatal unit. This will include admission data captured via Badgernet as well as transfer data which may be captured on a separate paper or electronic system.

	• If a data recording process is not already in place to capture all babies transferred or admitted to the NNU this should be in place no later than **Monday 18 July 2022.**
	Evidence for standard d) to include: • Data is available (electronic or paper based) on transitional care activity (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.). • Secondary data is available (electronic or paper based) on babies born between 34+0-36+6 weeks gestation at birth, who did not have surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered to inform future capacity management for late preterm babies who could be cared for in a TC setting.
	Evidence for standard e) to include: • Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to share on request, for example to support service development and capacity planning, with the LMNS, ODN and/or commissioner.
	Evidence for standard f) to include: • An audit trail is available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. • If not already in place, an audit trail is available which provides evidence that reviews from Monday 18 July 2022, now include **all** term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. • Evidence that the review includes: the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there.

	• Evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting.
	Evidence for standard g) and h): • An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point f).Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter.
	• Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) The expectation is that the pathway has been in place since year 2 of the scheme and should now be business as usual. If for any reason this is not in place it should be by Thursday 16 June 2022 at the very latest. b) The expectation is that the audits have been in place since year 3 of the scheme and should now be business as usual. If for any reason, audits have been paused, they should be recommenced, using data from quarter 1 of 2022/23 financial year and be completed on a quarterly basis. There should be evidence that audit findings are shared with the neonatal safety champion each quarter. c) Reviews of babies transferred to the neonatal unit, including those not captured on BadgerNet and regardless of length of stay should be in place from no later than Monday 18 July 2022. d) Data collection process should have been met and in place in year 3 of the scheme. If for any reason it was not, this should be achieved by no later than 16 June 2022. Secondary data collection process for late pre-terms in place by no later than 16 June 2022. e) Commissioner returns on request – as per ODN request f) The expectation is that the reviews have been in place since year 3 of the scheme and should now be business as usual. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year and be completed on a quarterly basis.

	Reviews of babies transferred to the neonatal unit, including those not captured on BadgerNet and regardless of length of stay, should be included from Monday 18 July 2022. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. There should be evidence that review findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting. g) Evidence of an action plan (to address points b, and f) being agreed with the maternity and neonatal safety champions and Board level champion and signed off by the Board no later than 29 July 2022. h) Evidence of progress with the action plan being shared with the neonatal, maternity safety champion, Board level champion and LMNS and ICS quality surveillance meeting each quarter following sign off at the Board.
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 3

Technical guidance	
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process has been carried over from year three of the maternity incentive scheme as a means of informing future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the ODN, LMNS and/or commissioner but must be readily available should it be requested.
What members of the MDT should be involved in Atain reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).
Why has the standard now been changed to include all babies transferred and admitted to a NNU?	Feedback from regional maternity colleagues identified variation in ATAIN reviews being undertaken, with some units reviewing all babies admitted and transferred to the NNU and some only reviewing those admitted onto Badgernet. There is valuable learning in both and to avoid unwarranted variation and maximise the opportunity to learn, ATAIN reviews must include **all babies transferred or admitted to the NNU for any period of time**. As a minimum, a high-level review of the primary reasons for all transfers and admissions should be completed, with a focus on the most frequent reason(s) for transfer or admission through a deep dive to determine relevant themes to be addressed.
What do you mean by ‘transferred to the NNU’	This is when a baby is transferred to the NNU for any period of observation and / or intervention, regardless of whether this was recorded on Badgernet. **We are fully supportive of this practice and would not discourage perinatal services from doing this as this might impact on safe care being provided.**
We have undertaken some reviews for term	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the

admissions to NICU, do we need to undertake more and do all babies admitted or transferred to the NNU need to be included?	ATAIN work to date. The expectation is that reviews have been continued from year 3 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of the 2022/23 financial year (beginning 1 April 2022). **This may mean that some of the audit is completed <u>retrospectively</u>.** For units where previous reviews have not included term babies transferred to the NNU with a short stay, or babies not admitted on BadgerNet, reviews must now include these babies no later than Monday 18 July 2022. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. We recommend **ongoing reviews, at least quarterly** of unanticipated term admissions to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. A high-level review of the primary reasons for all transfers and admissions should be completed, with a focus on the most frequent reason(s) for transfer or admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are transferred or admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were transferred or admitted due to observation for hypoglycaemia and 35% of with hypothermia then focus on these two cohorts of babies. **It is important to monitor emerging trends in transfers and admissions and these should also be factored into the quarterly review. For example, if there is an increasing number of babies transferred each month due to hypothermia, or to receive IV antibiotics, even if this is not the most frequent reason, a deep dive should be performed so that actions are put in place to mitigate any future separation of mother and baby.** In addition to this the number of babies transferred or admitted to the NNU that would have met current TC admission criteria but were transferred to the NNU due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.
Do we include babies that were transferred to the NNU rather than TC	No, these babies do not need to be captured.

due to the parents declining to stay for TC, but not due to staffing or capacity issues?	
What do mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year, for example quarter 1 covering 01/04/2022-30/06/2022).
ATAIN audit – what should the audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template, however the audit needs to include aspects of the local pathway. The audit tool can be found here https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/ We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.
What "*nor were transferred during any admissions*" mean?	This refers to babies that are transferred between Units of a Trust (e.g. if they needs an uplift in care).
"If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0 - 36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admissions, to monitor the number of special care or normal care days where supplemental oxygen was not delivered" **FAQ - If women are booked at another hospital and come in for delivery at our hospital and deliver**	The statement refers only to neonatal transfers (not to e.g. an ex-utero transfer).

here, does this count as a transfer as well as an ex-utero transfer as mum was transferred in not the baby?	
If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0 - 36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admissions, to monitor the number of special care or normal care days where supplemental oxygen was not delivered" **If a baby is transferredfor ITU or HD care initially and subsequently to TC, do we exclude them completely, or just count the special care days they have?**	The aim of this requirement is to count all babies who would be fit for TC when they get to that point- either directly at birth, or subsequently (as this is still mother/baby separation, which is what we are aiming to reduce). If Badgernet/NNAP data is used, it would include babies initially transferredto ITU/HDU. **<u>These babies should be captured as a number but do not need to be included in a detailed review.</u>**
How long have the neonatal safety champions been in place for?	Trust board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.
What is the definition of transitional care?	Transitional care is not a place but a service and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/ https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk)

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required standard	a) Obstetric medical workforce 1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ 2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS. **b) Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1) **c) Neonatal medical workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements **had not been met** in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

	If the requirements **had been met** in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. **d) Neonatal nursing workforce** The neonatal unit meets the service specification for neonatal nursing standards. If the requirements **had not been met** in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements **had been met** in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.
Minimum evidential requirement for Trust Board	**Obstetric medical workforce** Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022. **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies.

	A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal College of Nursing (cypadmin@rcn.org.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	**a) Obstetric medical workforce** 1. By 16 June 2022 2. By 29 July 2022 and monitored **monthly** from then. **b) Anaesthetic medical workforce** Any six month period between August 2021 and 5 December 2022 **c) Neonatal medical workforce** A review has been undertaken any 6 month period between August 2021 and 5 December 2022. **d) Neonatal nursing workforce** Nursing workforce review has been undertaken at least once during year 4 reporting period (August 2021 and 5 December 2022).
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 4

Technical guidance	
Obstetric workforce standard and action	
How can the Trust board evidence that the department has acknowledged and committed to incorporating the principles of the RCOG document?	Documented evidence of discussion at relevant meetings e.g. consultant meeting, divisional governance meetings, new consultants' induction etc. Circulation to all staff who work in maternity and Gynaecology. Mandatory consultant attendance list to be included in departmental escalation policies.
How can the Trust monitor adherence with the standard?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
Can we self-certify compliance with this element of safety action 4 if consultants have not attended clinical situations on the mandated list?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
RCOG "Roles & Responsibilities" - Are we required to evidence compliance with the obstetric attendance requirements or also the Gynae ones included in the RCOG list?	Trusts should monitor their compliance against the RCOG standards in relation to Consultants with any obstetric commitment to intrapartum care.
What period is the audit to cover and is it a snapshot or day by day audit?	Trusts should monitor their compliance day by day on a monthly basis from 29 July 2022

Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

Anaesthetic medical workforce

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.

Neonatal medical workforce

Technical guidance	
Neonatal Workforce standards and action	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If no, Trust Board should outline progress with the action plan developed in year 3 of MIS and submit this to the Neonatal ODN. There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps.
BAPM **"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021** **or** **"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018**	
NICU **Neonatal Intensive Care Unit**	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. **Tier 1**

	Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3 NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice **Tier 2** A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) **Tier 3** Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.

LNU **Local Neonatal Unit**	**Tier 1** At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7 In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework **Tier 2** An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7 **Tier 3** Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training
SCU **Special Care Unit**	**Tier 1** A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours.

	Tier 2 A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit **Tier 3** In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology)
Our Trust do not meet the relevant neonatal medical standards (Tier 1, 2 and/or 3) and in view of this an action plan, ratified by the Board has been developed. Can we declared compliance with this sub-requirement?	If the requirements are not met, Trust Board should outline progress against the action plan developed as part of year three of MIS in order to meet the recommendations. Action plan and related progress details should be shared with the Neonatal ODN. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 4 reporting period.
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021) A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Neonatal nursing workforce

Technical guidance
Neonatal nursing workforce

Where can we find more information about the requirements for neonatal nursing workforce?	Between 8 August 2021 until 5 December 2022, each neonatal unit should perform a nursing workforce calculation using the CRG work force staffing tool. Units that do not meet the service specification requirement for nursing workforce should have an action plan signed off by their Trust board, as per MIS year 3 requirements. Trust Board should evidence progress against the action plan and share those with the RCN, LMNS and Neonatal ODN.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to meet the recommendations. The action plan and related progress, signed off by the Trust Board, should be shared with the Royal College of Nursing (cypadmin@rcn.org.uk) and Neonatal ODN Lead. This will enable Trusts to declare compliance with this sub-requirement.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service d) All women in active labour receive one-to-one midwifery care e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.
Minimum evidential requirement for Trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio -The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not

	included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for Safety action 5

Technical guidance	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice**.	• Redeployment of staff to other services/sites/wards based on acuity • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to midwives at birth when required, supporting junior

	midwives undertaking suturing etc. This should not be counted as losing supernumerary status. Supernumerary status will be lost if the labour ward coordinator is required to be solely responsible for any 1:1 care for a labouring woman or relieve for break, (or any short period of time) a midwife who is providing 1:1 care for a high risk woman requiring constant observation. This includes supervising a student midwife providing 1:1 care.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and includes a timeline for when this will be achieved. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 4 of MIS.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board, and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Required standard	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract. 2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. 3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.
Minimum evidential requirement for Trust Board	**Element one** Process indicators: A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. B. Percentage of women where CO measurement at 36 weeks is recorded. Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe). If there is a delay in the provider Trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator. If the provider Trust is unable to record these data on their maternity information system an audit of 60 consecutive cases

would be acceptable evidence to demonstrate >80% of women having a CO measurement recorded at 36 weeks. The denominator for the audit should be 60 consecutive women at 36 weeks gestation, whereas the denominator for the electronic audit would be the total number of women at 36 weeks gestation. In addition to this, the audit should be accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

In addition, the Trust board should specifically confirm that within their organisation they:

1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.
2) Have a referral pathway to smoking cessation services (in house or external).
3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service.
4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period:
    - Percentage of women with a CO measurement ≥4ppm at booking.
    - Percentage of women with a CO measurement ≥4ppm at 36 weeks.
    - Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment.

Additional information

If your Trust is planning on using the maternity dashboard to evidence an average of 80% compliance over four months, please be advised that there is a three month delay with MSDSv2 data, for example data submitted at the end of August 2022 will be published on the dashboard at the end of November 2022.

If your Trust does not have an in house stop smoking service or a pathway to an external service, please contact your local authority stop smoking service or escalate to your local maternity system to enable the Trust to ensure provision is in place.

	***Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded*.** **Women declining CO testing at booking / 36 weeks appointment** Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at booking and at 36 weeks respectively and that this is recorded in the Trusts' information system. In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching the 80% testing rate. We suggest Trusts proactively monitor their testing rate and consider interventions to maintain adequate compliance.
	Element two **Process indicator:** 1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g. Appendix D). Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records should have been undertaken to assess compliance with this indicator. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.** In addition the Trust board should specifically confirm that within their organisation: 2) Women with a BMI>35 kg/m^2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards

	3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network. 7) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.
	Element three Process indicators: A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation). Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.**
	Element four There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are

	conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness. The Trust board should specifically confirm that within their organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. Please refer to safety action 8 for more information re training.
	Element five Process indicators: A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators. **The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance with process indicators A, C and D. The percentage for process indicator B should be as low as possible and can be reported as the proportion.**

	A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%. In addition, the Trust board should specifically confirm that within their organisation: • They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf • Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network. • Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Trusts should be evidencing the position as of 2 February 2023 at 12 noon

Technical guidance for Safety action 6

Technical guidance	
Where can we find guidance regarding this safety action?	SBL care bundle: https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/ The SBLCB v2 Technical Glossary which includes the numerators and denominators for all of the process indicators can be found on the NHS Digital webpages here: https://digital.nhs.uk/binaries/content/assets/website-assets/data-and-information/data-sets/maternity-services/sblcbv2-msds-v2.0-technical-glossary-for-publication.xlsx Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net For any other queries, please email nhsr.mis@nhs.net
Further guidance regarding element 2 of the SBL care bundle V2	Compliance with the intervention for surveillance of low-risk women does not mandate participation in the Perinatal Institute's Growth Assessment Protocol (GAP) or the use of customised fundal charts. Providers should however ensure that for low risk women, fetal growth is assessed using antenatal symphysis fundal height charts by clinicians trained in their use. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated. All women should have a risk assessment for FGR at booking. It should be appreciated that some women will develop additional risk factors after the booking appointment such as significant bleeding or risk factors that will only be evident after the mid-trimester anomaly scan, such as echogenic bowel or EFW <10th centile. When these risk factors are identified their clinical pathway will change as per SBLCBv2 Figure 6 in Appendix D. If a Trust chooses to meet this standard using an electronic audit which is unable to capture risk factors after booking then the Trust should include a brief description of how women with significant bleeding after booking, echogenic bowel or EFW <10th centile are triaged to the appropriate pathway described in fig. 6 of appendix D in SBLCBv2. There will be a variety of ways Trusts choose to do this, but what is important is that women with these risk factors receive the appropriate care.

	An example might be that when a risk factor is identified at the mid-trimester scan the ultrasonographer alerts the antenatal clinic midwife who then arranges obstetric review and the additional scans indicated. A similar process of escalation should be described for significant bleeding after booking. Confirmation by the Trust Board that the Trust has implemented the Tommy's Centre Clinical Decision Tool within a research programme will meet the requirement that standard 1-2 above have been implemented.
What is the deadline for reporting to NHS Resolution?	2 February 2023 at 12noon

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Required standard	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
Minimum evidential requirement for Trust Board	**Evidence should include:** • Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems • Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff. • Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes. • The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it • Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way. • Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality. • Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.

Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for Safety action 7

Technical guidance	
What is the Maternity Voices Partnership?	A Maternity Voices Partnership is a multidisciplinary NHS working group for review and coproduction of local maternity services. For more information see: • Implementing Better Births: A resource pack for Local Maternity Systems Chapter 4 and Annex B • National Maternity Voices
How often should the Maternity Voices Partnership meeting be held?	MVP should meet "no less than four times per year" in line with MVP Terms of Reference template, available here: https://nationalmaternityvoices.org.uk/toolkit-for-mvps/ This should include meeting with Maternity Leadership to ensure progression of the work plan.
We are unsure about the funding for Maternity Voices Partnerships	The maternity commissioner is responsible for facilitating and organising any agreed funding, this may be provided by the commissioner alone or in conjunction with local providers. Local discussions will need to take place to agree how the costs of the Maternity Voices Partnership will be shared between commissioner and provider organisations

Safety action 8: Can you evidence that a **local training plan** is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', **one-day, multi-professional training day** which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Required standard and minimum evidential \requirement	Can you evidence that: a) **A local training plan** is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021. b) 90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day, that includes maternity emergencies starting from the launch of MIS year four in August 2021? c) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring, starting from the launch of MIS year four in August 2021. d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Any 12 consecutive months within the period: 1st August 2021 until 5th December 2022

Technical guidance for safety action 8

Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A training plan should be in place to cover all six core modules of the Core Competency Framework. The training plan will span a 3-year time period and should include the following 6 core modules: • Saving Babies Lives Care Bundle • Fetal surveillance in labour • Maternity emergencies and multi-professional training. • Personalised care • Care during labour and the immediate postnatal period • Neonatal life support
Core competency framework-maternal critical care What is the expectation of those unit that don't provide enhanced maternal critical care in the maternity setting?	This should relate to recognition of deterioration, escalation, stabilisation and monitoring of the woman until transfer takes place
Core competency framework – which modules should our unit focus on?	For MIS year 4, Trusts only need to focus on the 6 core elements – and do not require the 2 modules relating to directly to COVID care (core modules 7 and 8).
Covid-19 impact on training. **Does 'in-house' training have to be face to face?**	We encourage the reinstatement of face to face training wherever possible, however where this is not possible hybrid and/or remote training formats that meet the requirements of the safety actions, can all be counted to meet the proportion of staff attending training.

What training should be covered for the one-day multi-professional training?	The one-day training programme should include: • Antenatal and Intrapartum Fetal monitoring • 4 Maternity emergencies • Neonatal life support Local maternal and neonatal outcomes should be provided on the training days, ideally benchmarked against other organisations with a similar clinical profile. These data may be local, drawing on learning from case studies, local incidents and/or exemplars or from National programmes e.g. National Maternity Perinatal Audit (NMPA), Getting It Right First Time (GIRFT) and others.
What should be covered in the training programme?	**Fetal monitoring and surveillance (in the antenatal and intrapartum period)** Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum: • Risk assessment • Intermittent auscultation • Electronic fetal monitoring • System level issues e.g. human factors, classification, escalation and situational awareness • Use of local case histories • Using their local CTG machines **Multi-professional maternity emergencies training** • The training day should include 4 of the minimum requirements for multi-professional maternity emergency scenarios, as set out in the Core Competency Framework, with the aim that all scenarios will be covered over a 3-year period. • The 4 scenarios will be based on locally identified training needs, drawing on learning from local serious incidents, near misses and local reviews. • At least one scenario should include a *'learning from excellence'* case study where care was excellent. • Ideally, at least one of the four emergency scenarios should be conducted in a clinical area, ensuring full attendance from the relevant wider multi-professional team. This will enable local system and environmental factors within the clinical setting to be identified with an action plan developed to address issues identified. **Neonatal life support** • All staff in attendance at births should attend local neonatal life support training every year.

	• Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard. • Those attending a NLS programme every 4 years will attend annual local neonatal life support training in between. Training should include as a minimum: • Preparing for neonatal resuscitation, including suitability of the clinical environment, and preparing the resuscitation device(s) • Identification of a baby requiring resuscitation after birth • Knowledge and understanding of the NLS algorithm, annual updates should be following the latest NLS edition. • The timing and how to call for help within the organisation • Situation, Background, Assessment Recommendation (SBAR) or equivalent communication tool handover on arrival of help.
How do maternity units include the remaining components of the Core Competencies Framework that are not listed above? **The remaining 2 components are:** • **Personalised care** • **Care during labour and the immediate postnatal period**	For the remaining 2 components of the Core Competencies Framework, maternity teams should choose 2 subjects per year from those listed in each of these core competencies, and these should be based on identified unit priorities, audit report findings and locally identified learning (e.g. ATAIN reviews) involving aspects of care which require reinforcing and national guidance. The aim is that all subjects within the Core Competencies Framework will be covered over the three-year period.
Which maternity staff attendees should be included for the 'in house' maternity emergencies multi-professional training day?	Maternity staff attendees should include 90% of each of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants

	• All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota
Training timeframe - What if we had a large number of staff trained in July/ and August 2021– do we then have to have these staff do their training again before 12 months are up?	The MIS year 4 reporting timeframe referred in safety action 8 is between the launch of MIS year 4 in August 2021 and 5th December 2022 with a submission deadline of 2nd February 2023. Trusts should assess their compliance based on the proportion of staff trained in 12 consecutive months within the reporting period. 90% compliance should be demonstrated by the end of the 12 month period.
Should the anaesthetic and maternity support workers (MSWs) attend fetal surveillance in labour and neonatal life support training?	Anaesthetic staff and MSWs are not required to attend fetal monitoring. The staff groups below are not required to attend neonatal resuscitation training: • All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)
What compliance is required for maternity theatre staff?	Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the one-day maternity emergencies and multi-professional training, however they will not be required to meet MIS year four compliance assessment.
Which staff should be included for immediate neonatal life support training?	Staff in attendance at births should be included for immediate neonatal life support training - listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres.
Which maternity staff attendees should be included for the local intrapartum fetal	Maternity staff attendees should be 90% of each of the following groups: • Obstetric consultants

surveillance in line with Saving Babies Lives Care Bundle (SBLCBv2)?	• All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres.
Fetal monitoring training- Should GP trainees attend fetal monitoring training as stated in safety action 6/8 even though our unit has a protocol that GP rotational doctors do not undertake CTG reviews in any circumstances?	GP trainees should also attend the fetal monitoring training session if they have any obstetric commitment to intrapartum care.
What if staff have been booked to attend training after (add in date) for the 'in-house' multi-professional training day?	Only staff who have attended the training will be counted toward overall percentage. If staff are only booked onto future training sessions and/or have not attended training, they cannot be counted towards the overall percentage.
Will we meet the action if one of our staff group is below the 90% threshold for the 'in-house' maternity emergencies and multi-professional training day?	No, you will need to evidence to your Trust Board that you have met the threshold of 90% for each of the staff groups by 5th December 2022.
Training compliance - breakdown by staff groups	Compliance should be presented by staff group mentioned e.g. obstetric consultants 90%, obstetric trainees 89%, anaesthetic consultants 92% etc.
What if Covid-19 restrictions are still in place for in house training?	If social distancing guidelines preclude face to face training then remote or hybrid formats will be acceptable.
I am a NLS instructor, do I still need to attend neonatal resuscitation annual training?	If you have taught on a NLS course at least once during that year, you do not need to attend local neonatal resuscitation training as well
I am a Medical Obstetric Emergencies and Trauma (MOET) instructor, do I still need to attend the emergency training session?	MOET instructors do not need to attend annual training if their NLS instructor status is still valid.

I have attended my NLS training, do I still need to attend neonatal resuscitation annual training?	For MIS purposes, not during the same year that you completed NLS training, but you will need to attend neonatal resuscitation training annually for the 3 years in-between each NLS course.
Which members of the team can teach in house neonatal resuscitation training?	Best practice would be for this training to be delivered by a trained NLS instructor. The minimum standard would be for training to be provided by staff who hold an in-date NLS provider certificate and have a teaching role such as a clinical skills facilitator.
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard.
What is the required timeframe?	One day training on multi-professional, maternity emergencies, including a learning from excellence case study and intrapartum fetal surveillance should be undertaken by each staff group within the MIS reporting period.
Where can I find the Core Competencies Framework and other additional resources?	• NHS England and NHS Improvements Core Competency Framework (December 2020) https://www.england.nhs.uk/publication/core-competency-framework/ • https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth • All link to forthcoming national intrapartum fetal surveillance programme • Toolkit for high quality neonatal services (October 2009) http://www.londonneonatalnetwork.org.uk/wp-content/uploads/2015/09/Toolkit-2009.pdf

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required standard	a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need. b) Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. c) Trust Boards have reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)

Minimum evidential requirement for Trust Board	**Evidence for points a) and b)** • Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model. • Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. • Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and engagement sessions; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022 NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. • Evidence of the engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board. • Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users. • Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting. **Evidence for point c):** This is to be evidenced by a minuted Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted.

	Evidence for point d): Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to: • active participation by staff in **contributing to the delivery** of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities • **engagement** in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member • support for clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network • utilise insights from culture surveys undertaken to inform local quality improvement plans • maintain oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	**Time period for points a and b)** • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action is in place no later than 16 June 2022. The expectation is that work has already commenced on this in line with the Ockenden response (Ockenden, 2021). • Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if

	required. This additional level of training detail will be expected by 16 June 2022. • The expectation is that quarterly engagement sessions have continued from year 3 of the scheme. If for any reason these have been paused, they should be recommenced no later than 16 June 2022. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 16 June 2022. • Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (board or directorate) quality meeting each quarter, beginning no later than quarter 2 of 2022/23 (July 2022). **Time period for points c)** • Board level discussion and decision since 1st April 2022 on how a trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted. **Time period for points d)** • Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event by 5th December 2022. • Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5th December 2022.
What is the deadline for reporting to NHS Resolution?	By Thursday 2 February 2023 at 12 noon
Where can I find additional resources?	implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk)

	Measuring culture in maternity services: Add in link to Safety Culture Programme for Maternal and neonatal services: https://drive.google.com/file/d/1bzAqOcf5A5XHR8HWBZnLzH6qsG_SgXoa/view?usp=sharin Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme

Technical guidance for safety action 9

Technical guidance	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: - Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board - Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician
What do we need to include in the dashboard presented to Board each month?	The dashboard can be locally produced and must include; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashboard can also include additional measures as agreed by the Trust.
We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do?	Parts a) and b) of the required standards build on the year three requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions in order to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 16 June 2022.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.

What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names the relevant leaders will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here https://resolution.nhs.uk/2021/10/28/2021-scorecards-launch/?utm_medium=email&utm_campaign=Resolution%20Matters%20October%202021&utm_content=Resolution%20Matters%20October%202021+CID_ac638a61c8ce1ac278298e3233f234af&utm_source=Email%20marketing%20software&utm_term=2021%20Scorecards%20launch https://resolution.nhs.uk/2020/10/27/claims-scorecards-for-2020/
What are the expectations of the Board safety champions in point d) as it asks that all Trust safety champions are supporting MatNeoSIP?	The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national driver diagram and key enablers. The Board level safety champion will continue to support staff as detailed in the minimum evidential requirements for Trust Board.
What is the expectation for Trusts to utilise previous SCORE culture surveys?	Whilst it is recognised that some Trusts SCORE culture surveys were completed several years ago, identified themes from the surveys are likely to still be relevant as it changes a number of years to change culture. This would include leadership and team dynamics. These insights, and any recent work in these areas should still be used to inform improvement work.
Evidence or representation at a minimum of two engagement events such as Patient Safety Network meeting,	MatNeoSIP Patient Safety Network events have continued during year 4 of MIS with good engagement. Recordings have and can be made available to listen to and feedback regarding the content. PSC also have attendance lists for the events.

MatNeoSIP webinars and/or the annual learning event.	There are PSN events planned for each quarter of 2022/23. The expectation is that Trusts still engage with a minimum of two of these.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

Required standard	A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022 B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022 C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: 1. the family have received information on the role of HSIB and NHS Resolution's EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for Trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB database and the National Neonatal Research Database (NNRD), and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
What is the relevant time period?	Reporting to HSIB – from Wednesday 1 April 2021 to 5 December 2022

	Reporting period to HSIB **and** to NHS Resolution - from 1 April 2022 to 5 December 2022
What is the deadline for reporting to NHS Resolution?	By 2 February 2023 at 12 noon

Technical guidance for Safety action 10

Technical guidance	
Where can I find information on HSIB?	Information about HSIB and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to HSIB?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [0r] • Was therapeutically cooled (active cooling only) [Or] • Had decreased central tone AND was comatose AND had seizures of any kind Once HSIB have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.
Changes in the EN reporting requirements for Trust from 1 April 2021 to 31 March 2022	Between 1 April 2021 to 31 March 2022, all qualifying cases should still be reported to HSIB. HSIB will then inform NHS Resolution of the case. Should you wish to discuss further, please contact HSIB at maternity@hsib.org.uk
Changes in the EN reporting requirements for Trust from 1 April 2022 going forward	With effect from 1 April 2022, Trusts will be required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB report with the EN team within 30 days of receipt of the final report by uploading the HSIB report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB reports in batches (e.g. waiting for a number of reports to be received before uploading).

	Once the HSIB report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
Changes in the Outstanding 2021/22 cases to be reported	If there are any outstanding cases which occurred from 1 April 2021 to 31 March 2022, Trust should report them as soon as possible to HSIB, following the process outlined above.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution.
Cases that do not require to be reported to NHS Resolution	- Cases where families have requested an investigation - Cases where Trusts have requested an investigation - Cases that HSIB are not investigating
What if we are unsure whether a case qualifies for referral to HSIB or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB reference number (document the HSIB reference in the "any other comments box"). Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or HSIB maternity team (maternity@hsib.org.uk).
How should we report cases to NHS Resolution?	Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB as under investigation.
What happens once we have reported a case to NHS Resolution?	On receipt of the HSIB report, following triage, NHS Resolution will overlay an investigation into legal liability. Where families have declined an HSIB investigation, no EN investigation will take place, unless the family requests this.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20

	In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB as soon as they occur and to NHS Resolution as soon as HSIB have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIB and where applicable to NHS Resolution and this is confirmed with data held by NNRD and HSIB and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.

FAQs for year four of the maternity incentive scheme

Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice?	**We expect Trust Boards to self-certify the Trust's declarations following consideration of the evidence provided.** It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we may escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the Care Quality Commission for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and DHSC for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the Accountable officer (AO) for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution The declaration form must be signed by both CEO and the Accountable Officer of Clinical Commissioning Group/Integrated Care System before submission.
Our current commissioning systems are changing, what does this mean in terms of sign off?	There have been structural changes for NHS Commissioning as a result of 2022 Health and Care Act. Where this has caused significant reconfiguration and adjustment of commissioning systems, sign off by the accountable lead for commissioning maternity services can be considered
Will NHS Resolution cross check our results with external data sources?	Yes, we will cross reference results with external data sets from: MBRRACE-UK data (safety action 1 point a, b, c), NHS England& Improvement regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to HSIB (safety action 10,

	standard a)). Your overall submission may also be sense checked with CQC maternity data, HSIB data etc. For more details, please refer to the conditions of the scheme.
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the CEO and, where relevant, an action plan is completed for each action the Trust has not met. **Please do not send your evidence or any narrative related to your submission to us.** Any other documents you are collating should be used to inform your discussions with the Trust Board.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2022. **It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on Thursday 2 February 2023, NHS Resolution will treat that as a nil response.** **The declaration form will be published later in 2022.**
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on Thursday 2 February 2023**. If not returned to NHS Resolution by 12 noon on Thursday 2 February 2023, NHS Resolution will treat that as a nil response.
What happens if we do not meet the ten actions?	Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.
Our Trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.

What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated link contacts via link on the NHS Resolution website. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/maternity-incentive-scheme/
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process and Trusts will be allowed 14 days to appeal the decision following the communication of results.
Merging Trusts	Trusts that will be merging during the year four reporting period (August 2021 to February 2023) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2022/23 and the reporting of claims and management of claims going forward.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the maternity incentive scheme?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Q2) Why have these safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Obstetric Anaesthetists Association, Royal College of Anaesthetists, HSIB, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England & Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Royal College of Paediatrics and Child Health
- Care Quality Commission
- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff
- HSIB

Q4) How will Trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at nhsr.mis@nhs.net **by 12 noon on 2 February 2023**.

Please note:

- Board declaration forms will be reviewed by NHS Resolution and discussed with the scheme's Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the Trust's responses, as detailed in the technical guidance above.
- If a completed Board declaration form is not returned to NHS Resolution by 12 noon on Thursday 2 February 2023, NHS Resolution will treat that as a nil response.

Whittington Health NHS Foundation Trust QRM

Ann Tasker – Maternity Investigations Team Leader

Harriet Wootton Link Maternity Investigator

09/09/2022

Maternity referrals: summary

1 April 2018 – 31 July 2022

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

Programme to date	Total referrals submitted	Rejected (no family consent)	*Rejected (other)	Progressed to investigation	Current live investigations	Draft reports at internal quality assurance	Draft reports with Family / Trust	Maternity reports completed
	4,398	440	1,074	2,884	283	54	63	2,484

Family Engagement

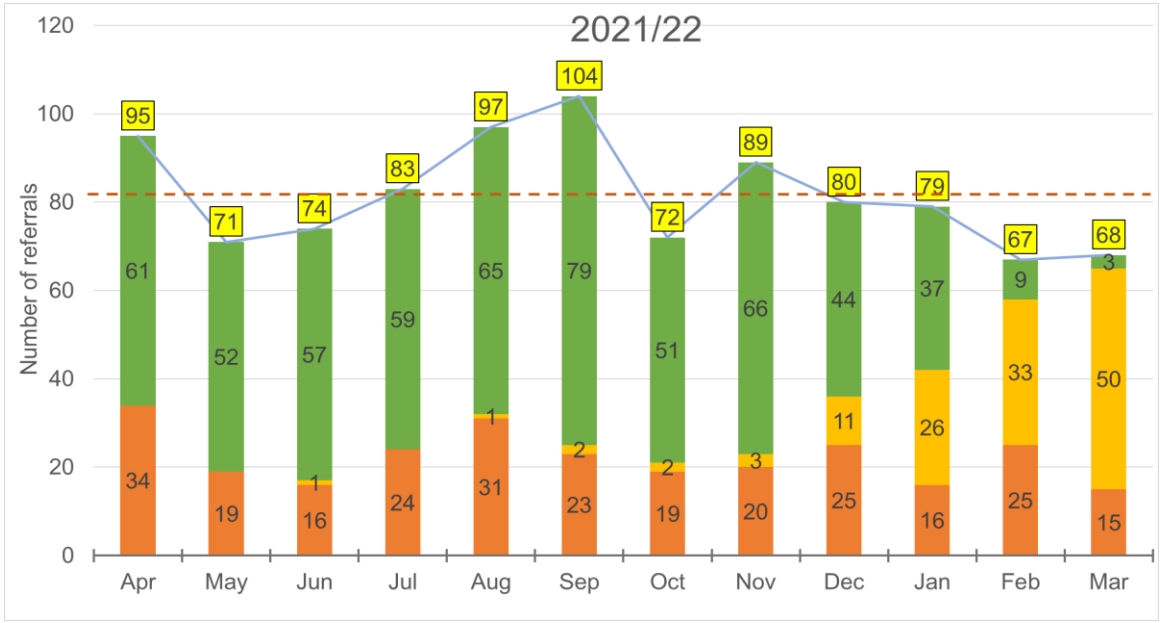
87%

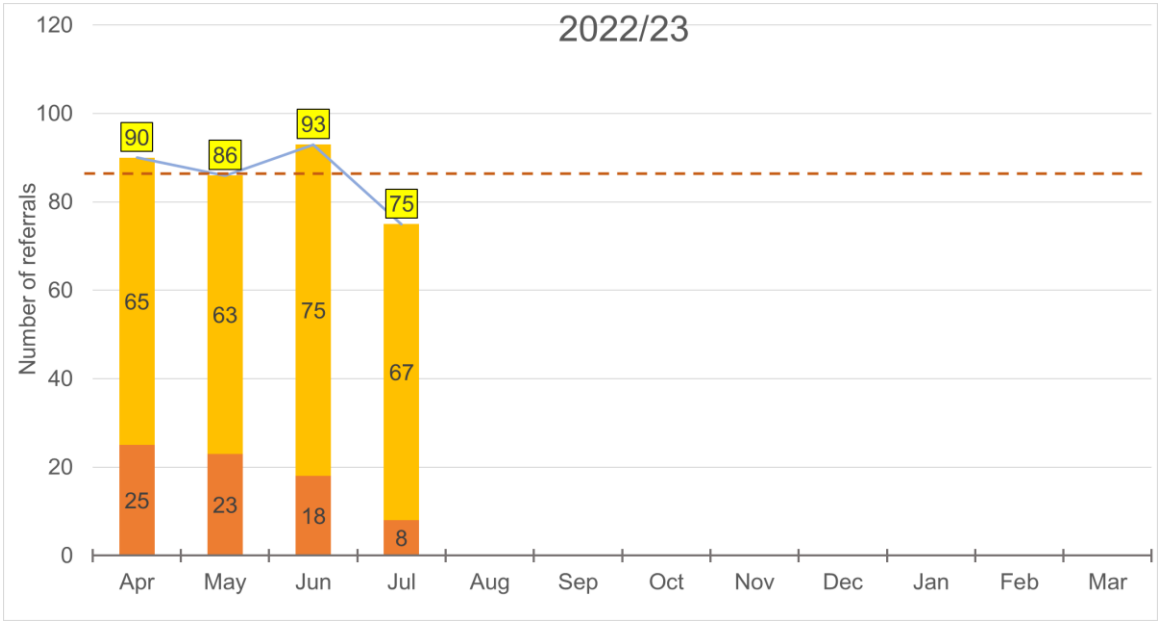
*1074 = 284 did not meet HSIB criteria, 372 duplicated, 44 congenital abnormalities, 3 Sudden Infant Death, 371 COVID-19 rejections

	2018/19	2019/20	2020/21	2021/22	2022/23
Progressed to full investigation	354	807	741	712	270
Investigations/reports completed	5	513	1023	706	237
Investigations at period end	349	643	361	367	400

Maternity referrals: breakdown

1 April 2021 – 31 July 2022

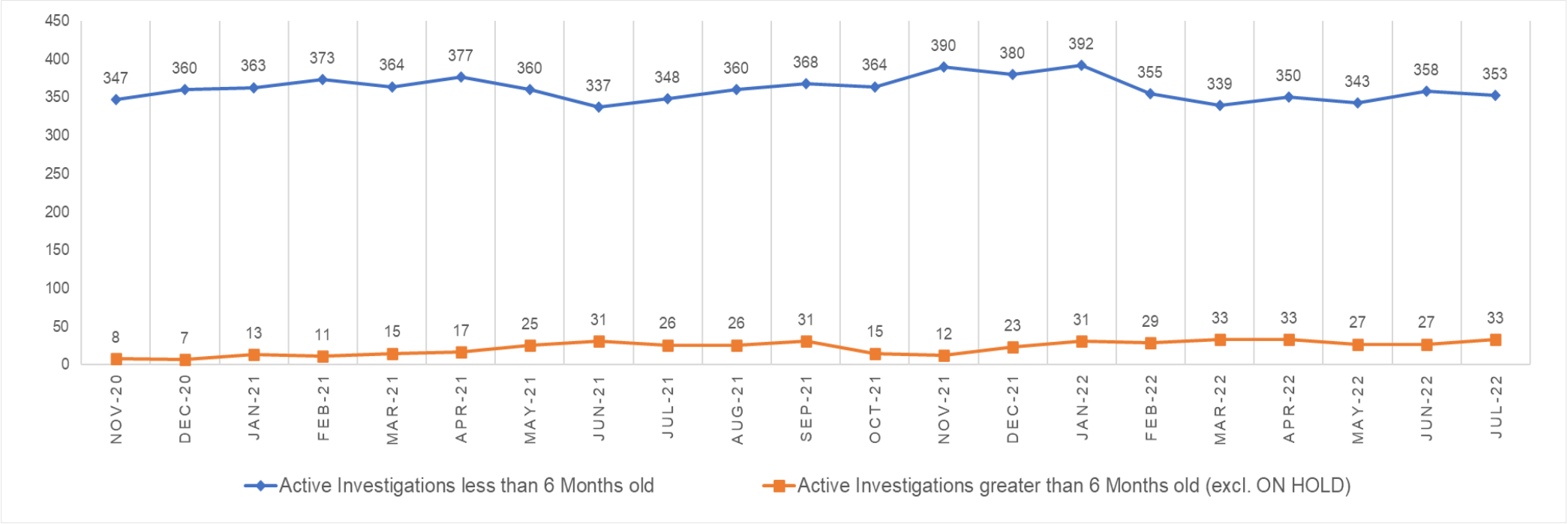




Completed Active Rejected (Consent & COVID-19) Total referrals that met HSIB standard criteria

There is one active case (2011-2701) referred in Nov-20 and currently on hold due to a police investigation.

Maternity referrals: active investigations

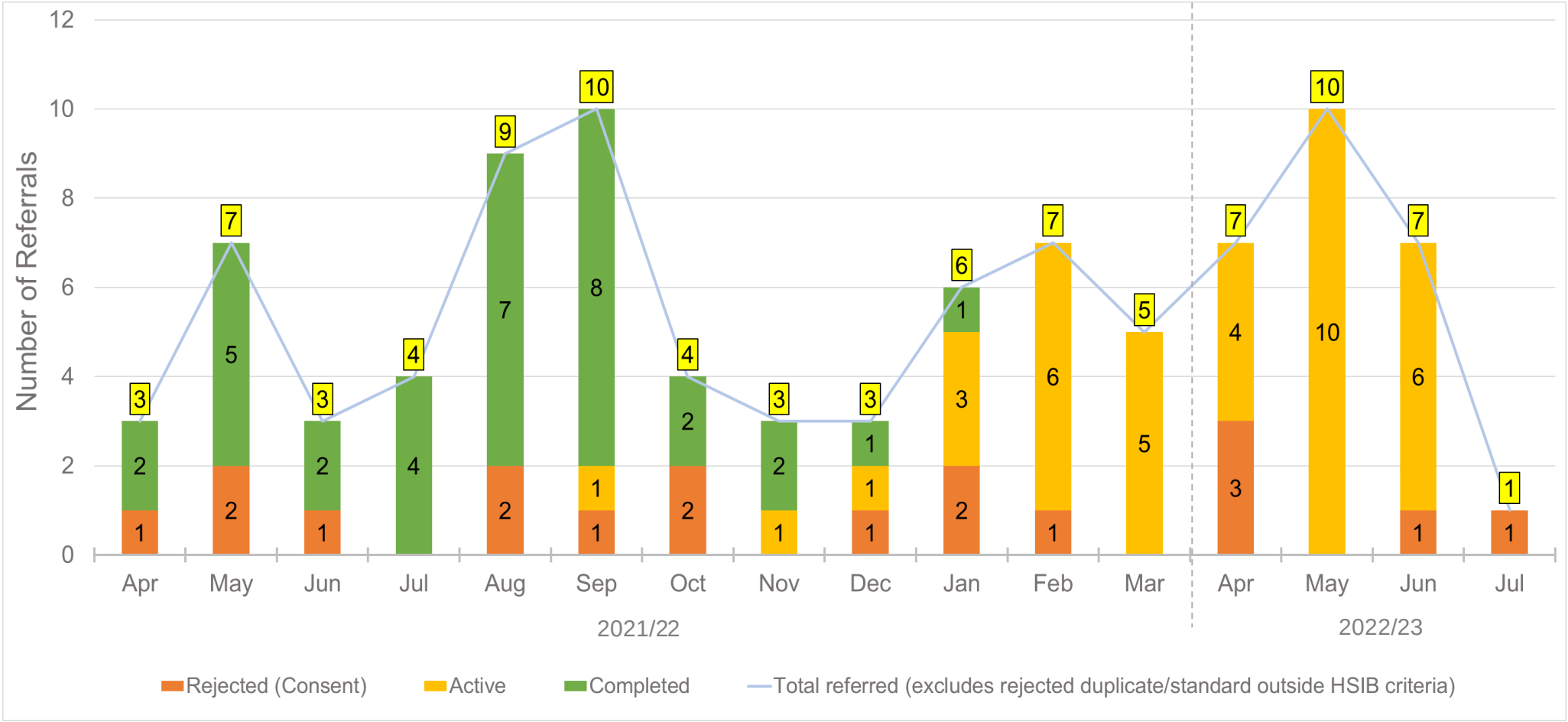


33 out of 386 (9%) active investigations are greater than 6 months old at 31 July 2022.

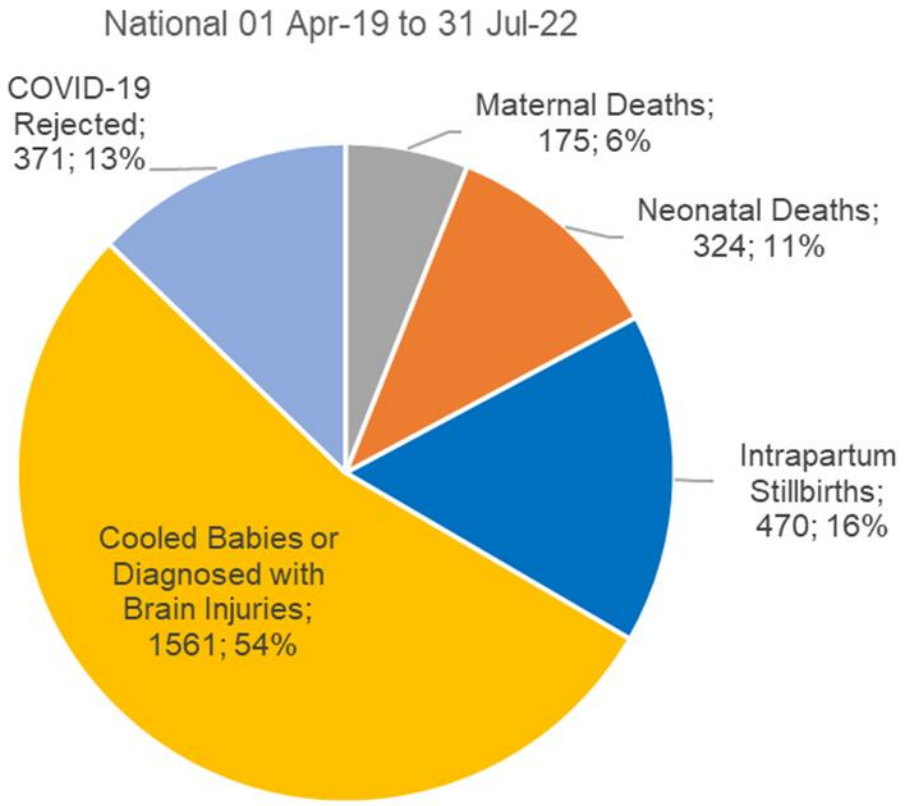
- 30 active investigations have been classed as ‘exceptions’ (21 delays during investigation, 1 delay during Trust factual accuracy and 8 investigation reports awaiting completion with family).
- 3 active investigations have been delayed due to operational reasons.
- 14 active investigations have been classed as ‘on hold’ (9 post-mortem examinations, 1 police investigation, 4 delayed consent) and removed from this graph.

Maternal death referrals

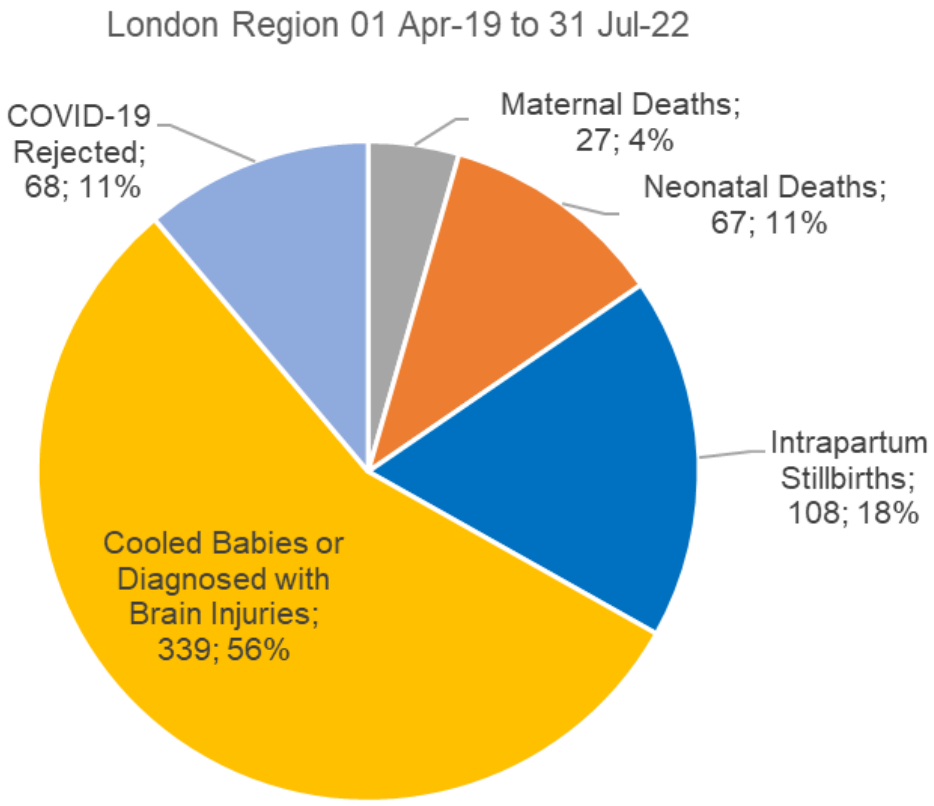
1 April 2021 – 31 July 2022



Maternity investigations categories



2530 investigations



541 investigations

Referrals made before 1st April 2019 have been excluded from this data set.

Top recommendations

National

- Guidance
- Clinical Assessment
- Fetal Monitoring
- Clinical Oversight
- Escalation

427 reports have no recommendations

London Region

- Guidance
- Clinical Oversight
- Clinical Assessment
- Risk Assessment
- Fetal Monitoring

88 reports have no recommendations

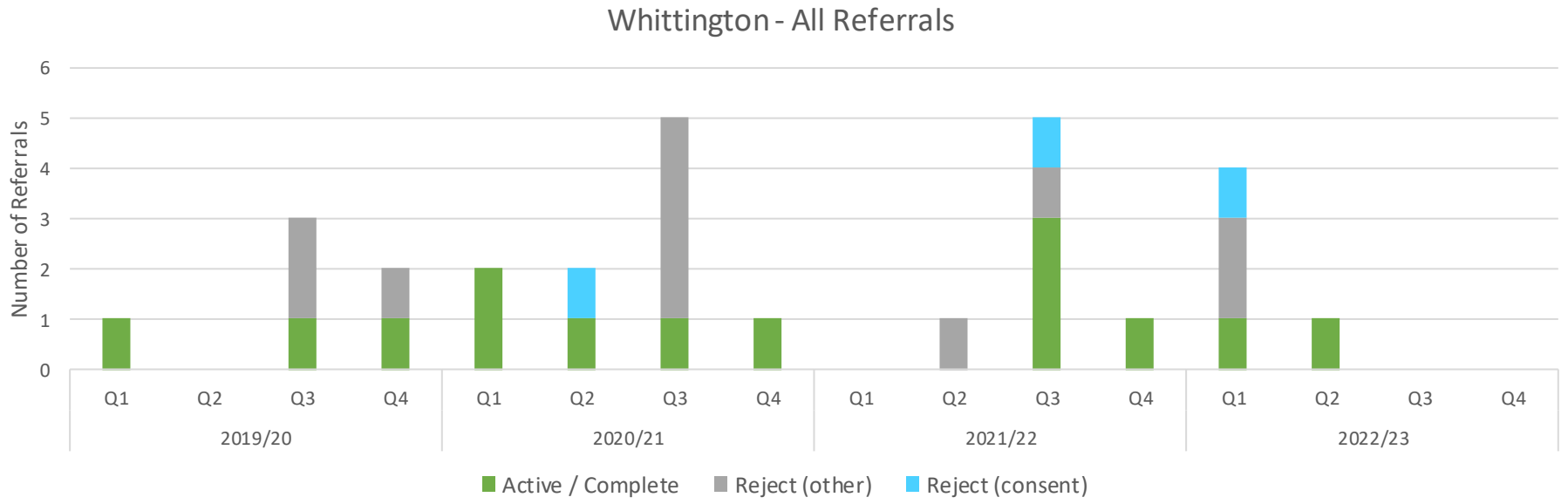
Recommendations presented in no particular order. National / Regional data covers completed cases referred between Apr-19 and Jun-22 (to the end of the last full quarter).

HSIB

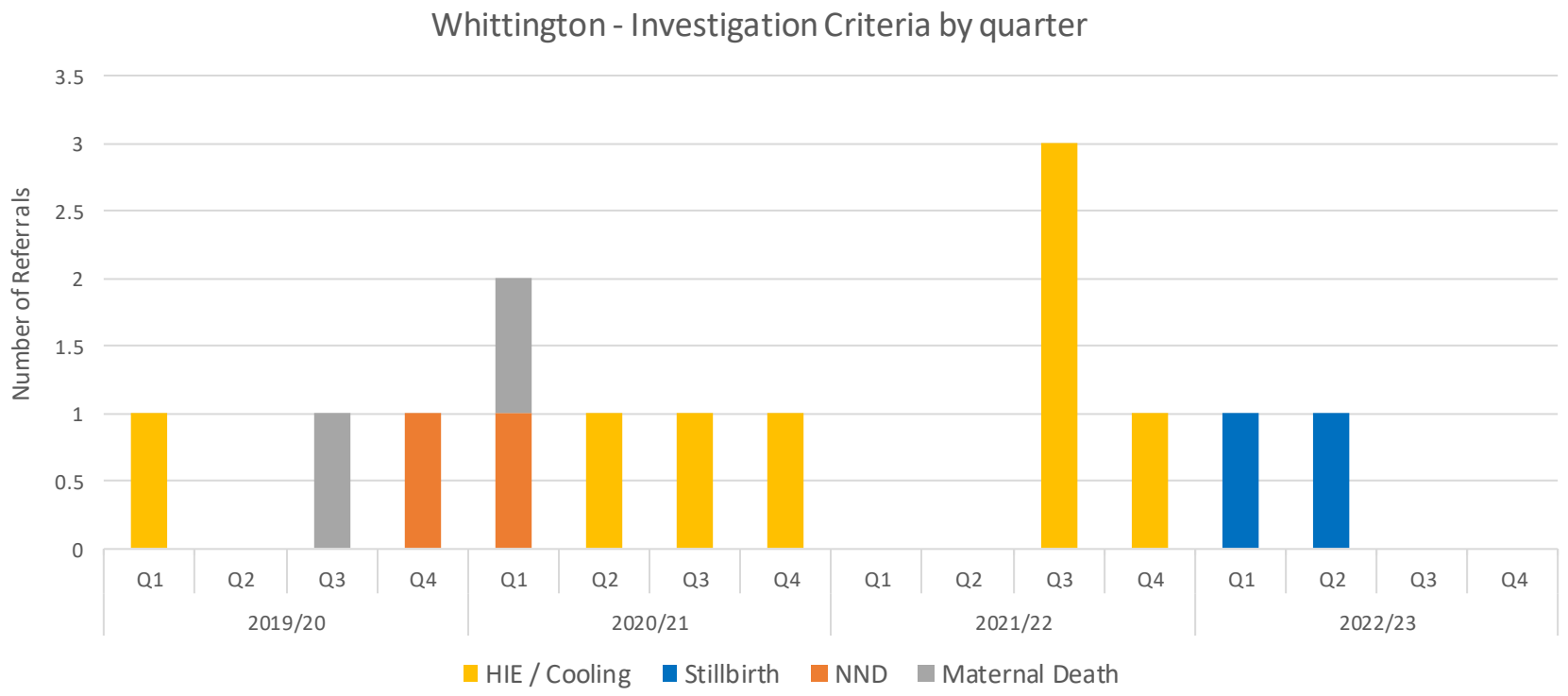
HEALTHCARE SAFETY
INVESTIGATION BRANCH

Trust investigation summary

Trends in referrals from Trust

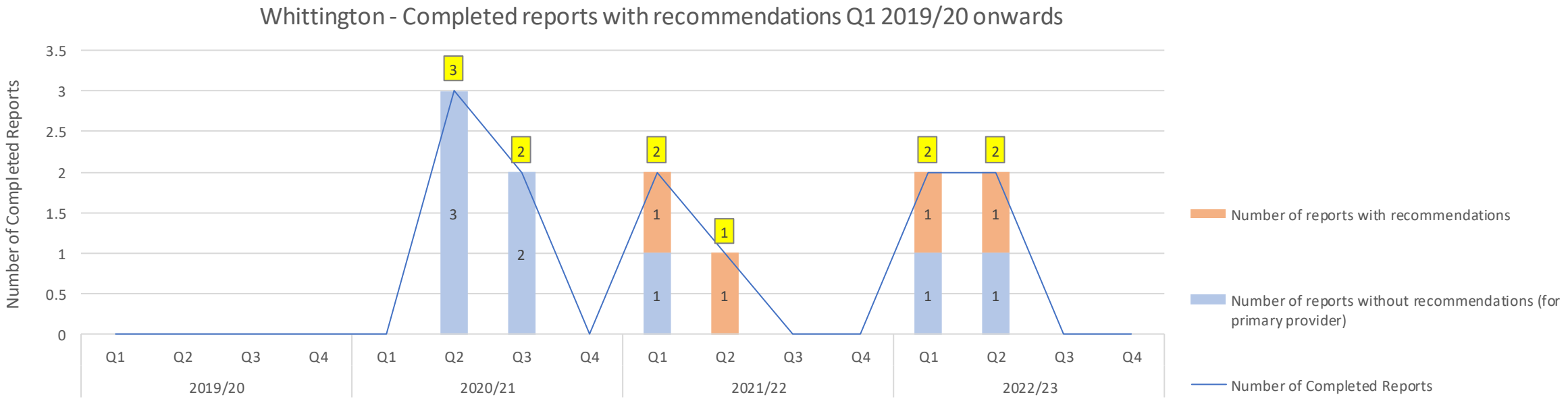


Trends in referrals from Trust



Presenting the thematic learning data

Completed reports and recommendations



Top recommendations

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

National

- Guidance
- Clinical Assessment
- Fetal Monitoring
- Clinical Oversight
- Escalation

427 reports have no recommendations

London Region

- Guidance
- Clinical Oversight
- Clinical Assessment
- Risk Assessment
- Fetal Monitoring

Whittington

Guidance

Clinical Oversight

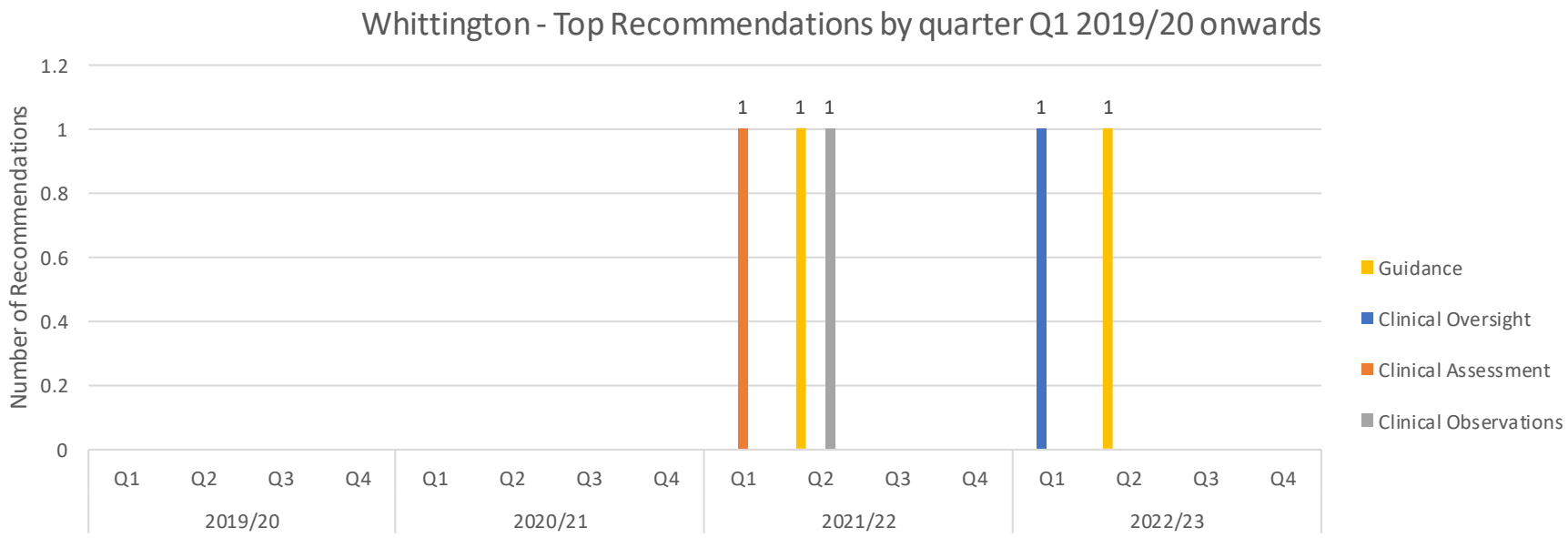
Clinical Assessment

Clinical Observations

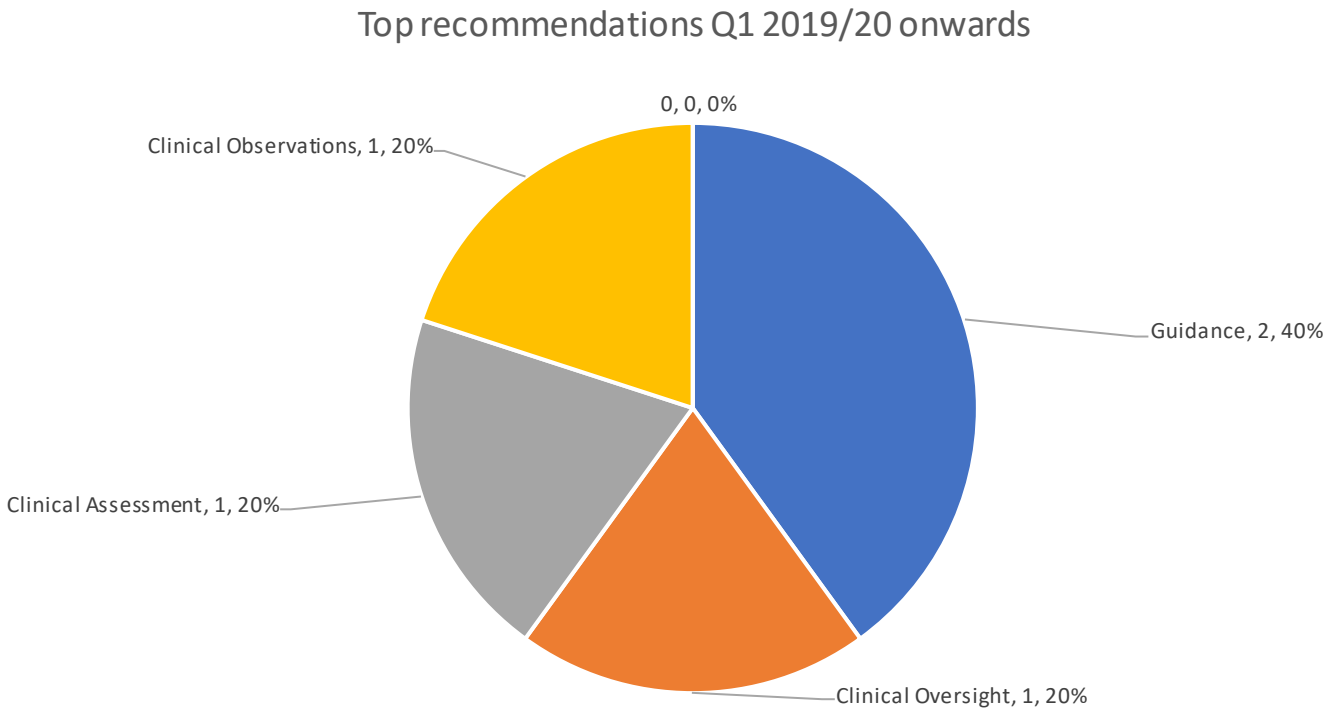
88 reports have no recommendations

Recommendations presented in no particular order. National / Regional data covers completed cases referred between Apr-19 and Jun-22 (to the end of the last full quarter).

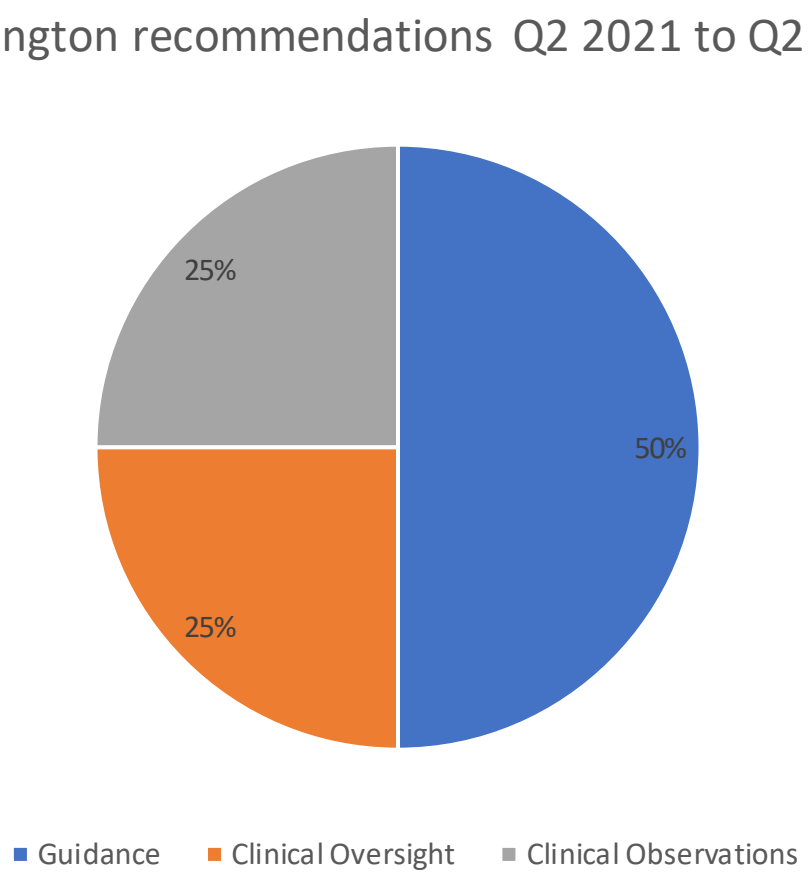
Whittington - Top 5 recommendations



Top 5 recommendations



Recommendations – rolling year



Escalation of concerns

Escalation letters

Escalation of concerns																
Insight and Temperature Check	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
Number of HOM/DOM/CD escalation emails																
Date of escalation stage 1 safety concern (themes)																
Date of outcome / response to stage 1 concern																
Date of escalation stage 2 safety concern (themes)																
Date of outcome / response to stage 2 concern																
Date of escalation stage 3 letter to executive team																
Date of escalation stage 4 response from trust																
Date of escalation stage 5 referral to regulator																

HSIB

HEALTHCARE SAFETY
INVESTIGATION BRANCH

Open cases overview

Open cases

Case number	Date of referral	Type	Status
MI-008139	04/04/2022	IPSB	SMART 2
MI-012860	10/08/2022	IPSB	SMART 1

Closed case review

MI-005736
Final report shared July 2022

- G2 P0
- History of ME and Crohn's disease
- High BP and proteinuria at 34+4 – sent to triage and admitted to AN ward due to pre-eclampsia
- Inpatient until delivery
- IOL commenced at 37+0 on AN ward
- Transferred to LW due to CTG concerns and tachysystole
- Forceps delivery and baby born in poor condition – 72 hours cooling
- MRI normal

1 safety recommendation (Guidance / Induction of labour):

The Trust to ensure that staff are supported to respond to uterine hyperstimulation in line with national and local guidance, including timely removal of a prostaglandin pessary.

Findings:

- COVID-19 – no impact on care and outcome
- Due to the Mother's family history of pre-eclampsia not being identified in the early antenatal period, the Mother was not offered aspirin in line with national guidance. This may have changed her pathway of care.

MI-005736

Final report shared July 2022

Findings (continued):

- Mother was appropriately diagnosed with pre-eclampsia at 34+5 weeks and admitted to hospital for the remaining duration of her pregnancy.
- The Mother had an USS for uterine artery dopplers and AFI cancelled at 36+1 weeks due to a lack of appointment capacity and not being deemed as necessary. This may have been an opportunity for further assessment of the Baby's wellbeing which may have changed the pathway of care.
- IOL commenced appropriately at 37 weeks, in line with national guidance.
- Due to reassurance that the Baby's heart rate was normal, the Mother's prostaglandin pessary was not removed when it was first identified she had hyperstimulation. This may have led to continued hyperstimulation, which may have impacted on the outcome for the Baby.
- When the CTG remained pathological, a category one CS was declared and the Baby was born 29 minutes later by assisted vaginal birth (forceps).
- MRI findings – associated with a good outcome
- Placental histology did not indicate any fetal compromise. The placenta weight was below the 10th centile of the expected weight for gestational age.

Coincidental findings

Coincidental findings from investigations

Coincidental findings	
Insight and Temperature check	**Current Quarter**
Engagement	
Referrals reported timely to HSIB	No concerns
Response day to day with governance team	No concerns
Response to notes requests	No concerns
Response to interview requests	No concerns
Clinical challenge to factual accuracy reports	No concerns
Engagement with Tripartite meetings	No concerns
Engagement with PMRT	
Engagement with QRM	No concerns
Attendance at QRM	No concerns
Feedback at QRM from Trust	No concerns
Learning at QRM	No concerns
Floor to Board oversight	
Family engagement	
Family consent to proceed with investigations	No concerns
Findings from investigations (including debrief)	
Culture	No concerns
Organisation	No concerns
Technology	No concerns
Tools	No concerns
Environment	No concerns
Engagement with LMS	No concerns

QRM Circulation List

Audience: The Whittington update 2022

Update to be circulated to the following specialties and staff roles within trusts, and they should also receive an invite to the QRM.

Specialty/Team Maternity	Staff role
Isabelle Cornet Isabelle.cornet2@nhs.net	Interim Head of Service (DOM) Midwifery Safety Champion
	Head of Service HOM
Dr Helen Taylor Helen.taylor28@nhs.net **02072885651**	Clinical Director
Filipa Braga **Clinical Governance Manager for Women's Health** filipa.braga@nhs.net **020 7288 5859** **Anna Lawin-O'Brien** anna.lawin-obrien@nhs.net **Kirsten Vogt** Kirsten.vogt@nhs.net	Clinical Governance Lead Obstetric Governance Leads
Jacqueline Plested Jacqueline.plested@nhs.net **02072885514**	Clinical Risk Midwife
Isabelle Cornet **Kirsten Vogt** Kirsten.vogt@nhs.net	Safety Champion(s)

Neonatology	
Wynne Leith – Consultant Neonatologist Clinical Lead for Neonatology wynne.leith@nhs.net **Adesegun Oremule** **Lead Nurse** adesegun.oremule@nhs.net **020 7288 5530**	Head of Service Lead Nurse
Erum Jamall erum.jamall1@nhs.net	Clinical Director Paediatrics/Neonates
Juliet Penrice – Consultant Neonatologist juliet.penrice@nhs.net **07843336358**	Clinical Governance Lead
Juliet Penrice – Consultant Neonatologist juliet.penrice@nhs.net	Patient Safety Consultant Neonatologist
Juliet Penrice – Consultant Neonatologist juliet.penrice@nhs.net	Safety Champion

QRM Circulation List

Obstetric Anaesthetics	
Dina Hadi - Consultant Anaesthetist, Consultant Lead for Obstetric Anaesthesia **Dina.hadi@nhs.net**	Service Lead
Dr Sola Makinde **Consultant Anaesthetist. Associate Medical Director – Workforce** **Sola.makinde@nhs.net**	Clinical Governance Lead
	Safety Champion(s)
Board level	
Sarah Wilding **Chief Nurse and Director of AHPs** **Sarah.wilding10@nhs.net**	Chief Nurse Safety Champion
Glenys Thornton **Glenyst@aol.com** **Copy Glenys in to HSIB quarterly national learning newsletters**	Safety Champions(s) non-executive

The below are currently on Ann's circulation list, who needs removing and who needs adding above with job role.

Alicia St louis – Matron delivery suite; alicia.stlouis@nhs.net

Chandrima Biswas

Claire Dollery - Executive Medical Director; clare.dollery1@nhs.net

Alys Kernan – Administrator for senior midwifery team and associate director of nursing and midwifery; alys.kernan@nhs.net

Gillian Lewis – Head of quality governance; gillian.lewis18@nhs.net

Lorna Wells – Interim community matron; lorna.wells3@nhs.net

Jayne Osborne – SI co-ordinator/risk management team; jayne.osborne@nhs.net

Coincidental findings from investigations

Culture	☹ Concerns with staff shortages ☹ Lack of debriefs ☺ Really good team, very happy working here, proud to work here ☺ Always feel I can escalate ☺ Very supportive to trainees
Organisation	☹ Delays uploading the records as no admin support ☺ Very helpful HSIB links
Technology	
Tools	☹ Timing of CTG meetings makes it very difficult for midwives to attend
Environment	

National Reports

- **Management of preterm labour and birth of twins published 25/8**
- **Maternity Investigation Programme year in view 2021/22**
- Detection of jaundice in newborn babies
- The assessment of venous thromboembolism risks associated with pregnancy and postnatal
- Risk assessment in the maternity pathway
- Perimortem caesarean section during the management of cardiac arrest in pregnancy

Education for NHS staff

Patient Safety Incident Response Framework 2022

We've developed a range of training courses, starting from Autumn 2022, to support NHS trusts to implement and use PSIRF.

- **Level 2** – A systems approach to learning from patient safety incidents.

Other professional healthcare safety investigation courses

- Level 1 – Introduction to a systems approach to investigation.
- Thematic analysis.
- Use of Systems Engineering Initiative for Patient Safety (SEIPS).
- Level 3 – A systems approach to learning from patient system incidents: theory into practice.
- Investigation Science for strategic decision makers and senior leaders in healthcare.
- Investigative interviewing.

Action log – June 2022

Action	Lead	Date Due	Status
Ann to arrange a catch up meeting 27/10 1200	AT / HSIB		Completed
Ann to arrange date for next QRM – 9/12 1400	AT / HSIB		Completed
Send slides to QRM group	AT / HSIB		Completed

HEALTHCARE SAFETY
INVESTIGATION BRANCH

Thank you

Meeting title	**Trust Board – public meeting**	**Date: 25.11.2022**
Report title	**Freedom To Speak Up Guardian Report (April – September 2022)**	**Agenda item: 6**
Executive director lead	Sarah Wilding, Chief Nurse and Director of Allied Health Professionals	
Report author	Ruben Ferreira, Freedom to Speak Up Guardian	
Executive summary	This paper provides: • A brief overview of the work of the Freedom To Speak Up Guardian (FTSUG) from April 2022 to September 2022 • Updates on the National Guardian Quarter 1 and 2 (2022) data • Updates on the Speak Up Advocate's role	
Purpose:	The report provides information about Freedom to Speak Up across Whittington Health with information covering the period March 2022 to August 2022	
Recommendation(s)	The Trust Board is asked to: • Support the recruitment of Speak Up Advocates and acknowledge the importance of providing protected time (within job roles) for the Advocates to support their colleagues • Encourage and promote with managers and senior leaders to engage with Freedom to Speak Up • Continue to support the implementation of Freedom to Speak Up training to staff.	
Risk Register or Board Assurance Framework	BAF entry 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.	
Report history	Six monthly report presented to Whittington Health Trust Board	
Appendices	1: NGO – Supporting the well-being of FTSU Guardians	

1 Introduction

1.1 The Freedom to Speak Up Guardian (FTSUG) role was created because of recommendations from Sir Robert Francis' Freedom to Speak Up Review, published in February 2015. Freedom to Speak Up Guardians are expected to work with trust leadership teams to create a culture where staff can speak up to protect patient safety and empower workers. As well as providing a safe and impartial alternative channel for workers to speak up to, they identify themes and provide challenge to their organisation to work proactively to tackle barriers to speaking up.

1.2 The National Guardian's Office (NGO) works to make speaking up become business as usual in health. The office leads, trains and supports a network of Freedom to Speak Up Guardians in England and provides learning and challenge on speaking up matters to the healthcare system. Since the establishment of the NHS National Guardian's Office in 2016 following the recommendation of the Francis Review, there is now a wide-ranging network of 818 Freedom to Speak Up Guardians in England supporting workers in 514 organisations, in primary and secondary care, the independent sector and national bodies.

2 Brief overview of Freedom To Speak Up Guardian and National Guardian Office

2.1 **The Whittington Health Guardian** is continuously working to engage with teams and services across Community and Hospital departments. The Guardian continues to offer staff members the option for remote appointments through phone, Microsoft Teams or Zoom, as face-to-face. Over the last few months, more people are now preferring face-to-face appointments as prior to the pandemic, this includes possibility of face-to-face appointments off-site where people may feel safer and more comfortable speaking up.

2.2 Communication and visibility continue to be two key points for the success of engaging with staff who may wish to raise concerns. The Guardian continues to work closely with the Communications Department to review the Trust's media activity and promotion. This collaboration is fundamental as it provides the tools to reach more colleagues, promoting visibility, helps with the recruitment of Speak Up Advocates and clarifications regarding the role. The Director of Communication has asked the Guardian to provide training to the team. This initiative was greatly welcomed. The intranet page was improved, enabling everyone to access it through the main page on the intranet. A second all-staff email was sent by the end of October to everyone in the organisation about Freedom to Speak Up, what we do, who we are and how to contact us. This is a reminder that everyone can reach out in a safe confidential way. Posters across the community sites are being updated displaying information about Speak Up Advocates present on that site.

2.3 The Guardian continues to work closely with all the staff networks to listen to staff concerns, promote a healthy and positive Speak Up culture and help remove additional barriers that workers may face in speaking up. Collaboration and mutual support are growing between the FTSUG and the network's leadership with the collaboration of the Joint Directors for Race, Equality, Diversity & Inclusion.

2.4 The Guardian continues to be part of the preceptorship study day and Newly Qualified Nurses Orientation Training, Health Care Support Worker (HCSW) Development Programme and medical education induction to explain how to raise concerns safely and confidentially, raising the profile of FTSU. The Guardian continues to attend the Trust's corporate induction day for all new starters. When the Guardian is not available to attend, Speak Up Advocates provide cover which helps to promote their role and adds a stretch opportunity to their experience.

2.5 The FTSU Guardian and Human Resources (HR) Business Partners continue their close collaboration listening and supporting colleagues in particular areas of concern. The Guardian and the HR Business Partners joined 1:1 drop-in informal and confidential sessions with staff members from areas of concern. This initiative, supported by senior management, was linked with several quality and staff concerns received regarding specific services. This leads to several staff sharing their experiences. The themes have been shared with the senior leadership team and actions taken to address concerns.

2.6 The collaboration between the FTSUG and the Organisational Development (OD) team is fundamental to reinforcing learning and acting on the concerns received. This collaboration allows the trust to challenge cultural behaviours, bullying and harassment and detriment in a serious, committed, and constructive way. Because of a positive approach to speaking up, the Trust can keep improving services and staff experience, addressing inadequate behaviours as necessary. The Guardian took the opportunity to refresh his knowledge and practice in Mediation and conflict resolution through training delivered through the OD team. This training provided useful and fundamental tools to keep improving the quality of work provided. The Guardian is now providing support doing Mediation. OD is also collaborating in the continuous development and training of the Speak Up Advocates network.

2.7 The Freedom to Speak Up Guardian continues to help and promote the de-escalation of conflicts and facilitate and improve routes of communication on a 1:1 level or within a team/ department.

2.8 NHS England has published its new and updated national Freedom to Speak Up policy, which is applicable to primary care, secondary care and integrated care systems. Together with NHS England (NHS England), the National Guardian's Office has also published new and updated Freedom to Speak Up guidance and a Freedom to Speak Up reflection and planning tool. Each will help organisations deliver the People Promise for workers, by ensuring they have a voice that counts, and by developing a speaking up culture in which leaders and managers value the voice of their staff as a vital driver of learning and improvement. NHSE is asking all Trust Boards to be able to evidence this by the end of January 2024: An update to their local Freedom to Speak Up policy to reflect the new national policy template; results of their organisation's assessment of its Freedom to Speak Up arrangements against the revised guidance; and assurance that it is on track implementing its latest Freedom to Speak Up improvement plan. Collaborating with HR colleagues, the Guardian plans to implement the new revised policy by the end of the year.

2.9 The **NGO (National Guardian Office)** published national data collected between 1st of April 2021 to 31st of March 2022. Key points included the following:

- Over twenty thousand (20,362) cases were raised with Freedom to Speak Up Guardians.
- The numbers of speaking up cases raised with Freedom to Speak Up Guardians are similar to last year (20,388 in 2020/21 20,362 in 2021/22).
- October to December 2021 had the highest number of cases reported in a single quarter (5,705) since Freedom to Speak Up Guardians were established in 2016. This may be a result of the awareness raising which takes place during Speak Up Month every October.
- The percentage of cases which were raised anonymously has fallen to ten percent (10.4%). This continues the downward trajectory from 2017 when 17.7% of cases were raised anonymously.
- Nineteen per cent (19.1%) of cases raised included an element of patient safety/quality, a slight increase from 18% in 2020/2. In response to concerns being raised during the pandemic, the NGO introduced a new reporting category of worker safety in 2021/22.
- Worker safety was a strong theme in Freedom to Speak Up guardians' reflections on the data they provide, with the impact of reduced staffing levels included in patient safety concerns, increased workloads and staff wellbeing. This theme was particularly linked to the COVID-19 pandemic, which had led to increased sickness, from COVID-19 itself and from stress/burnout.
- Over the year, 13.7% of cases had an element of worker safety. 32.3% of cases had an element of bullying and harassment, up from 30.1% in 2020/21.
- Detriment for speaking up was indicated in 4.3% of cases. Disadvantageous and/or demeaning treatment as a result of speaking up may include being ostracised, given unfavourable shifts, being overlooked for promotion or being moved from a team. Although this is down from 5.1% in 2017/18, this has risen since last year (3.1% in 2020/21). Dr Jayne Chidgey-Clark, National Guardian for the NHS stated: "I am greatly concerned by the increase in reported detriment for speaking up. When someone speaks up, it should be considered a gift – a gift of information which could prevent harm or lead to improvement. I expect leaders to role model this behaviour in their organisations and send a clear message that treating people badly for speaking up will not be tolerated."

2.10 The NGO conducted the fifth annual Freedom to Speak Up Guardians survey. The Guardian's views provided invaluable insights into both the implementation of the Freedom to Speak Up Guardian role and what further support and learning are needed to truly create a culture where speaking up is business as usual. The results also revealed details about guardians' perceptions of the barriers to speaking up, the sources of detriment for speaking up and the guardian network's demographics. The NGO published a report looking at the results of the 2021 Freedom to Speak Up Guardian Survey. This can be seen in detail as an appendix to this report. This document highlights the experience of Freedom to Speak Up Guardians amid the continued pressure of the pandemic on the healthcare sector. It looks in more detail at the responses from Guardians about their well-being and the support available to them, whether that's from their leaders, their guardian peers, or the National Guardian's Office. Just over half of Freedom to Speak Up Guardians who responded to the survey said that their role can negatively affect their emotional well-being. Yet when they can effect positive change, the role can be the most fulfilling. A key message from the results highlights again the importance of adequate ring-fenced time for carrying out the Freedom to Speak Up Guardian role. Almost half (49.2%) of respondents said the

Freedom to Speak Up Guardian role reduces their emotional and psychological well-being. A greater proportionate of respondents without ring-fenced time said that the role reduced their emotional and psychological well-being compared to their peers with some ring-fenced. Our Guardian received regular support from our IAPT team of therapists and works full-time in his role. This helps to improve his well-being and job satisfaction. Support is also provided by the two weekly London Guardians meetings and peer support.

2.11 The National Guardian's Office has issued guidance on speaking up training for workers in healthcare. In addition, in partnership with Health Education England, it has launched a Freedom to Speak Up e-learning package. Leaders are strongly encouraged to undertake training to support their understanding of the benefits and drivers of fostering a healthy speaking-up culture, including improving their knowledge of and support for the Freedom to Speak Up Guardian role. All the Guardians were also asked to complete mandatory training on the role and FTSU guidance.

3 Speak Up Advocate's role

3.1 The Guardian is offering supervision and support to consolidate the network of Speak Up Advocates. Currently, the network has 51 Advocates. More than half of the Advocates are from a black and minority ethnic (B.E). ethnic background. As some Advocates leave the Trust, others are sought from the same service, to ensure the continuation of the service provided.

3.2 The ambition remains to have an Advocate for each inpatient ward. The Guardian will continue to attend morning handovers in each Ward during the next 6 months, to raise awareness of FTSU and encourage Advocates recruitment. Other areas of interest remain the Day treatment centre, Finance team, Information Management and Technology and Estates and Facilities. The collaboration of Divisional Directors and Corporate Directors will be fundamental in this process. The Guardian is working alongside the new Head of Facilities to visit every team in the department to improve the culture around speaking up/ raising concerns.

3.3 In October we held our first face-to-face Speak Up network meeting since the pandemic. It represented a great opportunity to align FTSU goals, and jointly reflect on ways to keep improving and raising the profile of FTSU. We will be introducing the network to our Chief Executive and Chief Nurse, the executive director responsible for FTSU. In collaboration with the OD team, this event will be an opportunity to gain new knowledge about communication, coaching conversations and understanding strong emotions. It will also be an opportunity for a refreshment training on FTSU.

3.4 Speak Up Advocates continue to support colleagues by active listening to their concerns. Most of the Advocates report that colleagues often look for their support and advise as they are known to be a confidential and impartial support for everyone in the Trust. When the concerns raised required any actions, colleagues are signed post to the Guardian.

4 Local concerns raised Q1 and Q2 (April 2022 to September 2022)

4.1 In this reporting period (April 2022 to September 2022 – Q1 and Q2), the FTSUG received 52 initial concerns. This represented a significant increase compared with the same quarters (Q1 and Q2) for the previous year (April 2021 – September 2021) with

43 initial cases. This may reflect a change regarding the impact of COVID-19 felt in previous years. From the 52 concerns received, 6 were raised anonymously and have been reported internally.

4.2 Table one shows cases received by Integrated Clinical Service Units (ICSU) and Corporate Directorates. E&IM has the highest level of concerns alongside a good and proactive engagement with the Guardian from senior leadership. Nevertheless, during this reporting period, E&IM received the biggest amount of anonymous concerns (4 out of 6). A significant increment of concerns can also be observed in Acute Patient Access Clinical Support Services Women´s Health. Most of the concerns are regarding Attitudes and Behaviours and Quality and Safety. Surgery and Cancer have no reported concerns during this period. The Guardian will engage with this ICSU leadership to reinforce awareness around Speaking Up/ raising concerns.

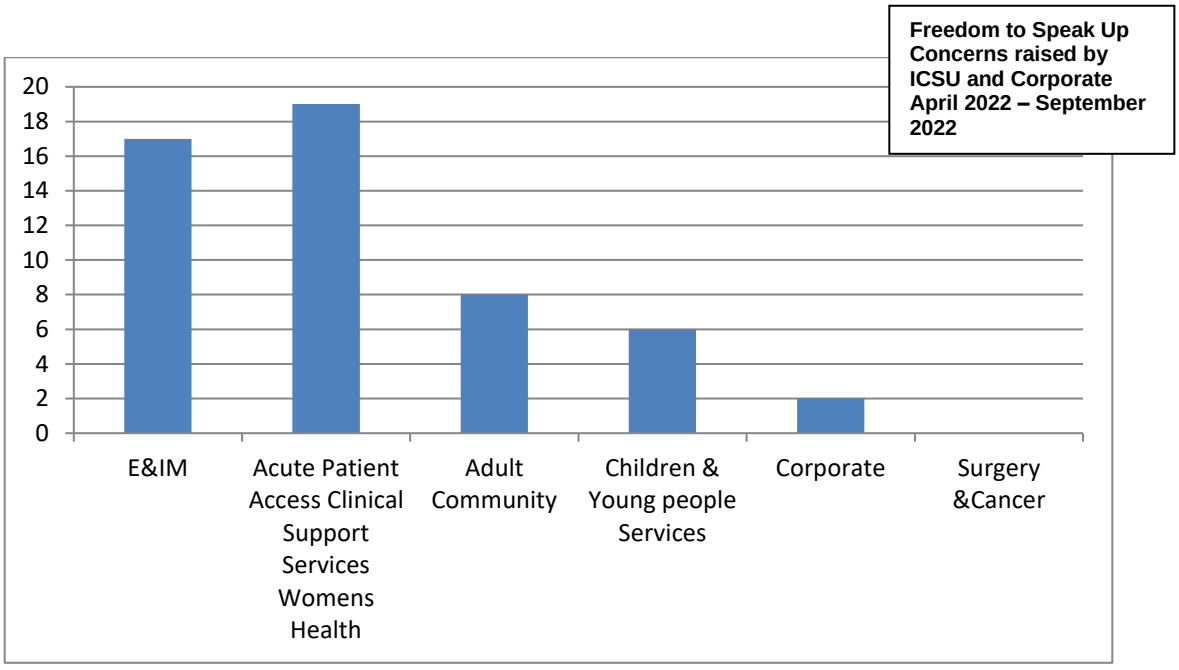


Table one: Freedom to Speak Up Concerns raised by ICSU and Corporate in April 2022 – September 2022

4.3 Table two describes the themes raised for the same period.

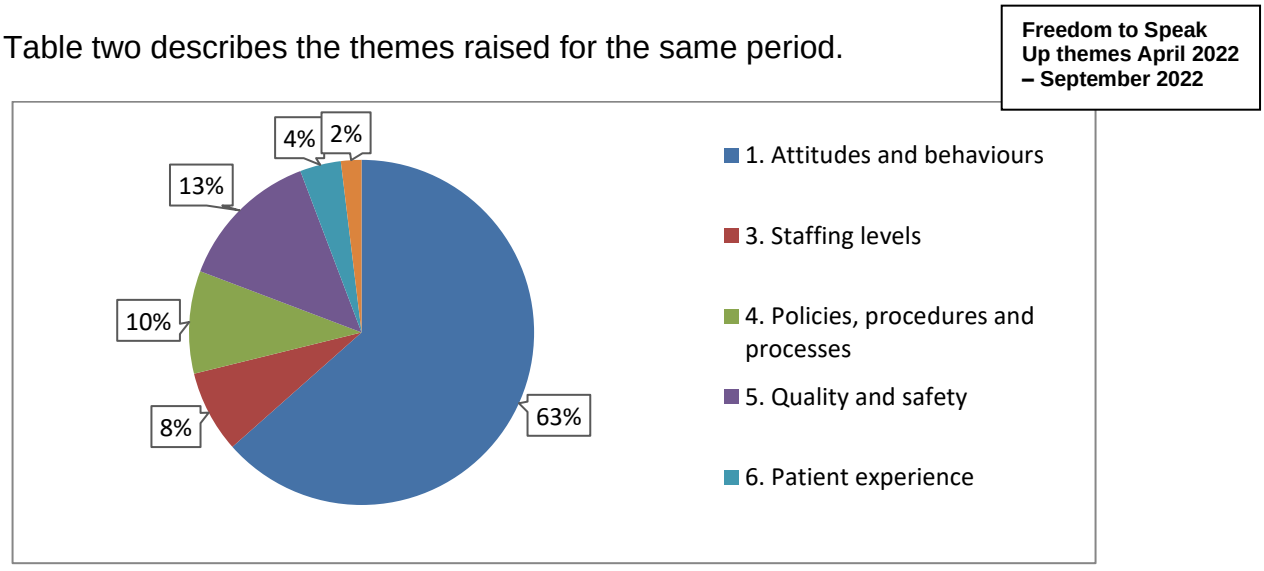


Table two: Freedom to Speak Up themes April 2022 – September 2022

4.4 Table three shows the ethnicity of staff raising concerns from April 2022 to September 2022. This data helps us to find areas that need more active engagement and awareness regarding FTSU. The FTSU Guardian, together with the Joint Directors for Race, Equality, Diversity & Inclusion and Staff Networks, continues to increase visibility, and knowledge on FTSU and Speak Up Advocates recruitment.

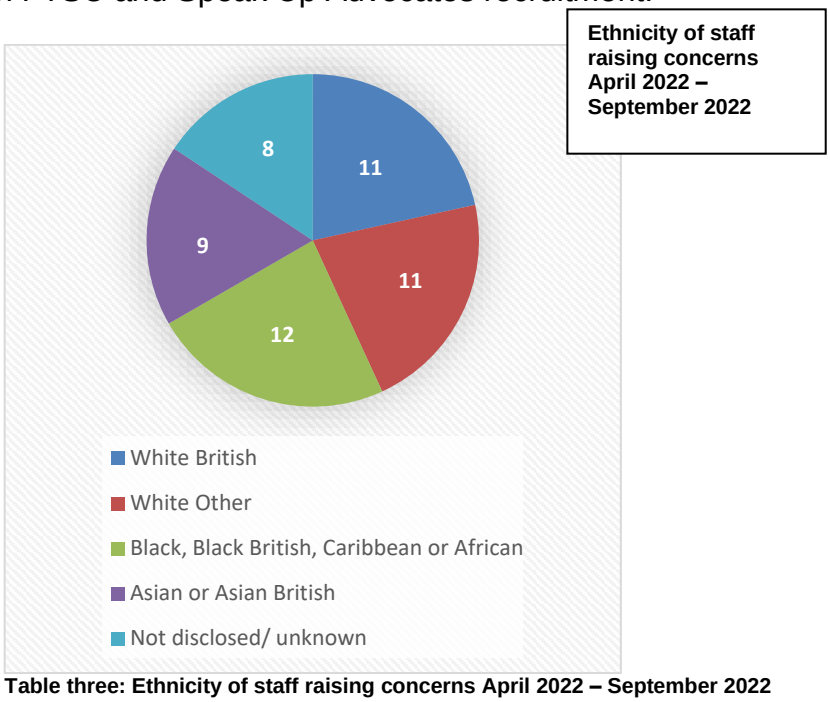


Table three: Ethnicity of staff raising concerns April 2022 – September 2022

4.5. Table four shows the number of cases raised by professional group. These new professional/worker group categories are informed by feedback from Freedom to Speak Up Guardians and based on NHS Digital's National Workforce data set.

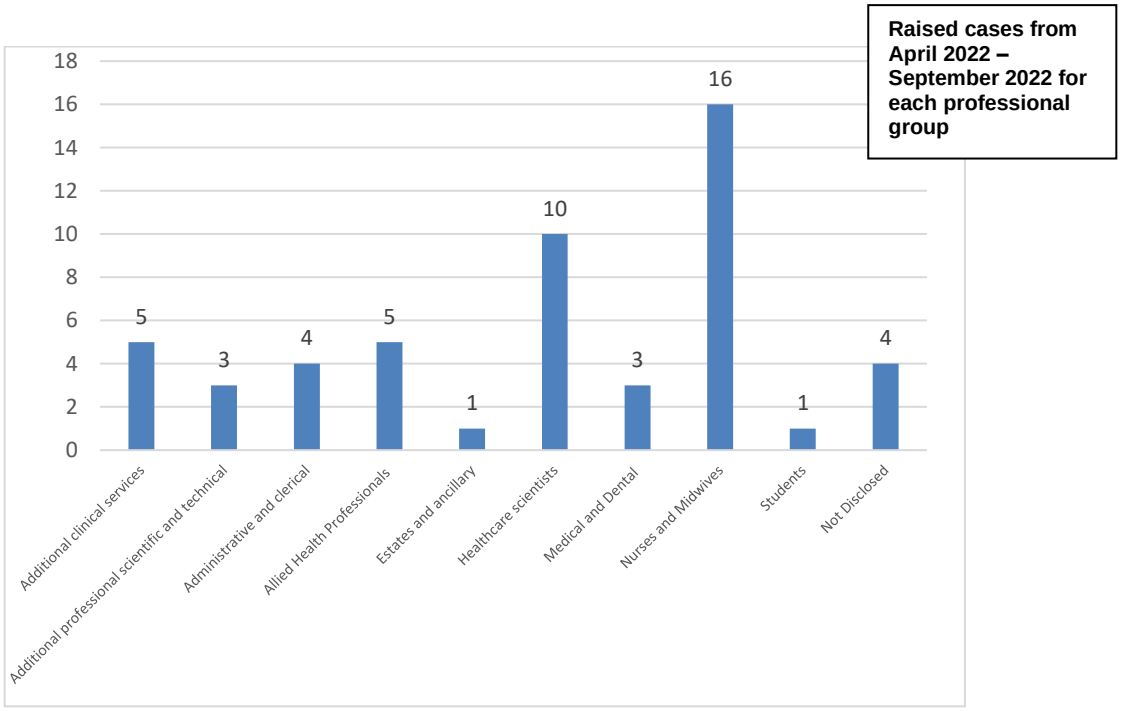


Table four: Raised cases from April 2022 – September 2022 for each professional group

5 Priorities for the next six months

5.1 The Guardian has identified several priorities for the next six months and they include:

1. Continue visits to Health Centres and services throughout the Hospital, including night visits.
2. Continue roll out of national FTSU training to executive and senior managers and front-line managers.
3. Support and supervise the Speak Up Advocates, recruiting and training new ones as necessary. Also, support continuous development within the role.
4. Provide support and profile in the Staff Networks.
5. Collaboration with the Communication department to raise the FTSU profile and visibility.
6. Undertake the FTSU Self-Assessment and review recommendations made by the NGO

6 Recommendations

- Support the recruitment of Speak Up Advocates and acknowledge the importance of providing protected time (within job roles) for the Advocates to support their colleagues
- Encourage and promote with managers and senior leaders to engage with Freedom to Speak Up
- Continue to support the implementation of Freedom to Speak Up training to staff.

SUPPORTING THE WELLBEING OF FREEDOM TO SPEAK UP GUARDIANS

Further analysis of the Freedom to Speak Up Guardian Survey 2021

June 2022

National Guardian

Freedom to Speak Up

National Guardian’s Office

The National Guardian's Office (NGO) leads, trains and supports Freedom to Speak Up Guardians, who support workers to speak up and work within their organisation to help identify and reduce barriers to speaking up.

The National Guardian’s Office supports and challenges the healthcare system in England on speaking up.

Acknowledgements

We want to thank Freedom to Speak Up Guardians for participating in the survey, particularly given the additional pressures on the healthcare system.

We also want to thank Picker Institute Europe for their expertise and support in running the survey.

Contents

Foreword 4
Introduction 6
Key findings 9
Actions 11
Health and wellbeing 14
Support and resources from the National Guardian's Office 21

Freedom to Speak Up Guardian Networks 26
Personal characteristics 32

Foreword

The role of a Freedom to Speak Up Guardian is challenging, and never more so than during the past two years of the pandemic response.

From the uncertainty and fear of the first wave to two years later and the 'new normal', with services still under sustained pressure dealing with the care backlog and a workforce recovering from the impact of the pandemic, Freedom to Speak Up Guardians have continued to listen and support their colleagues.

Their role means they often support people in distress, and the confidential nature of these discussions means that guardians can carry a great deal of emotional weight. Yet Freedom to Speak Up Guardians tell us that although this affects their emotional wellbeing, the role can be the most fulfilling when they can affect change positively.

My role as National Guardian is to support these special people who want to do so much for their colleagues and the organisations they support. They are at the heart of everything we do at the National Guardian's Office.

Which is why, as part of our annual survey of Freedom to Speak Up Guardians, as well as asking about the role and implementation of the role, we have also asked guardians about their health and wellbeing.

This report is our second publication looking at the results of the 2021 Freedom to Speak Up Guardian Survey. It looks in more detail at the responses from guardians about their wellbeing and the support that is available to them, whether that's from their leaders, their guardian peers, or from the National Guardian's Office.

A key message from the survey highlights again the importance of adequate ring-fenced time for carrying out the role. We know from the proportion of guardians who have responded that those who do not have ring-fenced time feel that the role reduces their emotional and psychological wellbeing. They are also more likely to say that they spend all their time in the guardian role on supporting colleagues – the reactive elements of the role (20% compared with 5% of those with ring-fenced time).

This compares with the greater proportion of respondents with ring-fenced time (34.6%) said they split their time equally between supporting colleagues and supporting their organisation - the proactive element of their role compared to 21.7% of respondents with no ring-fenced time.

This highlights the importance of sufficient ring-fenced time on Freedom to Speak Up Guardians' health and wellbeing and their ability to carry out their role effectively.

Lack of ring-fenced time has an impact, not just on the day to day fulfilment of the role, but also on Freedom to Speak Up Guardians' ability to access support to carry out their role. Respondents with ring-fenced time were more likely to attend guardian network meetings and they are more likely to attend events organised by the National Guardian Office, and to open the fortnightly communications bulletin. Network meetings are valuable opportunities to share good practice and psychological and emotional support with their guardian peers.

The National Guardian's Office has repeatedly called for Freedom to Speak Up Guardians to have sufficient ring-fenced time to carry out their role. I ask all leaders to discuss the findings of this report with their Freedom to Speak Up Guardian and assess with them the amount of ring-fenced time needed to carry out the role and meet the needs of workers in their organisation. This means not only the proactive and reactive elements, but also that their guardian has sufficient time to access wellbeing resources, including their guardian networks.

It is critical that guardians have the emotional and psychological support they need from their leaders and their organisations so that, in turn, they can support workers who speak up to them.

We included questions around guardians' perceptions of the impact of their personal characteristics (e.g. ethnicity, seniority etc). Results indicate that this is a complex area which, among other things, should be viewed through an intersectional framework rather than through single characteristics. We found that there was awareness among Freedom to Speak Up Guardians of the potential impact of characteristics on individuals speaking up to them.

The National Guardian's Office will continue to work in partnership with others to understand further the impact of personal characteristics on speaking up and effective interventions to help overcome barriers.

Feedback is a gift, and at the National Guardian's Office we have used this survey to examine the offer we have to support Freedom to Speak Up Guardians and to inform our future work programme.

Freedom to Speak Up Guardians provide a unique and valuable service to their organisations. As such they should be valued. Yet we have heard that some guardians face indifference from leadership, or in extreme cases that guardians have been victimised for effective performance of the very job expected of them.

I would encourage all leaders to use this survey as a prompt to have a conversation with their Freedom to Speak Up Guardian. Take the time to understand the challenges of the role and listen with gratitude and compassion to what they are telling you.

Dr Jayne Chidgey-Clark

National Guardian for the NHS
June 2022

Introduction

This is the second report regarding the results of our most recent Freedom to Speak Up Guardians survey. We undertake this survey annually to gain insight into the implementation of the Freedom to Speak Up Guardian role and how this could be improved. Feedback from respondents helps us assess developments since the launch of the Freedom to Speak Up Guardian role and identify and prioritise improvements that we may need to make to support the Freedom to Speak Up network.

We invited 745 Freedom to Speak Up Guardians to participate in the survey, which was open from 13 September to 31 October 2021. In total, there were 333 responses - a response rate of 44.7%.

All survey questions were voluntary, so the number of responses to each question varies. Therefore, results are shown as a percentage of each question's total number of answers.

Please see here for the Freedom to Speak Up Guardian Survey 2021 Question List.

In March 2022, we published our first report looking at the 2021 Freedom to Speak Up Guardian survey results.

In this second report, we take an in-depth look at Freedom to Speak Up Guardians' perceptions in the following areas:

- The impact of their role as Freedom to Speak Up Guardians on their wellbeing
- The effectiveness of Freedom to Speak Up Guardian networks
- The effectiveness of the National Guardian's Office's support and outputs for Freedom to Speak Up Guardians
- The impact of their personal characteristics (such as their seniority, age and ethnic background) on their ability to effectively carry out their Freedom to Speak Up Guardian role

This was the fifth survey of its kind. Please see here for reports from our previous surveys.

Freedom to Speak Up Guardians

Freedom to Speak Up Guardians provide an additional route to support workers to speak up, ensuring people are thanked, issues raised are responded to, and feedback given on the actions taken. They also work proactively to help identify and reduce barriers to speaking up, working in partnership with senior leaders to create a climate where speaking up, listening up and following up becomes business as usual.

The Freedom to Speak Up Guardian job description sets out the expectations of this important and far-reaching role.

Freedom to Speak Up Guardians are expected to be appointed by their organisation following a fair and open recruitment process. They need enough time and resources to carry out the role's reactive and proactive elements. This means sufficient ring-fenced time, a physical setting where people know they can be reached, a budget, a case recording system that satisfies National Guardian's Office guidance and, importantly, a direct channel to and support from leaders in their organisations.

Freedom to Speak Up Guardians cannot be effective in isolation and must maintain strong partnerships with senior leaders and decision-makers in their organisations. This ensures that they can function in accordance with role expectations, such as retaining their impartiality in investigations, not taking on a representative role, and being able to support anyone who needs it, even if on opposing sides of a dispute.

Freedom to Speak Up Guardians meet regularly in national and regional networks. Led by Freedom to Speak Up Guardian Network Chairs - and under the banner of the National Guardian's Office - these confidential forums provide an opportunity for peer networking and support, as well as learning and development opportunities.

A diverse, national network

There are currently over 800 Freedom to Speak Up Guardians supporting workers in hundreds of healthcare organisations across England, including NHS Trusts, independent providers, hospices, primary medical services and non-provider organisations such as Care Quality Commission, NHS England and NHS Improvement and other regulators.

Guardians come from diverse backgrounds; for example, representing different professions, roles, levels of seniority and time allocated to the role. Individual organisations determine how the role(s) will be implemented to meet the expectations of the universal job description within the unique context of their organisation.

Making a difference

Freedom to Speak Up Guardians share non-identifiable information with the National Guardian’s Office about the speaking up cases raised with them. This information provides invaluable insight into the implementation of Freedom to Speak Up.

Freedom to Speak Up Guardians have handled over 65,000 cases in the past five years. That is 65,000 opportunities for organisations to learn and improve.

Workers speak up to Freedom to Speak Up Guardians about a range of topics, from patient safety and quality of care to worker safety and wellbeing and many other matters.

Feedback is an essential part of the speaking up process. Freedom to Speak Up Guardians ask those they support whether, given their experience, they would speak up again. Workers answered ‘Yes’ (84.3%) in most cases where feedback was provided.

Please see here for more information about the speaking up cases raised with Freedom to Speak Up Guardians.

A challenging, rewarding and sometimes isolating role

Being a Freedom to Speak Up Guardian is a rewarding, challenging, and sometimes isolating role. Freedom to Speak Up Guardians must have the support, time and resources from their organisation and understand and take advantage of the other available support offers depending on what is right for them. This includes the support from buddies, guardian networks and the National Guardian's Office. The National Guardian’s Office provides access to a workplace assistance programme - which provides a 24-hour, 7-day-a-week helpline where Guardians can seek a range of support on various topics, including wellbeing.

Guardians are often approached by people in distress, wanting to speak up about the most serious of matters. However, respecting confidentiality means they can be holding a large amount of sensitive information, some of which they are not able to pass on. This can affect the health and wellbeing of Guardians. So, it is essential that leaders recognise the need to engage regularly with their Guardians to understand what tailored support can be offered.

A lack of leadership support can severely undermine Guardians' ability to do their job. For example, not having a direct line of communication with the most senior leaders suggests little value is placed on the role. This can diminish the role in the eyes of workers, managers and sometimes Guardians themselves. In extreme cases, we have heard of Guardians being victimised for the effective performance of the expected job.

Our annual survey helps us understand more about the disparity of support that exists and informs our discussions about what more is needed.

Key findings

Guardian health and wellbeing

- Almost half (49.2%) of respondents of respondents said the Freedom to Speak Up Guardian role reduce their emotional and psychological wellbeing.
- A third of respondents (33.7%) said the role had no impact on their emotional and psychological wellbeing. Seventeen per cent (17.7%) said the role improved their emotional and psychological wellbeing.
- A greater proportionate of respondents without ring-fenced time said that the role reduced their emotional and psychological wellbeing compared to their peers with some ring-fenced.

Support and resources from the National Guardian's Office

- Most respondents found most elements of support and output to be helpful, particularly the following: the fortnightly bulletins for guardians (93.1%), the National Guardian's Office website (89.6%) and the guidance documents (89.8%).
- A greater proportion of respondents with ring-fenced time said they found the support and outputs helpful.

Freedom to Speak Up Guardian Networks

- 87.0% of respondents had attended at least one network meeting, with over half (50.9%) saying they had attended three or more.
- Respondents with ring-fenced reported better attendance at regional network meetings. Less than one in ten (9.1%) of those with ring-fenced time had not attended any meetings compared to 21.1% of those with no ring-fenced time to carry out their role.
- Of those who attended at least one network meeting, 88.2% agreed or strongly agreed that the meeting(s) were helpful. Only 2.9% of respondents disagreed or strongly disagreed.
- Nearly three-quarters (74.1%) of respondents supporting NHS trusts said that network meetings were very or somewhat effective in providing an opportunity to engage with the National Guardian Office. In comparison, 83.9% of respondents supporting other organisation types thought that network meetings were very or somewhat effective compared in this regard.

Personal Characteristics

- Majorities of respondents identified their seniority and profession as influential characteristics in terms of whether workers spoke up to them. In comparison, majorities or near majorities of respondents thought that their protected characteristics - like age, ethnicity, gender, and sexual orientation - did not influence whether workers spoke up to them.
- Compared to the 2020 survey results, a greater proportion of respondents said that the various personal characteristics identified- including seniority, ethnicity and gender - influenced whether workers spoke up to them.

- Majorities of respondents thought that protected characteristics such as age, gender, sexual orientation and ethnicity did not influence their ability to carry out their role as Freedom to Speak Up Guardians.
- Seniority was the only characteristic identified by a majority of respondents (57%, 2021) as influencing their ability to carry out their Freedom to Speak Up Guardian role.
- Compared to those in a majority group, a greater proportion of respondents from minority or subordinate groups within a characteristic - such as women, lesbians, gays and bisexuals and those from a minority ethnic background - were more likely to think that their characteristics were not only consequently, but positively so.
- Compared to those in a majority group, a greater proportion of respondents from minority groups within a characteristic - such as women, lesbians, gays and bisexuals and those from a minority ethnic background - were more likely to think that their characteristics were not only of consequence, but positively so.

Actions

Supporting the health and wellbeing of Freedom to Speak Up Guardians

Freedom to Speak Up Guardians' health and wellbeing needs should be identified, assessed and met so that they can effectively and sustainably provide a vital, additional route for workers to speak up and work in partnership to bring about culture change.

- The **National Guardian's Office** will continue to seek feedback from Freedom to Speak Up Guardians to understand the effectiveness of the actions we have taken, as mentioned throughout this report, in response to their feedback.
- **Freedom to Speak Up Guardians** should understand and take advantage of the available support offers depending on what is right for them.
- **Leaders** should actively reach out and arrange regular conversations with their Freedom to Speak Up Guardian(s) about providing appropriate health and wellbeing support and seeking assurance that the support is effective.
- The findings in this survey and other research show the importance of sufficient ring-fenced time on Freedom to Speak Up Guardians' health and wellbeing and ability to carry out their role effectively. The National Guardian's Office has repeatedly called for Freedom to Speak Up Guardians to have sufficient ring-fenced time to carry out their role. The National Guardian's Office urges **leaders** to discuss the findings of this report with their Freedom to Speak Up Guardian and assess with them the amount of ring-fenced time needed to carry out the role and meet the needs of workers in their organisation.
- The National Guardian's Office has worked with colleagues in NHS England and Improvement on developing guidance on freedom to speak up for senior leaders in the NHS and organisations delivering NHS services. Scheduled for publication in Q1 2022/23, this resource includes guidance on how to support Freedom to Speak Up Guardians effectively. **Leaders** should effectively utilise this guidance.
- The **National Guardian's Office** will continue to work with NHS England and Improvement and the Care Quality Commission on methods to monitor compliance with the guidance about Freedom to Speak Up and the Freedom to Speak Up Guardian role.
- The National Guardian's Office has issued guidance on speaking up training for workers in healthcare. In addition, in partnership with Health Education England, it has launched a Freedom to Speak Up e-learning package. **Leaders** are strongly encouraged to undertake training to support their understanding of the benefits and drivers of fostering a healthy speaking-up culture, including improving their knowledge of and support for the Freedom to Speak Up Guardian role.

Supporting the effectiveness of Freedom to Speak Up Guardian networks

Freedom to Speak Up Guardian networks provide, among other things, opportunities for peer support and networking, and the sharing of learning, ideas and challenges and successes in a confidential environment. Network meetings are also forums for

Freedom to Speak Up Guardians to be informed about and have input into the National Guardian's Office's plans.

- **Freedom to Speak Up Guardians** are expected to join and participate in Freedom to Speak Up Guardian network meetings to benefit from the learning and development opportunities on offer and to give and receive peer support, which helps support their wellbeing.
- **Leaders** should encourage and facilitate the effective participation of Freedom to Speak Up Guardians in network meetings, including through the provision of sufficient ring-fenced time.
- The **National Guardian's Office** will continue to work with network chairs to support:
    - the refreshed expectations of the chair role
    - the effectiveness of network meetings, including agreeing on measures of success
    - including providing training and support to facilitate the above.

Enhancing the National Guardian's Office support for Freedom to Speak Up Guardians

The National Guardian's Office leads, trains and supports Freedom to Speak Up Guardians.

- The **National Guardian's Office** is committed to exploring effective levers to ensure Freedom to Speak Up Guardians are supported locally in accordance with expectations.
- The **National Guardian's Office** will produce guidance for Freedom to Speak Up Guardians to support effective and confidential case management processes, including when Freedom to Speak Up Guardians step down.
- The **National Guardian's Office** will continue to monitor feedback following the launch of the new style of foundation training and aims to work collaboratively on developing annual refresher training to support the needs of Freedom to Speak Up Guardians in diverse settings.

Appreciating how what we bring to the workplace impacts speaking up

Personal characteristics (like ethnicity, seniority and profession) may impact how we speak up and whether colleagues speak up to us. The National Guardian's Office is committed to continuing to promote much-needed discussion and reflection about the role of characteristics in speaking up.

- The **National Guardian's Office** will conduct research to build on our work and shed light on the impact of characteristics from workers' perspectives. We look forward to sharing further information about this research in the year's second half.
- The **National Guardian's Office** is working with the Workforce Race Equality Standard (WRES) team in NHSE to deliver training for Freedom to Speak Up Guardians on supporting inclusive speak-up cultures. The **National Guardian's Office** is committed to exploring how the learning from this can translate into future learning and development for Freedom to Speak Up Guardians.

- **Freedom to Speak Up Guardians** are expected to continue to reflect on the impact of their characteristics on speaking up in the organisations they support.
- We all need to reflect on what we bring as individuals to the workplace for speaking up to become business as usual. Therefore, we strongly encourage **leaders** to consider this as part of the Freedom to Speaking Up training.
- **Leaders** should work with their Freedom to Speak Up Guardian(s) to identify potential groups that face barriers to speaking up and work towards addressing those barriers in their speak-up culture improvement plans.

Health and wellbeing

Impact on emotional and psychological wellbeing

We asked respondents about the impact of their role on their emotional and psychological wellbeing.

Forty-six per cent (45.5%) of respondents said the role '*somewhat reduced'* their emotional and psychological wellbeing. In comparison, 14.8% said it somewhat improved it. A third (33.7%) said it had no impact on their emotional and psychological wellbeing.

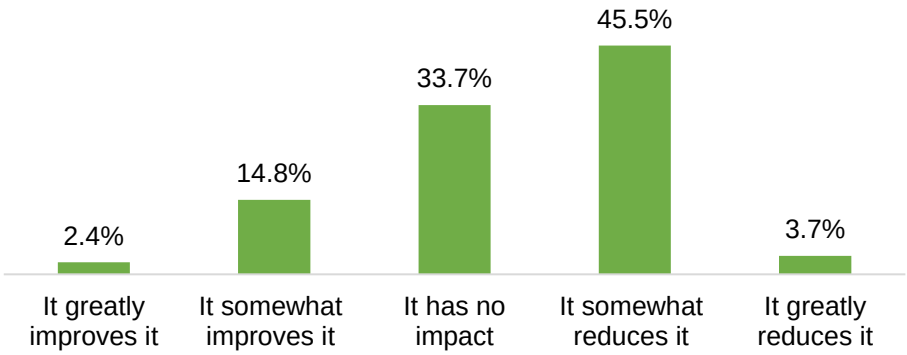


Figure 1: How do you feel your role as Freedom to Speak Up Guardian impacts on your emotional and psychological wellbeing?

We found variations in responses to this question, including the rating of the organisation supported by respondents. As can be seen in figure 2, a greater proportion of respondents supporting organisations rated *requires improvemen*t by the Care Quality Commission (CQC) said that their role reduced their emotional and psychological wellbeing.[1]

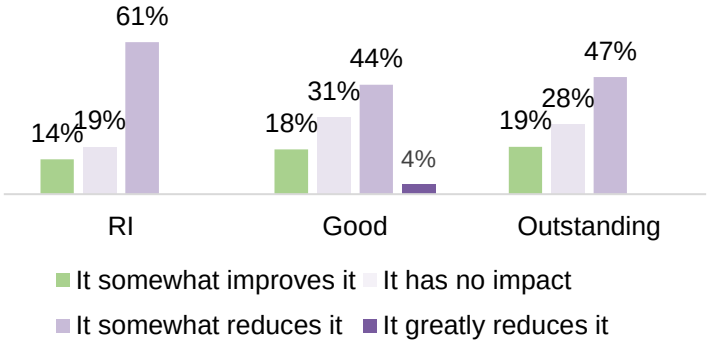


Figure 2: How do you feel your role as Freedom to Speak Up Guardian impacts on your emotional and psychological wellbeing? (CQC rating, where applicable)

[1] The Care Quality Commission (CQC) regulates and inspects many of the organisations with Freedom to Speak Up Guardians. The CQC gives one of four ratings to services they regulate: outstanding, good, requires improvement, and inadequate.

Similarly, compared to those with some ring-fenced time, respondents without ring-fenced time were more likely to report that their role as a Freedom to Speak Up Guardian was reducing their emotional and psychological wellbeing (figure 3).

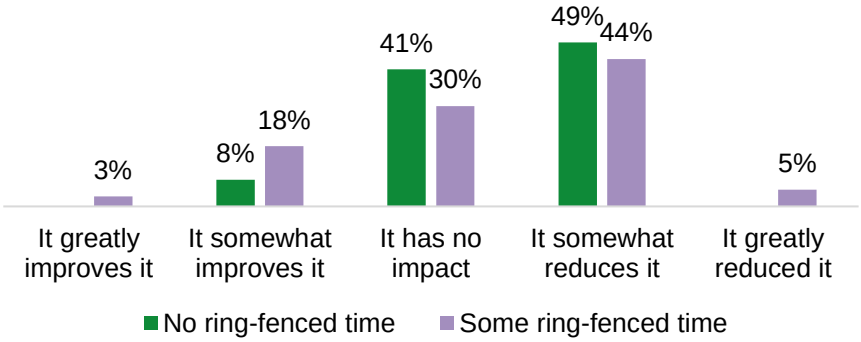


Figure 3: How do you feel your role as Freedom to Speak Up Guardian impacts on your emotional and psychological wellbeing? (ring-fenced time)

Support from employers

We asked respondents about the availability of health and wellbeing support from their employer.

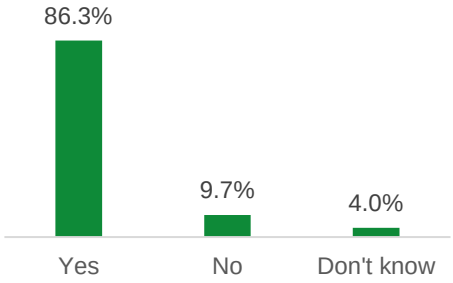


Figure 4: Does your employer offer you health and wellbeing support (such as access to occupational health or other emotional and psychological support services)?

Eighty-six per cent (86.3%) of respondents said their employer offered health and wellbeing support. Ten per cent (9.7%) said such support was not offered (figure 4).

Respondents who had been offered health and wellbeing support were then asked whether they had accessed this support and, if so, how helpful or unhelpful they found it.

Most respondents (74.1%) said that they had not accessed the support. Most of those who had accessed it – 90.8% - said they found the support helpful.

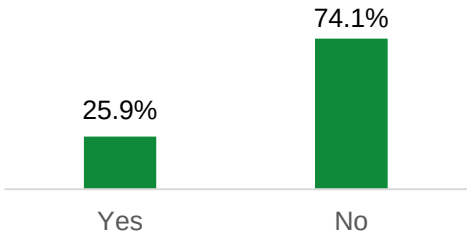


Figure 5: Have you accessed this support?

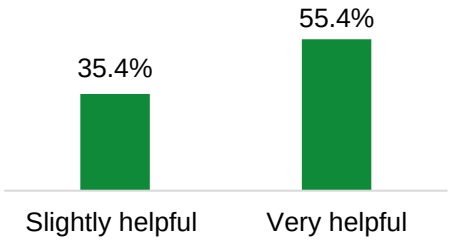


Figure 6: How helpful or unhelpful did you find it?

Respondents were invited to share further comments to explain their answers. Below, we have grouped their feedback thematically.

The impact of the role itself

Respondents described how the role was simultaneously rewarding and challenging. Respondents referred to their satisfaction from supporting workers and making a difference in their organisations. However, many also described the invariable impact on their emotional and psychological wellbeing.

“Supporting others to speak up, supporting leaders and managers to learn how to encourage speaking up directly to them within their teams and seeing the gradual culture change really warms the soul!”

“Like most roles in the NHS, the role of Freedom to Speak Up Guardian is simultaneously very satisfying and sometimes stressful…”

"the offers for wellbeing are useful, sometimes though you cannot help but feel weighed down emotionally by the concerns raised and feel worried for others’ wellbeing. This is, at times, hard to handle and can lead to increased stress and anxiety, no matter how good the support is, it doesn't take away those feelings. Good job I am a resilient individual and, on the whole, can cope."

“Some days what people tell me really hits home, and then others lift you. It's a balance.”

"... the role both negatively and positively impacts on my health and wellbeing. Sometimes negatively due to the burden of risks and emotional/psychological charge I am left carrying and the frustration of trying to get anything done but it also positively impacts: nothing compares to doing a fulfilling role and seeing changes big or small and the impact on staff."

"On occasions, a speaking up concern can cause you to worry. On another day, when a staff member tells you how grateful they are for your support and how "I could not have achieved this without you," you feel very positive."

...

Some respondents spoke about the frustrations resulting from misunderstandings of the Freedom to Speak Up Guardian role.

"I have been questioned as to why I am involved…: "This has got nothing to do with Speaking Up". On each occasion, having explained why it does have something to do with Speaking Up, I have been able to get them to understand. But the process of defending my position cannot be done without some stress! I have [been] given protocols as to exactly how I will operate, which I have resisted as this compromises my independence… but this has also been stressful. Occasionally, I have been concerned enough… to… lose sleep over those cases."

"… although managers say they support Freedom to Speak Up I still hear comments like "the staff member will get what they want by speaking to Freedom to Speak Up". This does not discourage me but makes me more determined that staff have a voice."

...

Similarly, respondents mentioned the challenges when colleagues don't take speaking up matters seriously.

"[It is] also worrying when concerns raised are not seen as a priority by some senior leaders, or not taken seriously."

...

Many respondents mentioned how the role could feel lonely and isolating.

"Being a Freedom to Speak Up Guardian can be lonely and isolating. This is due to the confidentiality you have to abide by. Standing by the ethics of confidentiality and not sharing any concerns raised."

"It can be a stressful, emotional and isolating role."

The availability, use and effectiveness of support

A common theme among the responses received was that support was available, though this was not the case across the board.

"My employer regularly sends emails promoting wellbeing, yoga, and reflexology sessions. In addition, there are helplines for mental health support and a weekly newsletter to encourage people to share their experiences at work."

“It is difficult to deal with sometimes when you have distressing Freedom to Speak Up conversations at the end of the day or on a Friday afternoon when there are limited avenues to download or seek advice.”

...

While some respondents had accessed support, others noted that they had not needed it.

“I can ‘self-manage’.”

"I can access support and have not yet felt the need to do so"

...

Many respondents distinguished between general support offers and ones that were more direct and tailored (such as supervision, buddying and networks). Respondents reported that the latter was more practical, though not always available.

“I have a psychologist for Supervision which is really important to work out how and why I have responded to speaking up in a certain way, what I could have improved on or done differently.

A safe, confidential space for Freedom to Speak Up Guardians is essential."

"Recognition of own support mechanism is more useful than a generic referral to Occupational Health. Self-support is accessed through the regional buddy and Clinical Supervision monthly session within own organisation provided by Safeguarding team."

"The support is not necessarily what I would find helpful... Supervision, where I could talk through concerns and challenges, would be far more useful, [but]... is not available."

"Peer support from other Guardians in the network and from a buddy is often more effective as they understand the challenges well."

"… all Freedom to Speak Up Guardians should have regular access to Clinical Supervision… Supervision or professional counselling provides a safe space to discuss the emotional pressures and helps build resilience."

...

Some respondents spoke about the challenges of accessing support through their employer.

"I am concerned about the potential conflict of interest in accessing emotional wellbeing support from inside my organisation."

"It is very difficult to access support internally when you feel so protective about colleagues' anonymity. Always thinking carefully about what the next word out of your mouth is going to be can be draining, so I don't access internal support."

"In our organisation, occupational health can only be accessed with a referral from your line manager... Therefore, I cannot access this service to discuss matters confidently. In the first instance, I would need to share my reasons with… [my line manager] to enable a referral."

...

Respondents suggested potential ways to address these challenges.

"Identifying supervision resources externally is hard and requires additional financial resources. One idea is for [the organisation] … to cooperate and offer support to a neighbouring guardian."

Support from senior leaders and others

Freedom to Speak Up Guardians do not work in isolation. Their ability to carry out their role effectively depends on the willingness of others to work together.

Another theme in the respondent's feedback was the importance of support from leaders in organisations. Many respondents mentioned the positive impact of this support on their emotional and psychological wellbeing.

“I feel my emotional wellbeing and mental health has not been impacted by the role, and I think this is because … [the organisation/s I support is] very supportive of me and keen to do whatever I need to help me achieve in the role."

"I receive regular 1:1 meetings with two executive directors.. and 1:1 meetings with the non-executive director. These are sufficient and supportive."

"I'm being praised for my work so far. I have gained positive feedback and reassurance I’m doing well from those I engage with and help, plus senior management. It’s a positive and supportive space right now.”

...

However, many respondents reported that they did not have this support.

"I feel the wellbeing of... guardians was overlooked by our senior management throughout the pandemic as we were not considered 'frontline workers', and the emotional impact upon us was underestimated and poorly understood, despite our speaking up numbers being very high and the emotional intensity overwhelming."

Ring-fenced time: amount of work

Freedom to Speak Up Guardians should have ring-fenced time to effectively carry out their essential role. Under two-thirds (65.6%) of those responding to our latest survey said they had ring-fenced time to carry out their role, down from 70.3% in 2020. Please see our preceding report for further information.

Some respondents spoke about the demands on the role and its impact on their wellbeing. Similarly, some respondents reported not having the time to utilise support.

“… Being continuously on call is cumulatively the most stressful part of the role – this particularly applies if only one person is doing it for a whole Trust.”

"There is not enough time to access wellbeing support. This should be offered as ring-fenced time."

"It’s just a lot of work to do in a short space of time and whilst they say there's no expectation to work outside your hours the reality is that it will be hard not to"

"Don't have the time to get through the work and seek support for the impacts of undertaking the work on me."

Response from the National Guardian’s Office

Freedom to Speak Up Guardians' health and wellbeing needs should be identified, assessed and met so that they can effectively and sustainably provide a vital,

additional route for workers to speak up and work in partnership to bring about culture change.

- The National Guardian's Office has called for Freedom to Speak Up Guardians to have sufficient ring-fenced time to carry out their role.
- In association with Health Education England, we have launched the third and final module of our Freedom to Speak Up eLearning package. This module is designed for leaders at all levels to help them foster a speaking up culture in their organisations, including improving understanding of and support for the Freedom to Speak Up Guardian role.
- We have worked with NHS England and Improvement on the development of *Freedom to Speak Up for the NHS and organisations delivering NHS services*, which offers guidance to leaders on, among other things, effective support for the Freedom to Speak Up Guardian role.

Support and resources from the National Guardian's Office

The National Guardian's Office provides a range of support and resources for Freedom to Speak Up Guardians, including:

- Regular webinars on topical issues to share learning and provoke discussion.
- Guidance documents to help understanding of the practical elements of the Freedom to Speak Up Guardian role.

We asked respondents how helpful they found this range of support and resources.

The following three items attracted the most positive ratings:

- 93.1% of respondents said that the fortnightly bulletins for Freedom to Speak Up Guardians was very or slightly helpful
- 89.8% of respondents said that the guidance documents from the National Guardian's Office were very or slightly helpful
- 89.6% of respondents said the National Guardian's Office website was very or slightly helpful

Please see the figure 7 below for a further breakdown.

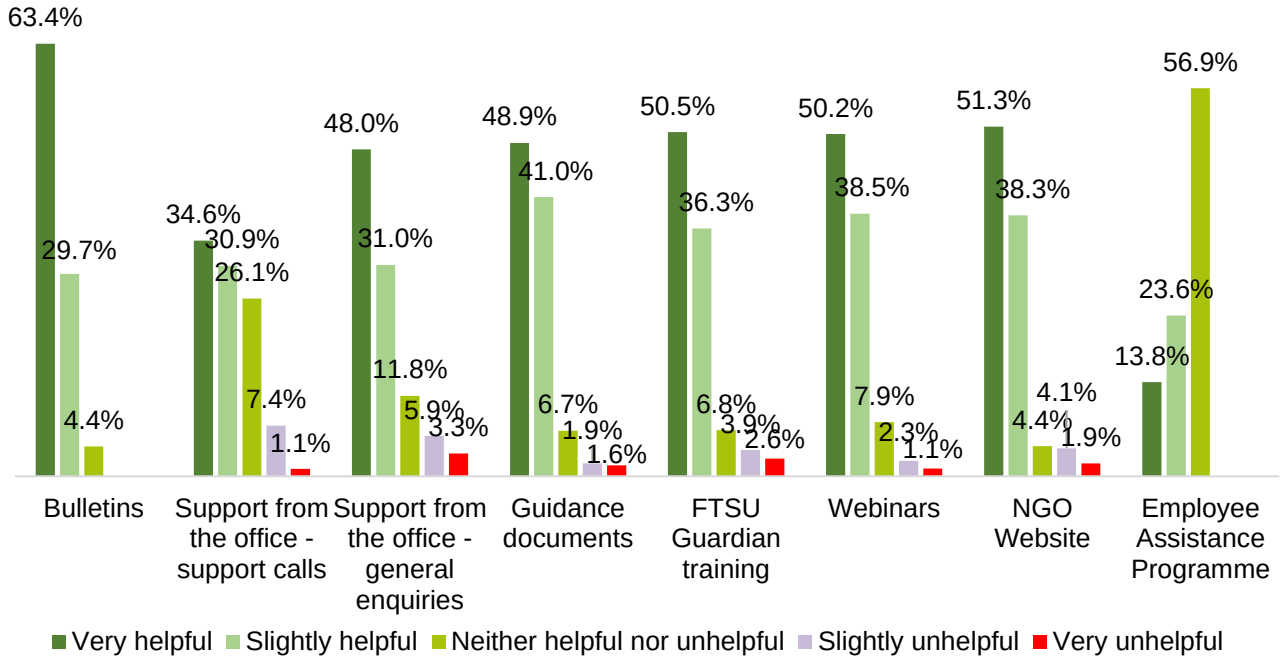


Figure 7: How helpful or unhelpful do you find the following from the NGO

- The item that attracted the least positive ratings was the workplace assistance programme arranged and offered by the National Guardian's Office to Freedom to Speak Up Guardian.

- Most respondents (56.9%) said they found the employee support programme neither helpful nor helpful.
- The qualitative comments from the survey indicated that many respondents had not heard of the service and were unaware of how it could help and support them in their role as Freedom to Speak Up Guardian

Ring-fenced time

Responses varied depending on whether respondents had ring-fenced time.

Compared to respondents without ring-fenced time, a greater proportion of respondents with ring-fenced time said they found the support and resources very or somewhat helpful.

The variation in responses was smaller regarding items such as the bulletins and the website. However, the divergence was starker for items like webinars, general enquiries and support calls, where a greater proportion of respondents answered 'not applicable'.

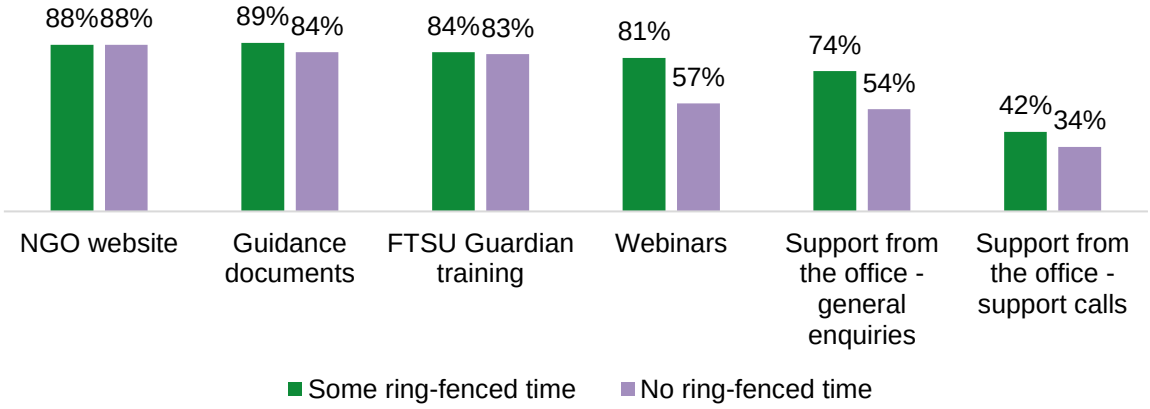


Figure 8: How helpful or unhelpful do you find the following from the NGO: percentage of respondents who answered, 'very helpful' or 'slightly helpful'.

The results may reflect that utilisation of support and resources, such as webinars and support calls, often require more time than receiving and reading bulletins and accessing resources on the National Guardian's Office website, which respondents without ring-fenced time may be less likely to have spare. This was also indicated in some of the comments shared by respondents:

"It is incredibly difficult to read all the literature and guidance documents as I do not have protected time for my role."

"I've had little time to engage with you or your website regularly due to my workload, and only employed in this new role part-time."

Respondents were invited to share further comments to explain their answers. Below, we have grouped their feedback thematically.

Training for Freedom to Speak Up Guardians

Respondents provided feedback on the training they received from the National Guardian's Office. Some respondents said the training was helpful, though many said it could be improved.

"I feel the training… was helpful."

"I am unsure whether it equipped me for the role. I think more real-life examples of speaking up and how to support would be helpful. I think refresher training via the NGO would also be helpful."

"I would like to receive more training from the NGO and more continuous development by looking at case studies."

"it was a good start… [with] a good presenter. However, it was nowhere near as detailed as I thought it would be… [T]here were two case studies…. [but] these were not relevant."

...

The National Guardian's Office adapted its training in response to the COVID-19 pandemic, and the impact of this was reflected in the feedback from some of the respondents.

"I feel that the original Guardians training was extremely helpful. However, I am unsure that the short virtual introductory sessions would provide the relevant information for guardian update training."

"Due to Pandemic did not receive the full induction – only had a short half-day induction – would welcome more when… possible."

...

Respondents also shared suggestions regarding training for Freedom to Speak Up Guardians.

"I would like very advanced training on how to deal with queries. Also, we need to be offered Mental Health First Aid and other wellbeing training as Guardians."

...

National Guardian's Office communication and engagement with Freedom to Speak Up Guardians

Respondents stated that the fortnightly bulletins and Lunch & Learn webinars for Freedom to Speak Up Guardians were informative and a good way to stay connected. However, some noted that the topics covered in the webinars were more useful than others.

"The bulletins and webinars are really good at ensuring we are in touch and up to date with what is happening."

...

Respondents commented on the value of measures to reach all Freedom to Speak Up Guardians.

"The recorded webinars are helpful as sometimes it is hard to attend live."

...

Respondents welcomed the NGO's revamped website, launched in 2021. However, many respondents noted areas for improvement, including navigation and maintenance of the website.

"I use the website regularly, but I don't always find it easy to find what I'm looking for."

...

Respondents also mentioned the responsiveness of the NGO and its general engagement with Freedom to Speak Up Guardians.

"I am pleased at the responsiveness of the NGO to feedback from Guardians – new items have been added to the website, and the data collection protocols have been much improved as a result."

...

However, respondents noted areas for improvement in this regard.

"Freedom to Speak Up Guardians are often the last to know or find out."

"I don't think the engagement and consultation are there."

…

Several respondents mentioned that they were not aware of their ability to access the workplace assistance programme arranged by the National Guardian's Office.

The effectiveness of National Guardian's Office support for Freedom to Speak Up Guardians

Respondents commented on the responsiveness/effectiveness of the support and resources from the Office.

"The office has been helpful with queries around submitting data…[..]… I have always received great communication.

...

However, many said that this was an area for improvement. Broadly, this feedback fell into four areas:

- NGO responsiveness

- Practicality of support from the NGO
- Availability of guidance, including on stepping down
- Universality of the NGO's focus

"The office response time can sometimes be slow, which is frustrating if it is a quick question/query."

"When a Freedom to Speak Up Guardian contacts the NGO, they are usually asking for urgent support – to get a response that says you may respond within three weeks is not helpful."

"Some guidance/advice could do with being pinned downed more carefully; it can be a little too ambiguous."

"I asked a question... I ... did not get a response."

"There isn't guidance for how Freedom to Speak Up data is handled when a Guardian leaves their organisation."

"I think everything still assumes an NHS environment. As a Hospice, that is not always applicable."

...

Improvement suggestions

Respondents shared suggestions for improvement.

"It is difficult to find the section for confidential guardian information. It would be far better to have a sign-in section - that may be linked to the portal - that allows access to all the information."

...

Response from the National Guardian's Office

We have acted in response to feedback from Freedom to Speak Up Guardians, including the following:

- We developed a password-protected area of our website for Freedom to Speak Up Guardians only to access wellbeing and development resources. The resources pages include a newly designed Freedom to Speak Up Guardian logo and associated communications resources.
- We updated our auto acknowledgement to emails, and since March 2022, we have started monitoring and improving our response times for enquiries.
- We have promoted the workplace assistance programme offered to Freedom to Speak Up Guardians.

Freedom to Speak Up Guardian Networks

Freedom to Speak Up Guardians are expected, as part of the role, to join and participate in regional and national network meetings with other Freedom to Speak Up Guardians.

These meetings seek to provide the following:

- Peer support and networking
- Sharing of learning, ideas, challenges, and successes in a confidential environment
- Being informed about and inputting into NGO plans
- Contributing to and furthering the Freedom to Speak Up agenda

We asked respondents how often they had attended networks meetings:

- 87.0% of respondents had attended at least one meeting
- 50.9% of respondents saying they had attended three or more meetings

Over a fifth of respondents (21.1%) with no ring-fenced time to carry out their role reported that they had not attended any meetings. In comparison, 9.1% of those with ring-fenced time had not attended any meetings. Similarly, a smaller proportion of respondents with no ring-fenced time said they had attended three or more meetings (39.4%) compared to respondents with ring-fenced time (57.2%).

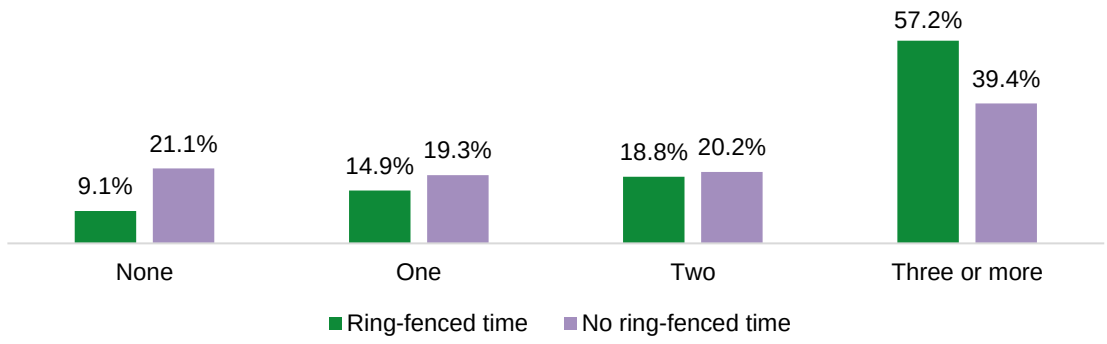


Figure 9: How many network meetings have you attended in the last 12 months?

Of those who attended at least one network meeting, 88.2% agreed or strongly agreed that the meeting(s) were helpful. Only 2.9% of respondents disagreed or strongly disagreed.

Respondents also shared their views about how well network meetings met their aims and objectives.

In four out of five areas identified, over half of respondents said the network meetings were very effective. Thirty-six per cent (36.2%) of respondents said the

meetings were effective (very or slightly) in providing an opportunity to engage with the National Guardian's Office.

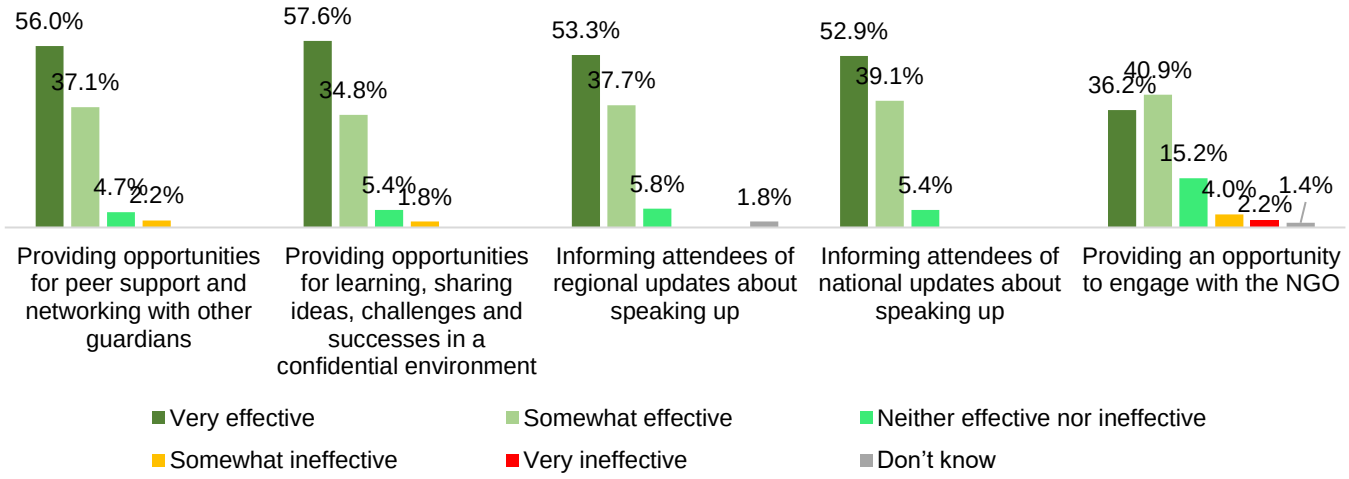


Figure 10: How effective was the network meeting(s) for…

Organisation type

A larger proportion of respondents supporting NHS trusts found network meetings very or somewhat effective in most of the areas identified compared to respondents supporting other organisation types (figure 11, below). The only area where this was reversed was when it came to the effectiveness of network meetings in providing an opportunity to engage with the National Guardian's Office. In this regard, 83.9% of respondents supporting other organisation types agreed the network meetings were very or somewhat effective compared to 74.1% of those who supported NHS trusts.

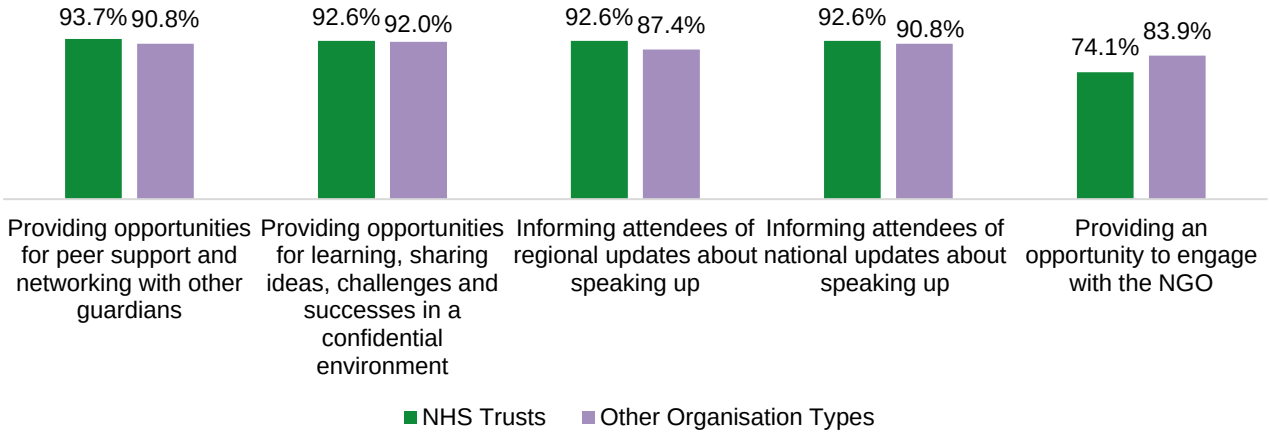


Figure 11: Somewhat/very effective responses by organisation type

Respondents were given the opportunity to provide further comments about network meetings.

The impact of Freedom to Speak Up Guardian networks

Feedback highlighted the importance of these meetings to Freedom to Speak Up Guardians, including in the following areas:

- engagement and networking
- information sharing, learning
- peer support
- case handling

"The meeting has provided the opportunity for networking, sharing ideas and supporting each other."

"I don't know what I'd do as a Guardian without the networks. It's a crucial forum for support and guidance."

"It is really helpful when other Guardians (particularly experienced ones) prioritise these meetings -it provides valuable learning opportunities for new guardians in post."

...

Many respondents mentioned how the role can be isolating and lonely and how the networks are invaluable for support. Respondents also referred to the importance of network meetings as a safe, confidential space.

"These meetings are essential lifelines for Freedom to Speak Up guardians whose roles are often quite isolated... ."

"Being a Guardian can sometimes feel quite an isolating role - being part of the network makes it feel like you're part of a team with similar experiences who can support each other."

...

Many respondents praised their peers in their networks.

"I find the community spirit and openness helpful, the sincerity of each individual."

"Our Chair... is fantastic."

“We have established a very strong, effective, supportive and collaborative group. There is always someone ready and willing to offer help and guidance.”

...

Respondents also commented on the network opportunities to engage with the *National Guardian’s Office, including how this could be improved.*

“… it was very helpful to have someone from the office attend.”

“The most useful elements are the discussion of issues … presentations from the NGO and other organisations for information or as case studies and the ability to ask questions.”

“Due to the recent changes within the NGO, there has been limited input from them.”

“Information provided by regional NGO colleagues tends to be what has already been received via the Bulletin. It might be helpful to understand any cases they have supported or talk through some case studies.”

…

Planning and running of network meetings

Respondents commented on the planning and running of network meetings.

"Meetings are really … well run ... ."

...

Many also shared feedback on how this could be improved.

“I also feel more structure would be helpful - often minor points can be discussed, at length, without any resulting decisions or actions.”

“In terms of sharing of learning, more time could be given for engagement, e.g. active participation after a presentation, so probably having fewer items on the agenda to allow meaningful discussions would be helpful.”

“…earlier announcements of dates… .”

“It's a little nerve-wracking to attend at first - I would find it super helpful if there was a guardian mentor appointed for me rather than leaving it to newly appointed Guardians to approach people.”

"It would be helpful if they are recorded so that they can be accessed afterwards."

...

Some respondents said that they had not always been invited to attend or were aware of the dates when network meetings were taking place.

“I have not been invited to these meetings but would much like to attend.”

“NGO could provide regional chairs with updated contacts list for Freedom to Speak Up guardians in the area ensuring that all guardians are linked into the correct region.”

Several comments highlighted the pandemic's impact on their engagement with their networks, particularly the move towards virtual meetings. Many welcomed the move towards virtual meetings, remarking how it has made it easier for peers to engage. At the same time, several respondents mentioned that they missed in-person meetings.

"Easier to attend them online as would struggle to attend if needed to travel although maybe one face-to-face a year would be good once permitted to improve networking."

"Due to Covid, we had to move to virtual meetings. This has helped with the engagement and regularity of the meetings and, therefore, the peer support. It

would, however, still be great to see each other face to face once or twice a year, as conversations flow far better when you are in a room together."

"Doing online meetings means that peer support is dramatically affected."

"I think whilst things are online, it's difficult to network well as it can sometimes feel like there are friendship cliques but nothing I can't cope with. In-person, I would approach people to chat but can't do this in the same way and not sure we can do more than share small talk. So many members don't make any effort to engage, so it's difficult to hear other voices or views and to be a newbie I'm conscious that people don't know me yet, and it may seem strange for them to answer my questions or trust me."

...

Some commented that they didn't always have time to engage with their networks.

"It would be great to have dedicated time to attend these network meetings as I have found them incredibly informative and supportive. However, I don't feel the Guardian role is fully recognised by Trust leaders as there is much more to it than just casework."

"I have a very busy schedule in my full-time job, and as there has been such a staff shortage, it is very difficult to get time allocated for the Freedom to speak up role."

...

Some respondents noted that the meetings focused on particular organisation types.

"I am a Freedom to Speak Up Guardian .... not [in] a Trust. I find much of the info is understandably biased towards acute trusts."

"I find the specific hospice network meetings most beneficial as the issues and challenges are similar. I did not find the regional network meetings helpful as the organisations were much bigger, and there were staff members/teams responsible for this."

...

Some respondents said that networks and meetings are not always inclusive.

"The… network is starting to become … 'cliquey' and … non-inclusive."

"I attend the meetings for my learning but often do not find them a pleasant experience. The more 'established' Guardians dominate the discussions, and I feel they can be quite patronising to the newer Guardians… In addition, I feel my views and comments are not valued by the network - often comments aren't even acknowledged."

"I feel most vocal attendees and dominant personalities monopolise the network."

…

There were varying views on the frequency of meetings.

"The frequency of the meetings increased during the height of the pandemic- I miss them now!"

"Can only attend a proportion as the meetings are too frequent."

...

Reflections on the broader infrastructure of networks

The comments also provided areas for improvement that the National Guardian's Office can take forward to ensure the network meetings are fully effective in supporting Freedom to Speak Up Guardians.

"We have had a regional group for .. years, and many of us rely on it for a safe space to confidently share difficult conversations. However, as the membership has expanded, this feels less like the appropriate place for this conversation and more business-driven."

"Regional forums… are well executed. However… much of this is based on the goodwill of the regional chair, how the appointment is conducted into this role and what resources are allocated to the role."

"I do not believe the appointment of the Chair and Vice-Chair … followed an open and transparent process."

"I wonder how effective full-region meetings will be in terms of mutual support as the number of Guardians grows - but an advocacy of buddying relationships may help this."

"I see the variety of offers going on regionally for the Freedom to Speak Up guardian networks, and sometimes I feel a little sad that there isn't more consistency… I recognise that we have to coordinate these speakers and that regional needs might differ, but it would be good to have that offer, and those details shared for all regions."

"Admin support for the meetings is required as it is very time-consuming producing accurate minutes."

...

Response from the National Guardian's Office

The National Guardian's Office has an ongoing programme of work with network chairs to support the effectiveness of Freedom to Speak Up Guardian networks, including the refreshed expectations of the network chair role, the including agreeing on measures of success to facilitate effective network meetings, including providing training and support to facilitate the above.

Personal characteristics

As human beings, we possess a range of characteristics, visible or hidden, biological or social.

Our unique combination of these means that we all bring something special to the workplace. However, these characteristics may also impact on how we speak up, and how and whether colleagues speak up to us. For example, people will respond to our seniority (or their perception of our seniority). They may have a response to our accent or make a judgement based on our personal and professional relationships. We also possess what are described in law as 'protected characteristics', like age, ethnicity, sexual orientation or religious/political beliefs, and our colleagues will also have a response to these.

Personal characteristics: the make-up of the Freedom to Speak Up Guardian network

Freedom to Speak Up Guardians come from all walks of life.[2] Figure 12 (below) shows the demographic breakdown of respondents to our two most recent annual surveys (2021, 2020).

Characteristic	2020		2021	
Gender	Male 24%, 66	Female 72%, 194	Male 19%, 56	Female 80%, 232
Ethnicity	White 89%, 240	Minority ethnic 9%, 25	White 85%, 246	Minority ethnic 15%, 44
Age	51+ years old 51%, 138	50 or below 48%, 128	51+ years old 57%, 165	50 or below 43%, 126
Sexual orientation	Heterosexual / straight 89%, 233	Gay, lesbian or bisexual 6%, 17	Heterosexual / straight 87%, 251	Gay, lesbian or bisexual 6%, 17

Figure 12: Breakdown of respondents to the 2020 and 2021 Freedom to Speak Up Guardian survey: percentage and actual figure

As can be seen in the table above, there has been an increase in the percentage of Freedom to Speak Up Guardians from minority ethnic backgrounds responding to the survey from 2020 to 2021. Similarly, there has been an increase in the percentage of female respondents and the age profile of responders in 2021 compared with 2020.

[2] We asked respondents to share information – including demographic – to inform us of the make-up of the Freedom to Speak Up Guardian network. These results can be found in the first report we published into the results of the 2021 Freedom to Speak Up Guardian Survey.

Personal characteristics: whether and how it has an effect

We asked Freedom to Speak Up Guardians to share their reflections on whether and how their personal characteristics:

- Affected their ability to carry out their role
- Influenced whether workers spoke up to them

To what extent do you think 'X' influence(s) whether workers speak up to you?						
Characteristic	**Doesn't make a difference**		**Don't know**		**Does make a difference**	
	2020	2021	2020	2021	2020	2021
Seniority	35%	32%	16%	14%	49%	54%
Profession	38%	32%	15%	15%	47%	52%
Age	53%	51%	17%	16%	29%	32%
Ethnicity	53%	48%	24%	24%	24%	27%
Gender	61%	55%	22%	23%	16%	22%
Sexual orientation	70%	69%	25%	24%	6%	6%

Figure 13

In the case of both seniority and profession, most respondents said that their seniority and profession influenced whether workers speak up to them. In comparison, in the case of protected characteristics like age, ethnic background, gender, and sexual orientation, a majority or near majority of respondents did not think these characteristics influenced whether workers spoke up to them.

Compared to the 2020 survey results, a greater proportion of respondents said that the various characteristics - including seniority, ethnicity and gender - influenced whether workers spoke up to them. These results may reflect that there has been greater coverage about the impact of characteristics, especially during the pandemic.

There were similar responses with respect to whether certain characteristics influence a Guardian's ability to carry out their role (figure 14, below).

To what extent do you think 'X' influence(s) your ability to carry out your role as a Freedom to Speak Up Guardian						
Characteristic	**Doesn't make a difference**		**Don't know**		**Does make a difference**	
	2020	**2021**	**2020**	**2021**	**2020**	**2021**
Seniority	42%	32%	6%	11%	53%	57%
Profession	44%	40%	7%	10%	49%	49%
Age	62%	58%	7%	8%	31%	34%
Ethnicity	72%	64%	12%	15%	15%	20%
Gender	77%	68%	11%	17%	13%	15%
Sexual orientation	86%	77%	11%	18%	3%	5%

Figure 14

In comparison to the previous question, smaller proportions of respondents answered 'don't know' when asked about their views on the extent to which these characteristics influence(s) their ability to carry out their role as a Freedom to Speak Up Guardian. This greater certainty may be attributable to the fact that, unlike the previous question which invites respondents' perceptions of what other people may think or act, this question is more directly about respondents' own experiences and reflections.

When it came to characteristics such as age, gender, sexual orientation and ethnicity, most respondents thought that they did not influence their ability to carry out their role as Freedom to Speak Up Guardians, though the size of these majorities fell compared year-on-year.

Seniority was the only characteristic that most respondents (57%, 2021) identified as influencing their ability to carry out their roles.

We examined the results further to see how respondents with different characteristics answered these questions.

The tables below set out a breakdown of the results for some of the characteristics.

As can be seen in figure 15, most white respondents thought that their ethnicity did not:

- influence whether workers spoke up to them
- affect their ability to carry out their role

To what extent do you think your ethnicity…		Discourages / negative impact		No influence		Encourages / positive impact	
		2020	2021	2020	2021	2020	2021
…influence(s) whether workers speak up to you?	**White**	16%	17%	55%	53%	4%	3%
	Minority ethnic	12%	10%	28%	23%	48%	57%
… affects your ability to carry out your role as a Freedom to Speak Up Guardian	**White**	8%	12%	77%	70%	4%	2%
	Minority ethnic	8%	11%	28%	36%	48%	43%

Figure 15.

This was not the case for minority ethnic respondents. A majority (57%) of them said that their ethnicity encouraged workers to speak up to them and 43% of them said it positively affected their ability to carry out their role.

A similar picture emerged when looking at the results by gender and sexual orientation (please see figures 16 and 17).

To what extent do you think your gender…		Discourages / negative impact		No influence		Encourages / positive impact	
		2020	2021	2020	2021	2020	2021
…influence(s) whether workers speak up to you?	**Male**	11%	9%	63%	59%	5%	6%
	Female	2%	4%	60%	54%	14%	20%
… affects your ability to carry out your role as a Freedom to Speak Up Guardian	**Male**	2%	2%	82%	73%	6%	9%
	Female	3%	3%	75%	67%	11%	12%

Figure 16.

In comparison to male respondents, a greater proportion of female respondents said that their gender not only made a difference but that it encouraged workers to speak up to them as well as positively affected their ability to carry out their role (please see figure 16. above).

To what extent do you think your sexual orientation…		Discourages / negative impact		No influence		Encourages / positive impact	
		2020	2021	2020	2021	2020	2021
…influence(s) whether workers speak up to you?	**Heterosexual or straight**	2%	3%	72%	72%	1%	0%
	Gay, lesbian or bisexual	0%	0%	47%	24%	18%	47%
… affects your ability to carry out your role as a Freedom to Speak Up Guardian	**Heterosexual or straight**	1%	2%	87%	79%	0%	1%
	Gay, lesbian or bisexual	0%	6%	71%	47%	24%	30%

Figure 17

In all three cases, respondents in a minority or vulnerable group - minority ethnic, gay, lesbian or bisexual, and female - reported similar perceptions of the impact of their characteristics compared to their relevant counterparts.

Response from the National Guardian's Office

The National Guardian's Office is committed to continuing to promote much-needed discussion and reflection about the role of characteristics in speaking up.

- We commissioned research to understand workers' experiences of accessing Freedom to Speak Up Guardians and whether the ethnicity of a Freedom to Speak Up Guardian affected their decision to speak up, and the support they received. The findings of this research, carried out by Roger Kline OBE and Ghiyas Somra, was published in 2021.
- When training Freedom to Speak Up Guardians, the National Guardian's Office emphasises how various characteristics may influence the speaking up dynamic.
- The National Guardian Office will continue to work in partnership with others to understand further the impact of personal characteristics on speaking up and effective interventions to help overcome barriers.
- If we are to make speaking up business as usual, we all need to reflect on what we bring as individuals to the workplace and how we approach the speaking up dynamic when we speak up or respond to someone speaking up to us. To this end, we encourage everyone to consider this as part of the Freedom to Speaking Up training for all workers, including those in leadership, that we developed with Health Education England.

Meeting title	**Trust Board – public meeting**	**Date: 25.11.2022**
Report title	**Medical Appraisal and Revalidation: Annual Board Report: 2021-22**	**Agenda item: 7**
Executive director lead	Dr Clare Dollery, Executive Medical Director	
Report authors	Dr Sola Makinde, Associate Medical Director for Workforce, Revalidation and Appraisal, and Taniya Nasmin, Revalidation Support Officer	
Executive summary	This paper is the annual Medical Appraisal Board Report, in the format suggested by NHS England, as part of the quality assurance process for medical appraisal and revalidation. This report reviews appraisals completed, and revalidation recommendations submitted in the financial year 2021/22.	
Purpose	Assurance	
Recommendation(s)	The Board is asked to note the report and the actions which were previously approved by the Trust Management Group (TMG)	
Risk Register or Board Assurance Framework	Sustainability 2	
Report history	Previously presented at TMG	
Appendices	Newsletter	

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:.....2
Designated Body Annual Board Report.....4
Section 1 – General:.....4
Section 2a – Effective Appraisal.....6
Section 2b – Appraisal Data.....8
Section 3 – Recommendations to the GMC.....9
Section 4 – Medical governance.....9
Section 5 – Employment Checks.....12
Section 6 – Summary of comments, and overall conclusion.....13
Section 7 – Statement of Compliance:.....15

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

> Dr Clare Dollery has been Responsible Officer and Executive Medical Director since 10th June 2019.
>
> **Action for next year**: Not applicable.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

> Dr Sola Makinde has been the Associate Medical Director with a responsibility for workforce since April 2020.
>
> Ms Taniya Nasmin has been the Revalidation Support Officer since November 2019.
>
> The Trust employs a business manager for the Medical Director's Office (the current postholder has been on long-term sick leave and has now resigned the post. A new post holder has been recruited and will commence on the 1st of November 2022).
>
> **Action for next year**: Not applicable.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

> **Action from last year:** Not applicable
>
> **Comments**: The Trust has a process for maintaining an accurate list of prescribed connections via Electronic Staff Record (ESR) reports.
>
> A database is maintained by the Revalidation Support Officer of all doctors who work at the Trust, or hold honorary contracts with the Trust, to ensure that all have been linked appropriately to a designated body and are engaged with appraisal and revalidation.
>
> **Action for next year**: Not applicable

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Not applicable

Comments:

The Trust has a valid Medical Appraisal and Medical Revalidation Policy. This is due to be refreshed in October 2022.

Action for next year:

To review and refresh the Medical Appraisal and Revalidation policy.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: To complete a peer review of our appraisal and revalidation processes.

Comments: This was delayed in the year 2020/21 by surges of the COVID-19 pandemic and the retirement of the appraisal lead at our neighbouring Trust. The peer review process has now begun and is expected to be completed by the end of the year.

Action for next year: A commentary on the peer review results will be included in the Board report for 2023/24

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: There will be a continued focus on ensuring Trust-grade and short-term locum doctors are familiar with the process, including the regular recording of appraisals conducted at other Trusts.

Comments: The Revalidation Support Officer meets with new doctors with a prescribed connection to Whittington Health to whom we offer an appraisal, to ensure that they are familiar with the appraisal software, and to assist them in preparing for appraisal (either in person or more recently virtually). She will continue to do this in the 2021/22 year. The quarterly Appraisal Newsletter, sent to all the doctors who require an appraisal is an additional route by which doctors are alerted to the need for an annual appraisal.

Action for next year: As per last year, there will be a continued focus on ensuring Trust-grade and other doctors with a prescribed connection are

familiar with the process, including the regular recording of appraisals conducted at other Trusts.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: The Trust planned to survey both appraisers and appraisees to obtain objective evidence of the Appraisal 2020 model.

Comments:

A formal survey has not been possible due to repeated surges of the COVID-19 pandemic. Informal evidence, obtained during the quarterly Appraisers Network Meetings, has been favourable of the new model, and its focus on wellbeing.

In addition, complaints (and compliments) are sent to the Patient advocacy and Liaison Service; this information is uploaded into the appraisal software, as are any submissions that the doctor makes to Datix (the incident reporting system).

Clinical governance information is routinely sought if a doctor works in any organisation separate to the Trust and is uploaded to their appraisal file.

The Medical Appraisal and Revalidation Decision Making Group members include the associate medical director with the responsibility for patient safety, the Lead for Clinical Governance within the Trust and the Human Resources Business Partner with responsibility for Medical staffing. This ensures that all information that is relevant to a doctors' fitness to practice is considered by the Revalidation Group prior to making a revalidation recommendation decision. The Trust has adopted the Appraisal 2020 model.

Action for next year: Now that the Appraisal 2020 model is accepted and embedded into appraisal practice a survey of its acceptance amongst the appraisers and appraisees is no longer necessary.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Not applicable **Comments**: Not applicable **Action for next year**: Not applicable

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Not applicable. **Comments**: The Trust's 'Medical Appraisal and Medical Revalidation Policy' is valid until October 2022. **Action for next year**: Review and refresh the Revalidation Policy.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To recruit five new appraisers by April 2022 **Comments**: We have recruited three new appraisers (one is a previous appraiser who had stopped appraising – she is now updating her appraisal skills). Unfortunately, we have had several appraisers who have decided to stop, citing reasons of workload and work-life balance. **Action for next year**: We will continue in our efforts to expand the pool of appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: To hold an internal peer review of appraisal outputs Comments: A formal internal peer review of appraisal outputs did not take place, although appraisal outputs were the subject of discussion at the Appraisers quarterly Network Meeting. The meeting and Newsletter has continued to throughout 2021/22., and has been well received by appraisers

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Action for next year: The internal review of appraisal output has been superseded by the external review, which is on-going. The output of the peer review process will be disseminated and discussed withthe appraisers

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: The plan to subject our appraisals to an external quality review process by the completion of a peer review in 2020/21 was delayed by surges of the COVID-19 pandemic and the retirement of the Revalidation Lead in a neighbouring Trust.

The peer review is now in progress, and we plan to complete it by the end of the year.

Action for next year: We plan to review the results of the external review process and disseminate the results to our appraisers.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	283
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	153
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	75
Total number of agreed exceptions	55*

*This number includes the following

20 doctors who were on maternity leave / a career break / sick leave
11 doctors whose commencement date at the Trust was so close to their appraisal date it was inappropriate for them to have an appraisal
24 doctors whose appraisal was deferred by the COVID-19 surge in January / February 2022, but who completed it by 31st May 2022.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Not applicable

Comments: There were three missed GMC submissions in the year 2021/22. One related to a doctor who connected the day before they were due to be revalidated and is unlikely to be preventable in the future. The others prompted an internal review of the processes within the Medical Directorate and the introduction of a new process of layered safety nets to ensure that this does not recur. These processes are still being embedded.

Action for next year: We plan to continually review processes to ensure that GMC submissions are not missed.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Not applicable

Comments: Following discussion at the Medical Appraisal and Revalidation Decision Making Group, positive recommendations are submitted through the GMC portal and confirmations sent to the relevant doctors by letter from the Medical Director and AMD for workforce.

If there was a recommendation made for deferral, or if there was insufficient evidence to support revalidation, the doctor has been contacted prior to the initial submission date to see if, with support, a positive recommendation can be made. If this has not been possible, they are aware that their revalidation submission will be deferred and are supported to enable them to be able to provide the missing information ahead of their new revalidation date.

Action for next year: Not applicable.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Not applicable

Comments: The Trust has an appropriate system for clinical governance including review processes, executive oversight for complaints, incident management and infection control. Aspects of these arrangements are subject to internal audit at agreed intervals.

The Trust maintains certain corporate data which is issued to doctors prior to their annual appraisals. This data includes:

- Complaints and compliments;
- Incidents, including but not limited to Serious Incidents and high-risk incidents, and including incidents that the doctors reported even if they were not themselves responsible;
- Information on legal claims;
- Participation in registered local or national audit and contribution to clinical guidelines.

This data is shared with the doctor by the RO's team to ensure that it is included in the portfolio.

The Trust has a Quality Improvement Lead in post, and she has supported a number of teams and individual doctors to undertake quality improvement projects and share the learning from these projects.

Action for next year: Not applicable

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Not applicable

Comments: Conduct and / or performance issues related to doctors can be raised via several routes, including the clinical management structures and / or internal or national audits. All such issues are investigated, formally if appropriate, via the relevant policies, including 'Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff'. The details of any formal discussions with Executive Medical Director are confirmed in writing, and the doctor is required to reflect on it during the next appraisal.

Action for next year: Not applicable

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Not applicable.

Comments: The Trust has a local policy for 'Conduct, Performance and Ill-Health Procedures for Medical and Dental staff'. All conduct, performance and health concerns relating to doctors are managed by a Case Manager, and if investigation is necessary, are investigated by a Case Investigator with oversight from a nominated Non-Executive Director, as required by the national framework 'Maintaining High Professional Standards in the Modern NHS' and by local policy.

The Executive Medical Director has regular meetings with the Trusts GMC Employer Liaison advisor and discusses any concerns that she may have regarding a doctor's conduct, performance, or health with them. In addition, the Trust may initially discuss this on an anonymous basis with the Practitioner Performance Advice Service at NHS Resolution.

Action for next year: Not applicable.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Not applicable.

Comments: The Trust Board receive monthly reports if there are any doctor has been excluded from the Trust. Active cases are reviewed monthly with the HR teams and an extract report is compiled each month. This information includes a breakdown by protected characteristics.

Action for next year: Not applicable.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: Comments: We utilise the MPIT form where appropriate. Action for next year: Not applicable.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Not applicable Comments: The Trust has a Fair Treatment Panel that reviews processes conducted under HR policies; this includes any action under the Trust's Conduct, Performance & Ill-Health Procedures for Medical & Dental Staff. The Trust uses the Just Culture Guide when considering disciplinary cases. The Trust have a Medical Appraisal and Revalidation Decision Making Group to make decisions around revalidation recommendations. Action for next year: Not applicable

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Not applicable Comments: Pre-employment checks for doctors on permanent or fixed term contracts are performed by the Recruitment Team and Occupational Health. These include: • Verification of identity • Health clearance checks • Criminal records checks and the signing of a Criminal Convictions Declaration form

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

- Verification of right to work in the UK, where this is necessary
- Verification of license to practice and other relevant qualifications
- Filing of references and CVs

Honorary contracts are issued by the recruitment team with sign off via the Medical Directors office. Where a doctor applies for an honorary contract with Whittington Health, but also holds a substantive role at another organisation, verification of employment checks from their substantive employer is sought from the other NHS employing body.

Action for next year: Not applicable

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of actions since last Board report

- The Trust have successfully adopted the 'Appraisal 2020' model
- The Trust continue to run quarterly Appraiser Network Meetings
- The Trust continue to issue quarterly Appraiser Newsletters
- The Trust continue to actively support doctors to obtain 360-degree assessments, to avoid deferral of their revalidation dates
- A peer review of our appraisal outputs is on-going.

Actions still outstanding

Procurement of new appraisal software: The Trust had hoped to complete procurement of new appraisal software by 31st of March 2022. However, with the introduction of the North Central London Integrated Care System, a system wide solution was sought. The Trust continue to be under contract to our current supplier until the Summer of 2023, by which time a system-wide appraisal software package, if appropriate should have been identified. We aim to complete the procurement and have a new system in place by September 2023.

Review of the Output of the Peer Review

The MD team will review the output of the Peer review with our appraisers.

Current Issues

Medical Workforce shortages and its impact

Medical workforce shortages, at all levels, with a resultant need to work additional shifts to cover the gaps, coupled with increased patient numbers, and a need to recover the elective

surgical backlog has led to a tired and somewhat demoralised workforce. There is a reluctance to take on extra roles, including appraisal, and this is impacting on our ability to recruit additional appraisers.

New Actions:

- The number of doctors who have missed an appraisal is higher than we would expect. We will actively remind all doctors of the need for an annual appraisal, especially those who missed their appraisal last year.
- To review and refresh the Trusts Revalidation and Appraisal policy
- The Medical Directors office is prioritising medical recruitment to try to mitigate rota gaps at all levels.

Overall conclusion:

The Trust is compliant with the appraisal guidance for 2021/22, by continuing to focus on a developmental and supportive appraisal, by adopting the 'Appraisal 2020' model.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Whittington Health NHS Trust _ _

Name: _ Helen Brown Signed: _ _ _ _ _ _ _ _ _ _ _

Role: CEO

Date: _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

Appraisal & Revalidation

Quarterly Newsletter

Monday 31st January 2022

To all of our appraisers:

New appraisal system – what's happening?

We will be having drop-in events on the next audit / QI days on the **29th of March** and the **25th of May** when appraisees and appraisers will be able to see the products that have been shortlisted for our new appraisal system. Once we have decided on a new system we then need to save / transfer all the old appraisal records and make sure that everyone is trained on the new system. This needs to happen over the summer as our contract with Equiniti expires in September 2022.

Meet the team:

Dr Clare Dollery
Medical Director
clare.dollery1@nhs.net

Dr Sola Makinde
Associate Medical Director – Workforce
sola.makinde@nhs.net

Emily Clayton
Business Manager to Dr Clare Dollery
emily.clayton4@nhs.net

Welcome Back Emily!!

Taniya Nasmin
Revalidation Support Officer
taniya.nasmin@nhs.net

Appraisal & Revalidation Clinics

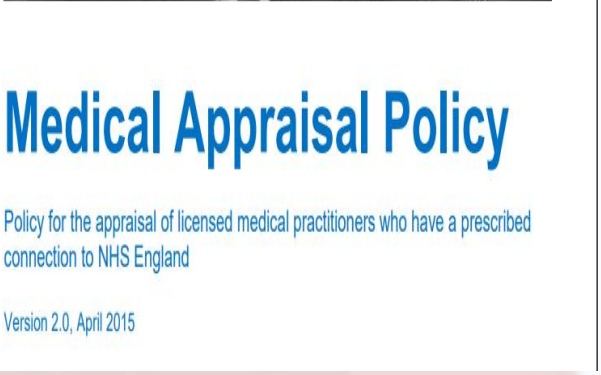
Run **weekly** - Wednesday @ 12 to 1pm – please book with Taniya

Medical Appraisal Policy NHSE,2015

States (about Appraiser allocations)

- A doctor should normally have no more than **3** consecutive appraisals with the same appraiser, and then must have a period of at least **3** years before being appraised again by the same appraiser…
- Once allocated an appraiser the pairing should normally be for **3** consecutive appraisals…
- A doctor should not act as an appraiser to a doctor who has acted as **their** appraiser within the previous **5** years…
- A doctor who has previously been in a training programme should not be allocated their educational supervisor as their appraiser for the first **3** years after exiting training.

If we have made a mistake with allocations, please let the Revalidation office know.



Medical Workforce Race Equality Standards (MWRES) and Appraisals: Indicator 4 suggests that BME doctors are more likely to be deferred and less likely to be revalidated than their white colleagues. Whilst we don't believe this to be the case at Whittington Health, the revalidation office will be monitoring our rates to identify any trends.

Please note: The appraisal year ends on the 31st March 2022.

This means your annual appraisal MUST be completed and written up by your appraiser by this date. Please book a date with your appraiser if you don't have one already!

Meeting title	**Trust Board – public meeting**	**Date: 25.11.2022**
Report title	**Integrated performance report**	**Agenda Item: 9**
Executive director lead	Jonathan Gardner, Director of Strategy and Corporate Affairs	
Report Owner	Paul Attwal, Head of Performance, Chloe Hubbard, Performance Manager	
Executive summary	The performance report attached is in the process of development towards a more analytical approach using Statistical Process Control (SPC) charts. This month we have converted the Effective, Caring and well Led sections to SPC format. Responsive (Access) and Responsive (ED) remain in SPC from previous months. Board Members should note that all metrics are shown in summary, but only certain measures have been highlighted for further analysis and explanation based on their trajectory, importance and assurance. **With regard to performance, areas to draw to Board members' attention are:** **Emergency Department (ED)** During October 2022, performance against the 4-hour access standard was 66.6%, similar to the NCL average of 66.46%, and lower than the London average of 69.53% and the national average of 69.31%. There were 289 12-hour trolley breaches in October. The breaches were due to challenges in allocation of beds due to capacity, discharges later in the day, and the high number of medically optimised patients in the trust. **Cancer** 28 Day Faster Diagnosis was at 62.1% against a standard of 75% in September 2022. 62-day referral to treatment performance was at 34.4% for September 2022 versus a target of 85%. All of these metrics are showing a decline over the last 6 months. **Referral to Treatment: 52+ week waits** At the end of October 2022 there were 653 patients waiting more than 52 weeks for treatment. This number been gradually growing since March. However there has been a reduction of those patients waiting between 40 to 52 weeks by 179 from September 2022 **Appointment Slot Issues** During October 2022, the Trust had 31.8% slot issues in month.	

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

Whittington Health
NHS Trust

Performance Report
November 2022

Month 07 (2022 – 2023)

A note on SPC charts

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

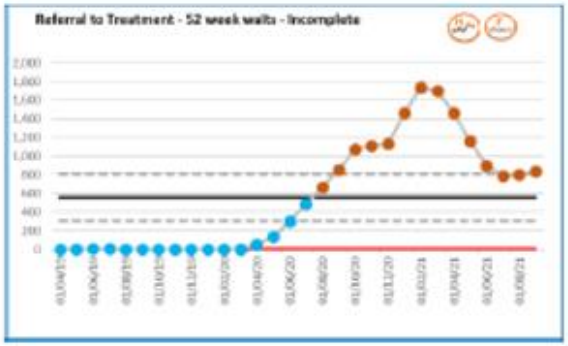
SPC rules – Special Cause Variation

Note: the data below is an example only and not Whittington Health data

A breach of the upper/lower control limit

2 out of 3 points close to the control limit

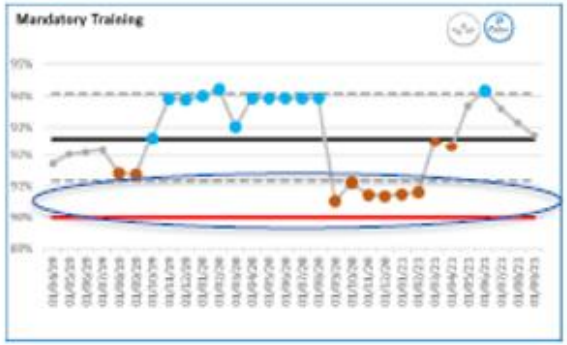
A run of ascending/descending data points



A run of points all one side of the mean

Variation indicating consistently failing the target – target line above upper control limit

Variation indicating consistently passing the target – target line below lower control limit



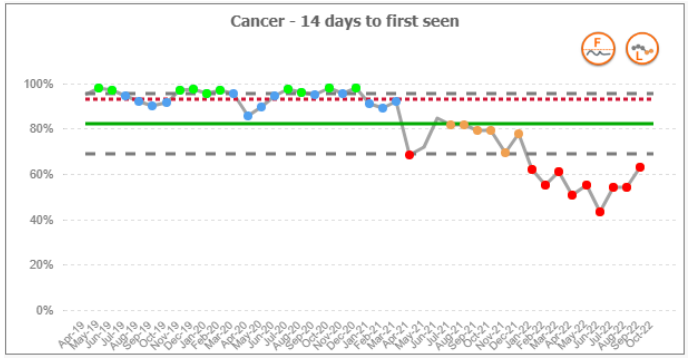
Indicator	Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	2022-2023	Performance
Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI C Difficile	<16	0	1	2	1	2	2		1	3	1	2	2	11	
Actual Falls	400	21	33	40	23	31	25	28	30	39	40	22	35	219	
Category 3 or 4 Pressure Ulcers	0	4	10	4	8	9	17	9	10	10	12	10	15	83	
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	0	0	0	0	0	0	0	0	0	0	0	0	
Serious Incidents	N/A	1	3	2	1	5	3	2	2	1	0	2	0	10	
VTE Risk Assessment %	>95%	80.7%	84.1%	93.1%	92.0%	91.2%	95.2%	95.2%	94.9%	95.1%	95.4%	95.8%	95.8%	95.4%	
Mixed Sex Accomodation Breaches	0	14	7	2	4	5	4	5	14	7	16	6	8	60	
Summary Hospital Level Mortality Indicator (SHMI)	1.14		0.89			0.91									

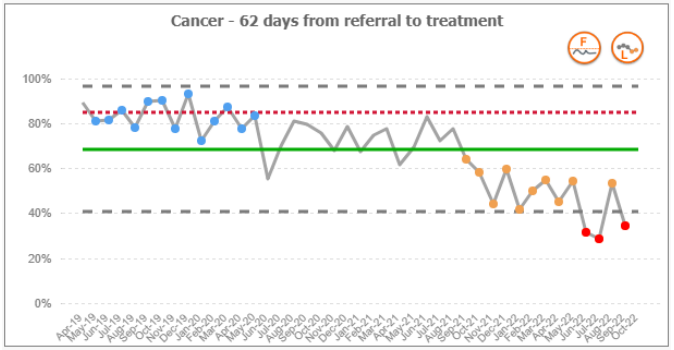
Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Category 3 or 4 Pressure Ulcers, Deep Tissue Injury and Device Related Pressure Ulcers reported in 2022/2023 **Pan Trust Standard (to be confirmed)** 10% reduction in the total number of attributable PUs 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 October 2022:** 51 (+6 deep tissue injuries) affecting 39 patients. There was only 1 medical device related pressure ulcer. **Breakdown:** Category 2: 25 (7 in hospital,18 in community) Category 3: 15 (3 in hospital, 12 in community Category 4: None Mucosal: 1 in hospital, medical device related Unstageable: 10 (1 in hospital, 9 in community) Deep Tissue Injury: 6 (3 in hospital, 3 in community). **Action to Recover:** • Good attendance OSCE based practical training as well as a fully booked Trust wide face to face training in December • Commencement of Webinar aSSKINg training for all clinical staff • Commencement of care home pressure ulcer training to help reduce pressure ulcer development in care home patients under remit of District Nursing services. • Task group established to look at Trust documentation and care planning with one focus on pressure area care • Following a community services review, additional funding has been identified to increase the tissue viability services in Haringey to provide increased support • Active recruitment into Tissue viability Team vacancies to optimise support for clinical areas ICSU led review of pressure ulcer incidents in Quality & Risk meetings	**Named Person:** Lead Specialist Nurse – Tissue Viability **Time Scale to Recover Performance:** 6 months
Mixed Sex Accommodation Breaches	**Variance against plan:** All 8 mixed sex accommodation breaches occurred from CCU (Critical Care Unit) step downs.	**Named Person:** Assistant chief nurse **Time Scale to Recover Performance:** Ongoing
HCAI C Difficile and MSSA (Methicillin-sensitive Staphylococcus aureus)	**Variance against Plan**: 2 C-Diff cases this month with a total Year to Date (YTD) of 11. The yearly target is to remain below 16. If trend continues as is (2/months since April 2022) we will breach the target. 2 MSSA cases reported in October of unknown source and 1 cannula related.	**Named Person:** Assistant Chief Nurse **Time Scale to Recover Performance:** Ongoing

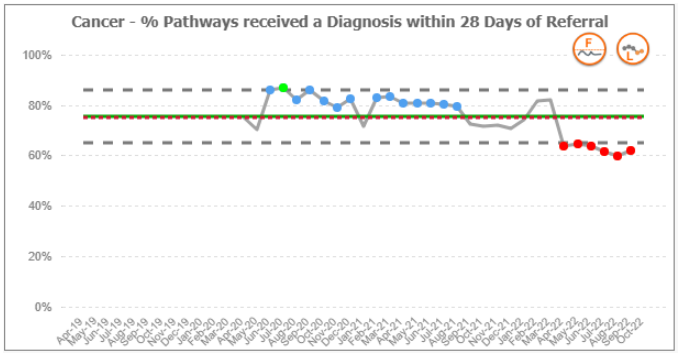
	Actions to Recover: **<u>Cdiff:</u>** Promote effective antibiotic stewardship within clinical areas and medical teams. Avoid cross contamination by monitoring hand hygiene and working with IPC team and our estate colleagues. Ensure isolation processes are actioned as soon as possible. **<u>MSSA</u>** Shared learning to be disseminated in bulletins, newsletters and through ward managers/matrons, and ensure clinical processes are followed.	

Indicator	Target	Last Reported Month	Performance			Variation	Assurance
			Latest Month	Previous Month	2022-2023		
Cancer - 14 days to first seen	>93%	Sep	63.0%	54.1%	52.8%	L	F
Cancer - 14 days to first seen - breast symptomatic	>93%	Sep	16.7%	42.9%	15.8%	L	F
Cancer - 62 days from referral to treatment	>85%	Sep	34.4%	53.3%	42.2%	L	F
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%	Sep	33.9%	50.6%	40.0%	L	F
Cancer ITT - % of Pathways sent before 38 Days	>85%	Sep	44.4%	22.2%	24.0%		F
Cancer - % Pathways received a Diagnosis within 28 Days of Referral	>75%	Sep	62.1%	59.7%	62.5%	L	F
Cancer - 31 days to first treatment	>96%	Sep	79.4%	93.0%	88.1%		F
Cancer - 31 days to subsequent treatment - surgery	>94%	Sep					
Cancer - 62 Day Screening	>90%	Sep	0.0%	100.0%	45.5%		F
DM01 - Diagnostic Waits (<6 weeks)	>99%	Oct	86.26%	83.99%	86.49%		F
RTT - Incomplete % Waiting <18 weeks	>92%	Oct	69.6%	69.4%	70.0%	L	F
Referral to Treatment 18 weeks - 52 Week Waits	0	Oct	653	549	3323	H	F
% seen <=48 hours of Referral to District Nursing Service	>95%	Oct	95.1%	96.3%	95.6%	H	P
Haringey New Birth Visits - % seen within 2 weeks	>95%	Sep	90.4%	92.4%	93.2%		F
Islington New Birth Visits - % seen within 2 weeks	>95%	Sep	95.0%	93.5%	95.4%		P
% of Rapid Response Urgent referrals seen within 2 Hours of Referral		Oct	61.6%	76.8%	74.4%		

Special Cause Variation – Performance/Assurance - Cancer 14 Days to First Seen, 62 days from referral to treatment and 28-day FDS



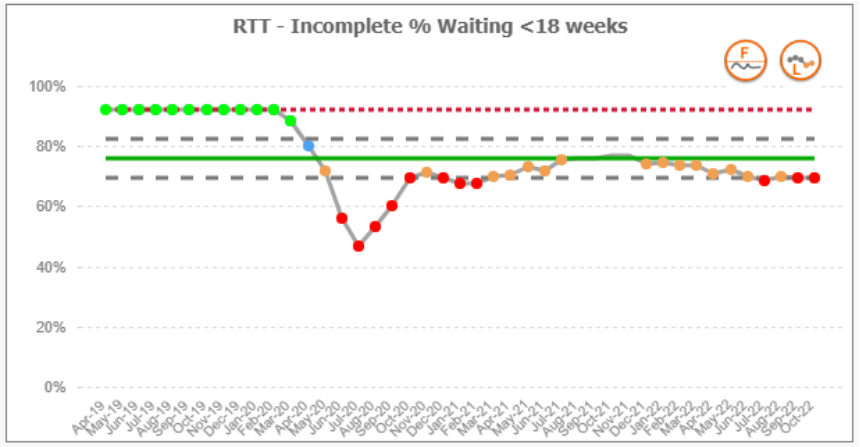


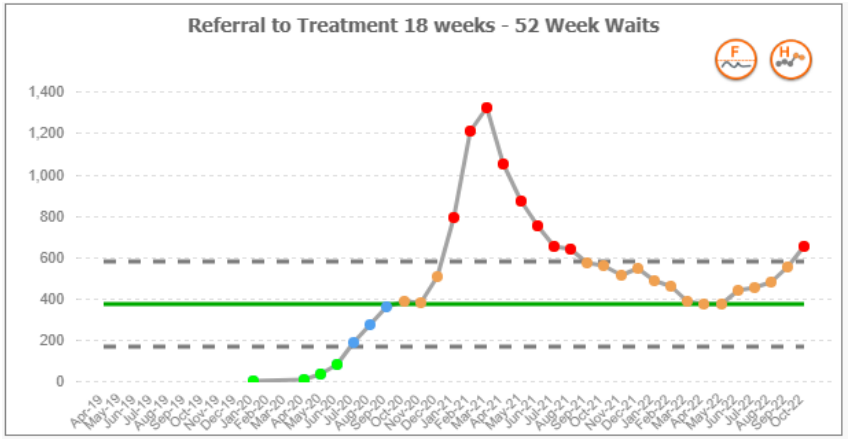


Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – 14 days to first seen target 93% 14 days to first seen – patients should be seen within 14 days of referral by GP or Dentist if they are suspected of having a cancer.	Current performance 63%, Since March 2021 performance has continually worsened. However this is an improvement from the previous month's performance of 54.1%.	There are several issues across all specialities including increases in referrals and capacity constraints seen in Breast, Colorectal, Dermatology and Gynaecology.	Breast: Capacity sufficient for current demand so ensuring all slots used and scrutiny of PTL (Patient Tracking List) daily Recruit to Rapid Access Consultant for Gynaecology (March 2023). Outsourcing of capacity to meet standard Dermatology: secure funding for Locum consultant agency and a Registrar to increase overall capacity.	Additional clinics for the Breast service can be set up if demand increases again Gynaecology additional clinics will be opened pending recruitment of additional nurse (January 2023) Project to get Teledermatology used for 2 week wait referrals across NCL If demand continues to rise review capacity plans

Cancer – 62 day performance target 85% 62 days from referral to treatment – patients who have cancer should be treated within 62 days of referral	62 day current performance 34.4%. As with 2 week wait performance, variation indicates consistently falling short of the standard from an assurance point of view and a trend of worsening over time.	There are several issues across all specialities including increases in referrals and capacity constraints seen in following: Breast: the length of the pathway Gynaecology: Significant workforce issues Current high demand Urology: Staffing levels due to absence & new reg team and late referrals to tertiary centres and tertiary centres have long waiting lists Colorectal: Historic significant demand	Scrutiny of Breast waiting list is being reviewed as part of multidisciplinary team review For all services clinic templates are being restructured to accommodate referral demand Rota now revamped to maximise workforce Prostate nurse clinic being introduced to support Urology service The Colorectal service is expected to be fully staffed from December 2022	Planning of roles and responsibilities in team Additional clinics can happen once more staff recruited Additional clinics could be arranged if necessary Secure funding for additional clinics
Cancer – Faster Diagnosis Standard (FDS) target 75% 28 Day FDS – patients who are referred on a 14-day referral should by day 28 in the pathway know whether they have cancer or not.	Current performance is at 62.1% against the FDS standard of 75%. This is an improvement from the previous month's performance of 57.4% however remains a cause for concern against variation and assurance.	The Colorectal and Gynaecology service are currently Booking at patients at day 28s of referral due to capacity constraints. The Urology service has experienced a number of staff capacity challenges. Dermatology has been pressured across North Central London, however, there has been an improvement against standard and to note 65% of patients discharged on the day of appointment	Colorectal service is increasing Outpatient capacity, patients sent Straight to Test has also started. Additional capacity for virtual discharge has been implemented. Gynaecology: Recruit to Rapid Access Clinic consultant and are exploring Wood Green CDC for ultrasound capacity Urology: outpatient patient templates have been restructured to accommodate referral demand including a telephone discharge clinic. Prostate nurse clinic to be introduced. MDT coordinator has now changed to pull patients through pathway and identify issues earlier. CNS to have weekly overview of PTL	Additional clinics if demand increased Explore further external providers Change job plans to target cancer performance Monitor demand and adjust workforce as necessary 2 week wait telederm project should speed triage and first part of pathway Monitor demand rates and adjust additional capacity as needed depends on workforce available

Special Cause Variation – Performance/Assurance – 18 weeks RTT and 52-week waiters

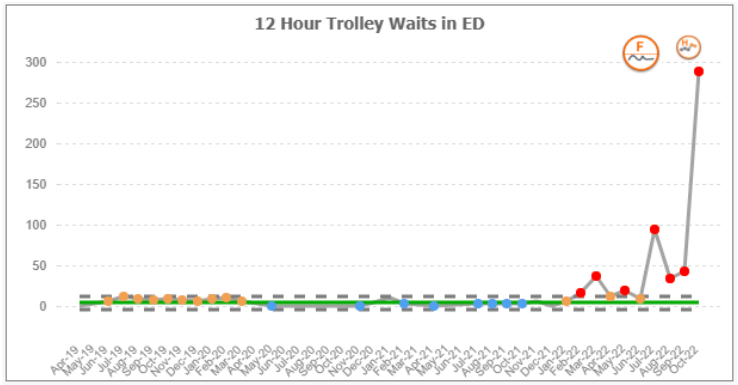


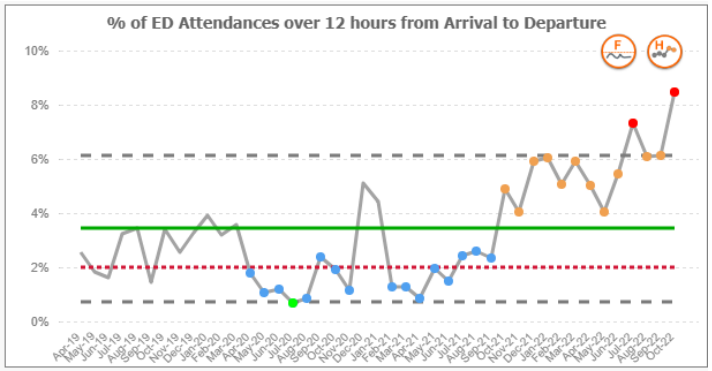


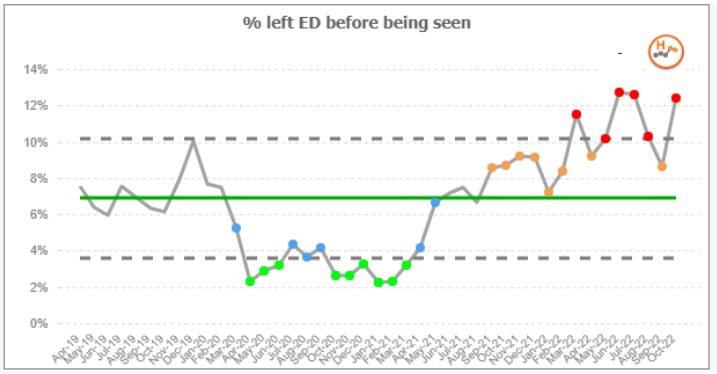
Background	What the Data tells us	Issues	Actions	Mitigations
The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient. It is a priority to ensure patients have access to timely care whilst also reflecting patient choice regarding timing and place of treatment.	Performance against 18-week standard for October is: 69.6%. The trust position against the 52-week position has risen to 653 patients waiting more than 52 weeks for treatment compared to the previous month's performance of 549. As a result of this increase this indicator is now a cause for concern against variation and assurance.	The majority of patients waiting 52 weeks, or more are in the Surgery and Cancer ICSU. The ISCU continues to have a high number of patients (671) waiting between 40 – 52 weeks that are at risk of tipping in to the over 52-week position in the subsequent months. However, this is a reduction of 179 patients compared to last month.	Ongoing review of 52-week waiters, with services validating and monitoring on daily basis. Services have now validated down to 40 weeks with actions identified. The Surgery & Cancer ICSU has re-established theatre productivity processes to increase overall throughput this has led to an increase in elective and day case activity through October 2022.	The Surgery and Cancer ICSU is carrying out ongoing reviews of their service capacity plans to support an overall improvement in the RTT standard through to the end of March 2023.

Indicator	Target	Latest Month Reported	Performance			Variation	Assurance
			Latest Month	Previous Month	2022-2023		
LAS Patient Handover Times - 30 mins	0	Sep		93	442		
LAS Patient Handover Times - 60 mins	0	Sep		24	107		
% streamed to an onsite service	>7.5%	Oct	2.5%	2.8%	2.5%		F
Median Wait for Treatment (minutes)	< 60 min	Oct	120	96	105	H	F
% of ED attendance seen by clinician within 60 mins of arrival		Oct	33.3%	37.2%	36.2%	L	
Median time from Arrival to Decision to Admit		Oct	05:12	04:52	04:32	H	
12 Hour Trolley Waits in ED	0	Oct	289	43	504	H	F
Total ED Attendances in dept for more than 12 hours (arrival to dept)		Oct	795	490	3810	H	
% of ED Attendances over 12 hours from Arrival to Departure	<2%	Oct	8.5%	6.1%	6.1%	H	F
Emergency Department waits (4 hrs wait)	>95%	Oct	66.6%	71.1%	72.2%	L	F
% left ED before being seen		Oct	12.4%	8.7%	10.9%	H	
% ED re-attendance within 7 days		Oct	9.9%	9.6%	9.9%	H	

Special Cause Variation – Performance/Assurance – 12-hour trolley waits in ED, % of ED attendances over 12 hours from Arrival to Departure, % left ED before being seen







Background	What the Data tells us	Issues	Actions	Mitigations
12-hour trolley waits in ED: This metric shows the numbers of patients who waited longer than 12 hours to be admitted to the ward following a decision to admit (DTA) **% of ED attendances over 12 hours from Arrival to Departure** This metric shows the % of patients who have been in the department for more than 12 hours from arrival.	While the data shows the 12-hour trolley breaches have been rising since February 2022, the month of October 2022 saw a steep rise to a record level of 289 breaches. The data includes 5 mental health and 284 acute breaches The data shows a significant rise in the percentage of patients spending more than 12 hours in the department from arrival to departure. This figure increased from 6.1% in September to 8.5 % in October. A larger	The issues that may have led to the number of breaches reported are: - High number of medically optimised (MO) patients awaiting hospital discharge - Larger proportions of hospital discharges occurring later in the day - Wards/bays closed due to infection prevention and control precautions - Lack of Mental Health beds in the system	All breached patients are reviewed for potential harm and presented at the Serious Incident Executive Approval Group. - Long Length of stay reviews on the wards - Review of internal escalation process to prevent breaches - External escalation with system partners to facilitate early discharge of MO patients - Early and regular review of patients in ED who can be supported at home rather than being admitted. - Creation of discharge lounge to help create early bed capacity on the wards - Better utilisation of alternative pathways such as Virtual wards, Rapid response and virtual monitoring to manage patients within their own homes	- Safety check for all patients awaiting beds - Escalation at huddle and access meetings - Review escalation triggers and actions to prevent long waits in ED including boarding decisions - Welfare checks of patients in the waiting areas. -

	proportion of these patients (5.4%) are those waiting to be admitted in the hospital..	- Higher acuity of patients requiring longer to complete treatments - Lack of availability of treatment spaces due to spaces occupied by patients awaiting hospital admission	- Relaunch of criteria led discharges to improve weekend discharges - Ensure patients are streamed to appropriate pathways - Relaunch and promote SDEC referral criteria to increase streaming to SDEC from its current 2.5% to 7.5% - Launch of consultant connect application to improve GP referrals to SDEC - Zero tolerance policy to boarding in SDEC - Relaunch of the internal professional standards	
% left ED before being seen This is the % of patients who have left the emergency department before being seen.	The data show a steep rise from 8.7% in September to 12.4 % in October	- Longer waits to lead to patients leaving the department before being seen.	- As above	- First assessment nurse review to ensure high acuity patients are triaged and treated in a timely manner reducing the risk of sick patients leaving the department.

Category	Indicator	Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Activity
ED	ED Attendances		9089	8179	8285	7990	9763	8787	9742	9387	9117	8081	8383	9392	
ED	ED Admission Rate %		12.1%	12.8%	12.6%	12.1%	11.5%	11.0%	9.8%	9.5%	10.2%	10.6%	10.1%	9.0%	
Community	Community Face to Face Contacts		44459	35404	37982	37985	45446	37760	45149	42304	40576	37343	40257	41542	
Admissions	Elective and Daycase		2004	1630	1669	1787	2009	1739	2090	2080	2177	2017	2299	2311	
Admissions	Emergency Inpatients		1934	1779	1725	1583	1910	1700	1707	1716	1674	1683	1563	1620	
Referrals	GP Referrals to an Acute Service		15000	12359	14247	14374	16122	12791	15335	13961	13874	14074	14002	15463	
Referrals	% of GP Referrals that were completed via ERS		85.2%	82.7%	83.4%	83.3%	84.8%	83.1%	82.4%	84.2%	86.4%	86.5%	86.0%	87.1%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	31.2%	35.2%	29.4%	31.8%	31.6%	32.9%	33.0%	32.6%	30.1%	31.5%	32.5%	31.8%	
Maternity	Maternity Births	320	324	279	249	237	271	265	244	262	264	271	237	254	
Maternity	Maternity Bookings	377	326	339	320	250	343	323	388	284	327	277	262	295	
Outpatients	Outpatient DNA Rate % - New	<10%	10.3%	11.2%	11.5%	10.6%	11.1%	11.5%	10.5%	10.5%	11.5%	12.7%	13.1%	12.7%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	10.0%	10.7%	10.5%	10.3%	10.9%	10.8%	10.0%	10.4%	10.9%	10.8%	10.6%	10.7%	
Outpatients	Outpatient New Attendances		9955	8424	8885	8927	10396	8679	10181	9916	9311	9378	9436	9803	
Outpatients	Outpatient FUp Attendances		17791	15548	15593	15065	17279	15510	17635	16937	15793	16228	17785	16981	
Outpatients	Outpatient Procedures		5762	5244	5250	5467	6245	5252	6338	5893	5988	6168	6283	6364	

Commentary

This data shows a good maintained low ED admission rate however is linked to an increase in patients in the Emergency Department over 12 hours, average community activity remains consistent, elective and day cases numbers hitting their highest volume over the last 12 months and outpatient procedure activity remaining consistent There continues to be a worrying trend in overall births and maternity bookings declining.

DNA rates for first appointments are worsening (see Effective section)

ASI issues remain high (See Effective section)

The below shows the current performance for elective and day-cases and outpatients based on volume, comparing current performance to 19/20. This continues to be monitored at the Trust Management Group. Overall progress has been positive but further analysis at the speciality level is ongoing with particular attention on the surgical specialities.

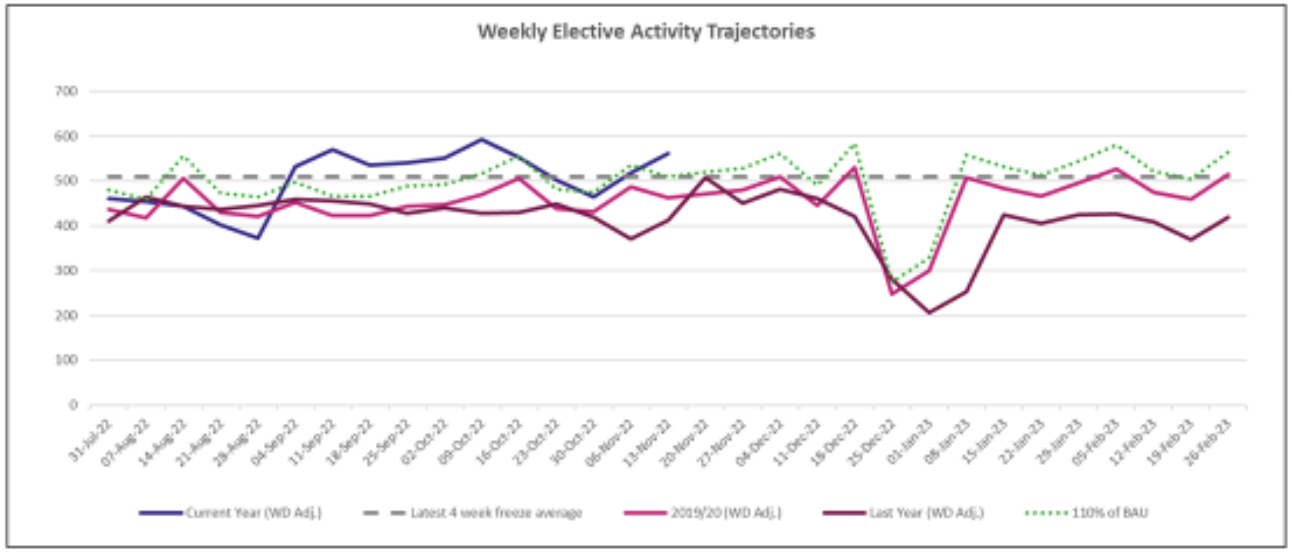
Recovery Trajectory – Electives & day cases

Actual

flex

W/E	31-Jul-22	07-Aug-22	14-Aug-22	21-Aug-22	28-Aug-22	04-Sep-22	11-Sep-22	18-Sep-22	25-Sep-22	02-Oct-22	09-Oct-22	16-Oct-22	23-Oct-22	30-Oct-22	06-Nov-22	13-Nov-22
Week No.	Wk_31	Wk_32	Wk_33	Wk_34	Wk_35	Wk_36	Wk_37	Wk_38	Wk_39	Wk_40	Wk_41	Wk_42	Wk_43	Wk_44	Wk_45	Wk_46
Weekly Activity - Current Year (WD Adj.)	460	453	443	402	373	531	570	536	541	550	593	553	502	465	518	562
Weekly Activity - 2019/20 (WD Adj.)	436	418	506	430	421	452	423	423	444	447	470	506	438	432	486	463
% of Baseline Year (2019/20)	106%	108%	88%	93%	89%	118%	135%	127%	122%	123%	126%	109%	115%	108%	107%	121%

Forecast



The latest flex position is at 121% of 19/20 levels.
Average activity over the last 4 weeks is at 113% of 19/20 (including flex).

*All figures are first cut and subject to further validation and outcoming.

Recovery Trajectory – Outpatients

First

W/E	31-Jul-22	07-Aug-22	14-Aug-22	21-Aug-22	28-Aug-22	04-Sep-22	11-Sep-22	18-Sep-22	25-Sep-22	02-Oct-22	09-Oct-22	16-Oct-22	23-Oct-22	30-Oct-22	06-Nov-22	13-Nov-22
Week No.	Wk_31	Wk_32	Wk_33	Wk_34	Wk_35	Wk_36	Wk_37	Wk_38	Wk_39	Wk_40	Wk_41	Wk_42	Wk_43	Wk_44	Wk_45	Wk_46
Weekly Activity - Current Year (WD Adj.)	2,836	2,925	2,981	2,759	2,757	3,243	3,054	3,013	3,383	3,121	3,037	3,149	3,239	2,897	3,236	3,186
Weekly Activity - 2019/20 (WD Adj.)	2,909	2,968	3,006	2,999	3,058	2,943	2,974	3,305	3,307	3,152	3,242	3,267	2,954	3,134	3,249	3,226
% of Baseline Year (2019/20)	97%	99%	99%	92%	90%	110%	103%	91%	102%	99%	94%	96%	110%	92%	100%	99%

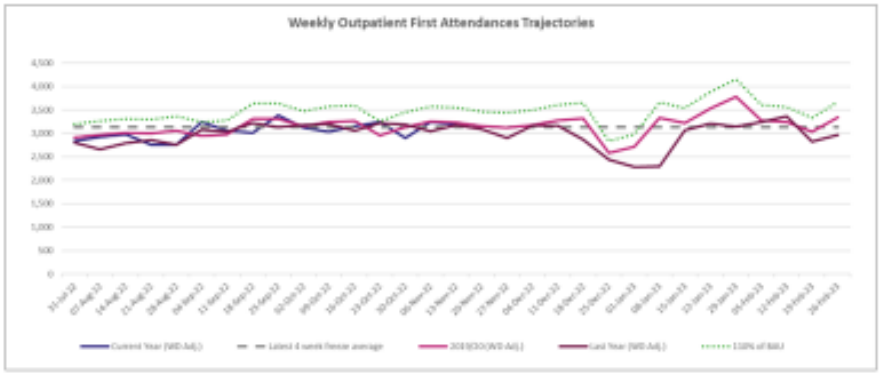
flex

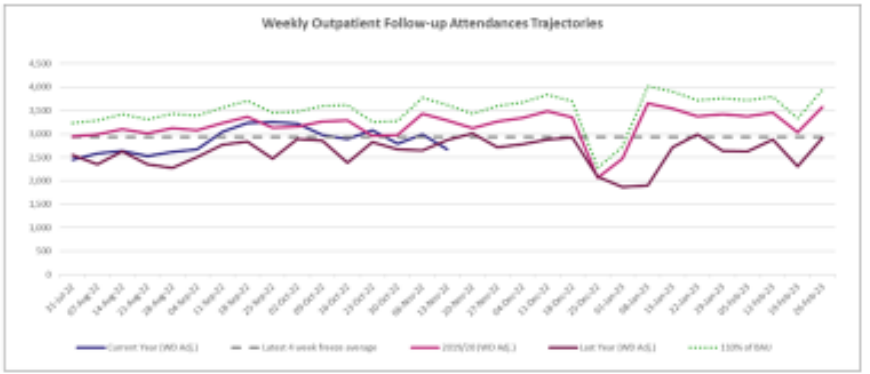
Follow-up

W/E	31-Jul-22	07-Aug-22	14-Aug-22	21-Aug-22	28-Aug-22	04-Sep-22	11-Sep-22	18-Sep-22	25-Sep-22	02-Oct-22	09-Oct-22	16-Oct-22	23-Oct-22	30-Oct-22	06-Nov-22	13-Nov-22
Week No.	Wk_31	Wk_32	Wk_33	Wk_34	Wk_35	Wk_36	Wk_37	Wk_38	Wk_39	Wk_40	Wk_41	Wk_42	Wk_43	Wk_44	Wk_45	Wk_46
Weekly Activity - Current Year (WD Adj.)	2,455	2,587	2,632	2,530	2,619	2,674	3,042	3,236	3,251	3,216	2,978	2,888	3,074	2,792	2,994	2,666
Weekly Activity - 2019/20 (WD Adj.)	2,940	2,992	3,104	3,012	3,119	3,077	3,235	3,368	3,133	3,156	3,266	3,283	2,959	2,979	3,426	3,288
% of Baseline Year (2019/20)	84%	86%	85%	84%	84%	87%	94%	96%	104%	102%	91%	88%	104%	94%	87%	81%

flex

Forecast



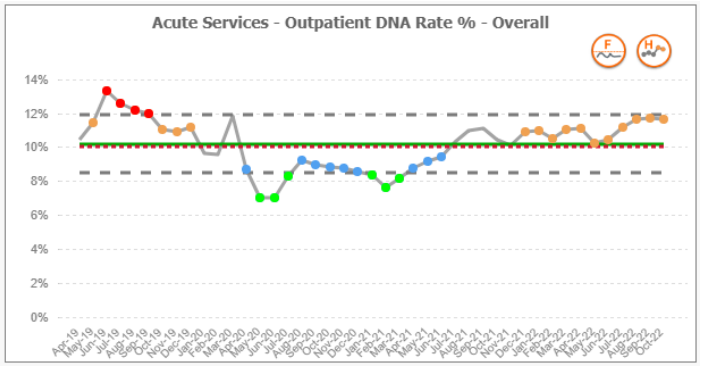


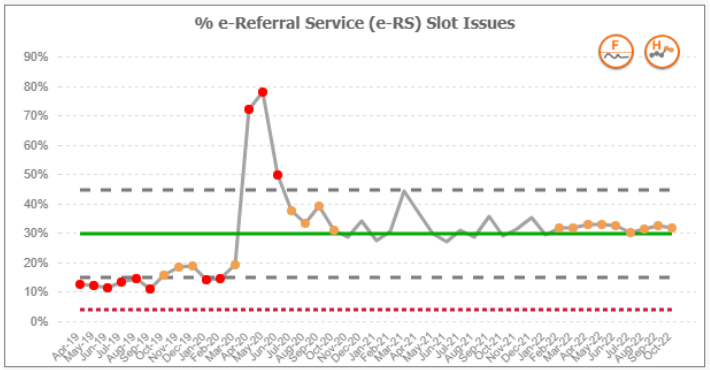
The latest flex position is at 99% (firsts) and 81% (follow-ups) of 19/20 levels. Average activity over the last 4 weeks is at 100% (firsts) and 92% (follow ups) of 19/20 levels (including flex).

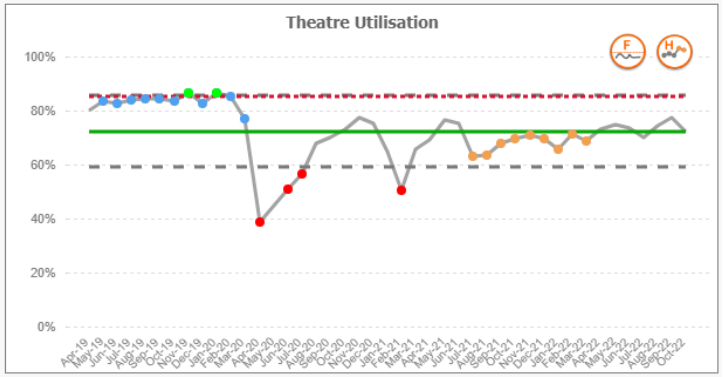
*All figures are first cut and subject to further validation and outcoming.

Indicator	Target	Last Reported Month	Performance			Variation	Assurance
			Latest Month	Previous Month	2022-2023		
Cancelled Ops not rebooked <28 Days	0	Sep	4	4	48		
Hospital Cancelled Operations	0	Sep	2	0	10		
Theatre Utilisation	>85%	Oct	72.20%	77.13%	73.45%		
Community DNA % Rate	<10%	Oct	7.4%	7.8%	7.7%		
Acute DNA % Rate	<10%	Oct	11.6%	11.7%	11.1%		
% e-Referrals Service (e-RS) Slot Issues	<4%	Oct	31.8%	32.5%	32.0%		
Outpatients New:Follow Up Ratio	2.3	Oct	1.73	1.88	1.75		
Non Elective Re-Admissions within 30 days	<5.5%	Oct	3.82%	3.15%	4.23%		
Rapid Response - % of referrals with an improvement in care		Oct	75.7%	75.8%	75.5%		

Special Cause Variation – Performance/Assurance – Acute DNA % Rate, % e-Referrals Service (e-RS) Slot Issues, Theatre Utilisation





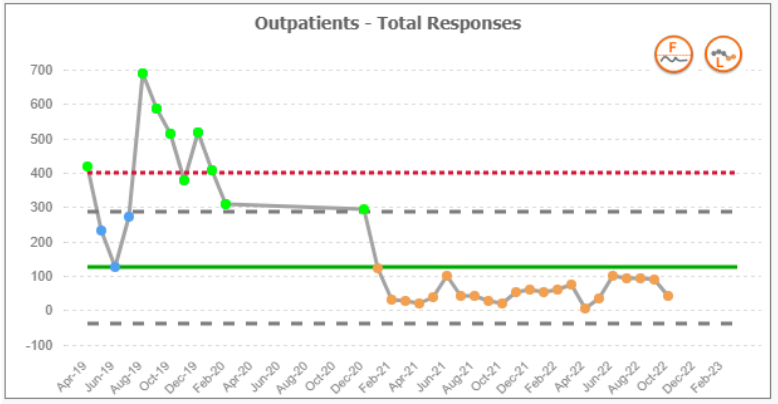


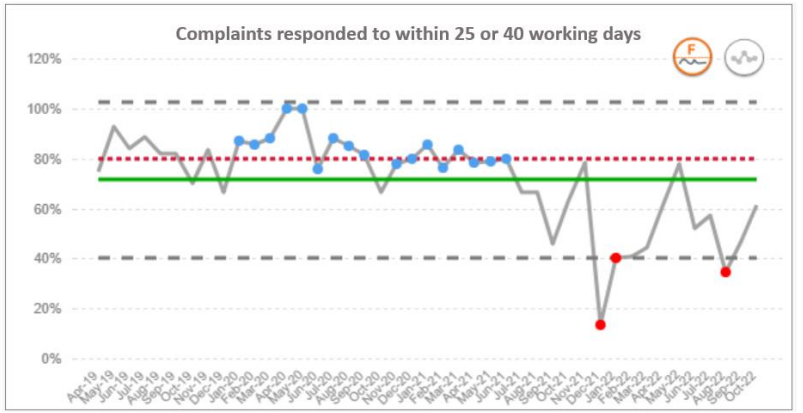
Background	What the Data tells us	ssues	Actions	Mitigations
Acute DNA % Rate The total percentage of patients who do not attend their outpatient appointment	The DNA rate for October 2022 is 11.6%. 40% of the Trust DNA's rates sit in the Surgery and Cancer services as well as Emergency Integrated Medicine ICSU, with the exception of Women's Health Service; Gynaecology.	There are a number of contributing factors that have impacted the Trust's DNA rates quite significantly. Below outlines the key reasons: Access policy not being followed correctly for appointment booking and rescheduling. Out of date contact details or incorrect patient information. Duplicate appointment booking by GP's.	1. Ensure patient contact details on all systems 2. Educate and refresh training for clinical/non-clinical staff on Trust Access policy. 3. Ensure clinics code are aligned to location and clearly stated on patient communication. This will support patient communication letters and text reminders. 4. Where feasible patients are being called to remind them of their appointments. 5. Discussions with GP liaison on GPs booking duplicate patient appointments.	1. The use of the ZESTY app will allow patients to manage their appointment booking once fully rolled out. 2. Check text Reminder+ are set up and being sent accurately more often. Plans under review on the frequency this is to be carried out. 3. Trust GP liaison discussing back-end review of appointment booking. Training for GPs will be considered by the Trust for high offenders.

%e-Referrals Service (e-RS) Appointment lot Issues When no clinic appointment is available for patients to book in e-RS, the referral can be forwarded or deferred to the patient's chosen provider known as an appointment Slot Issue (ASi) There are two reasons why there may ASIs 1. no clinic appointments available on e-RS due to technical reasons 2. The organisation providing directly bookable services have not made sufficient appointment slots available to e-RS.	31.8% against a target of <4%. The performance in October 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. This is now becoming a cause of concern. .	Main issues include: Management of available capacity Use of patient booking windows to see available patient slots	The Orthopaedics service is reviewing their outpatient booking windows to ensure clinics are open at least 6 weeks ahead. General Surgery will have a full registrar compliment of staff from November 2022, this will allow clinics to be opened 6 months ahead, to March 2023 with the idea of being used to reduce the overall ASI backlog. Urology have job planned their Consultant and Registrars to ensure triage processes are in place.	Central outpatients are now carrying out reviews of all patients over 12 weeks on the ASI list to transfer them directly on to the PTL. The impact is to be seen through November 2022.
Theatre Utilisation: target 85% Drive to increase theatre productivity: increased number of sessions open per week with focus on timely start to ensure higher cases / session. Utilisation alone suboptimal marker of theatre productivity	October performance against theatre utilisation is at 72.2%. Performance against this standard has been improving, however remains below target and has not returned to pre-covid performance. There has been a dip in performance of 4.93% from October 2022 from September 2022	October performance has seen a decrease despite an increase in overall activity. There has been higher volume with Low complexity resulting in more inter-case down time than 2 complex case large cases therefore resulting in lower utilisation despite higher productivity	1] Review of factors influencing Theatre flow 2] Restart practices lost over Covid e.g., Golden patient to start avoid delays at beginning of the list 3] Review Day surgery unit (DTC) capacity and strategy to maximise e.g., use of chairs rather than beds to further increase throughput	Ensure admissions booking similar case mix within list so we see less fluctuations of utilisation which might erroneously suggest decrease in activity. To benchmark against group of KPIs suggested by GIRFT rather than reliance on single metric

Indicator	Target	Last Reported Month	Latest Month	Previous Month	2022-2023	Variation	Assurance
ED - FFT % Positive	>90%	Oct	70.2%	79.6%	75.8%		F
ED - FFT Response Rate	>15%	Oct	11.5%	11.9%	11.5%	H	F
Inpatients - FFT % Positive	>90%	Oct	94.3%	91.6%	93.9%		P
Inpatients - FFT Response Rate	>25%	Oct	21.2%	20.6%	20.3%	H	F
Maternity - FFT % Positive	>90%	Oct	99.4%		64.4%		P
Maternity - FFT Response Rate	>15%	Oct	16.1%		11.6%		P
Outpatients - FFT % Positive	>90%	Oct	95.3%	89.8%	89.4%		P
Outpatients - FFT Response Rate	400	Oct	43	88	453	L	F
Community - FFT % Positive	>90%	Oct	96.8%	94.7%	96.6%		P
Community - FFT Response Rate	1500	Oct	929	792	4916	H	P
Complaints responded to within 25 or 40 working days	>80%	Oct	61.5%	47.1%	56.3%		F
Complaints (including complaints against Corporate division)		Oct	13	17	142		

Special Cause Variation – Performance/Assurance –FFT across all areas, with a focus on outpatient response rate and Complaints responded to within 25 or 40 working days



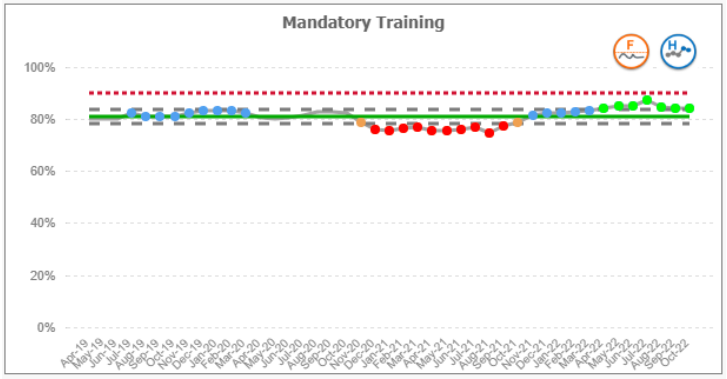


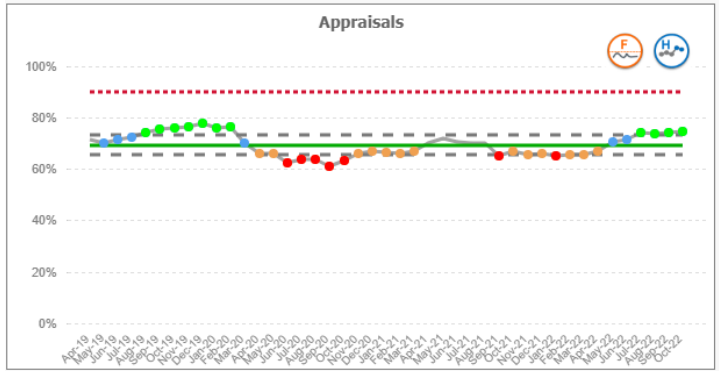
Background	What the Data tells us	Issues	Actions	Mitigations
The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The FFT asks people if they would recommend the services they have used and offers a range of responses from “1-Very Good to “5-Very Poor” or “6-Don’t Know”.	The data shows, following targeted intervention from the Patient Experience team, the maternity service results have achieved and maintained above target response and positive rates. Community services have achieved an increase in response rate, although remain below target of 1500 and % positive results have further improved, remaining above target. ED response rate and % positive response remains low, likely impacted by the pressures experienced in the hospital during October. Although the inpatient and outpatient response rate are below target, the results received remain above the % positive target. Outpatient response rate has not improved since significant drop-off in	Technical issues within maternity results have been identified, resulting in no available data for previous months. This has now been narrowed down to an error within the Postnatal ward responses – recording all responses as “6-Don’t know”, therefore this data has been removed whilst the error is investigated and resolved. Results received from Outpatients were all via postcard responses except from 1 online survey response, highlighting the importance of the work to increase digitisation of FFT responses via SMS, and use of QR codes at or after	Technical issues with Maternity responses have been escalated to IQVIA (service providing FFT) to resolve. Ongoing recruitment, once in place, work will re-start on the FFT response rate improvement plan. This includes: - Previous pilot undertaken in MSK using automated text messages in quarter 1, with a plan for further roll out if successful - Text message was introduced in ED during Quarter 2, with patients receiving a text message to complete an FFT questionnaire. Due to the staffing vacancy, the outcome of this has not yet been reviewed - In Quarter 1, the Patient Experience team renewed our series of QR code posters and disseminated to all ICSUs to streamline the	Improve availability of volunteers to support collection of responses.

	response rate coinciding with the Covid pandemic. Results started to show an upward trend from April 2022 with targeted intervention from the Patient Experience Project Lead.	appointments. Digitisation of FFT would also enable feedback from clinics that have continued virtually since the move to online platforms during the pandemic.	FFT process, minimising the use of paper cards to save on the administrative burden. The use of these will be reviewed and expanded to outpatients areas. - Since July 2022 all outpatient FFTs are available in the top 10 foreign languages, with roll out to all other areas to be continued.	
% Complaints responded to within 25 or 40 working days	There were 14 complaints received where a response was required in October 2022. One of these was de-escalated leaving 13 complaints due a response. The Trust performance for October 2022 was 62% (8/13). This is an improvement on previous months and work continues with regard to reducing the number of older open complaints due a response, and those more recent complaints.	The backlog of complaints has been the main contributor to delay in responding to complaints within the required standards.	The Complaints Team continue to work closely with the ICSUs to support with the completion of these and all complaint investigations.	All urgent issues are actioned and escalated as appropriate.

Indicator	Target	Last Reported Month	Performance			Variation	Assurance
			Latest Month	Previous Month	2022-2023		
Appraisals % Rate	>90%	Oct	74.4%	73.9%	72.1%	H	F
Mandatory Training % Rate	>90%	Oct	83.9%	84.1%	84.8%	H	F
Permanent Staffing WTEs Utilised	>90%	Oct	86.0%	85.7%	86.7%	L	F
National Quarterly Pulse Survey (NQPS)	800	Oct			1086		
NQPS Staff % recommended work	>50%	Oct			51.1%		
Staff Sickness abscence %	<3.5%	Sep	3.89%	3.75%	4.18%		F
Staff Turnover %	<13%	Oct	14.1%	13.9%	13.9%	H	F
Vacancy % Rate against establishment	<10%	Oct	14.0%	14.3%	13.3%	H	F
Average Time to Hire	<=63	Oct	69	84	81	H	F
Safe Staffing Alerts - Number of Red Shifts		Oct	11	4	82		F
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		Oct			8.8		

Special Cause Variation – Performance/Assurance – Average Time to hire, Mandatory Training % Rate and Appraisals % Rate





Background	What the Data tells us	Issues	Actions	Mitigations
Time to Hire The average time to hire from interview to start date.	North London Partners Shared Service (NLPSS) took over recruitment activity in December 2021. Current performance of time to hire is at 69 days, however this an improvement on previous months. October's data shows the pre-employment phase of recruitment at 40 days however this has reduced to 34.5 days in November.	The key bottleneck is the pre-employment check phase of recruitment which has a target of 20 days. North London Partners Shared Services (NLPSS) have reviewed the current operating model and have committed to changing this to a dedicated Trust team model to be implemented during October 2022. This will provide consistency to the recruitment process with individuals managing the end-to-end process and recruitment managers as a single point of contact.	Weekly meetings have been established to monitor progress with an escalation point in place with the HR Director.	Weekly monitoring of activity, performance and data to ensure any issues are identified early and can be resolved with limited impact on the Trust.

Mandatory Training and Appraisals: Mandatory training and appraisals have a target of 90%.	There has been no improvement and no reduction in improvement since last month in mandatory training (83.9%) or in appraisals (74.4%) in spite of the new more user-friendly learning platform.	The lack of improvement is likely to be the result of staff shortages and pressure of work which is ongoing since the pandemic.	Promote the login to the learning platform and encourage engagement in easy to find and complete courses.	Ongoing communication plan to improve compliance.

Appendix 1 – Community Performance Dashboard

Indicator	Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	2022-2023	Performance
IAPT Moving to Recovery	>50%	51.4%	49.5%	57.2%	47.6%	47.5%	48.5%	52.1%	50.2%	48.7%	48.3%	47.1%		49.2%	
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	90.0%	93.4%	88.5%	89.6%	91.9%	91.9%	92.6%	95.2%	93.3%	90.5%	94.1%		92.9%	
Haringey - 8wk Review % carried out before child aged 8 weeks	N/A	73.3%	68.8%	64.0%	62.6%	65.4%	62.0%	71.8%	62.0%	63.3%	72.4%	64.4%		66.0%	
Haringey - HR1 % carried out before child aged 15 months	N/A	69.2%	62.0%	56.9%	52.3%	72.3%	75.6%	67.9%	75.9%	75.3%	74.0%	69.1%		72.9%	
Haringey - HR2 % carried out before child aged 30 months	N/A	65.5%	66.1%	67.6%	61.8%	64.4%	53.5%	53.9%	67.1%	72.7%	65.2%	75.0%		64.7%	
Islington - 8wk Review % carried out before child aged 8 weeks	N/A	77.1%	79.3%	58.2%	69.4%	68.7%	67.5%	72.0%	77.8%	76.8%	71.4%	71.1%		72.8%	
Islington - HR1 % carried out before child aged 15 mths	N/A	85.9%	76.9%	77.9%	66.8%	81.0%	80.6%	80.0%	80.8%	86.5%	85.2%	79.5%		82.1%	
Islington - HR2 % carried out before child aged 30 mths	N/A	82.9%	81.6%	72.1%	73.5%	78.5%	79.3%	73.7%	77.6%	76.6%	80.6%	87.8%		79.2%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	78.4%	81.0%	88.9%	94.8%	91.5%	83.6%	73.5%	83.3%	88.6%	87.7%	87.9%	92.5%	84.1%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%			100.0%	60.0%	77.8%	82.4%	80.0%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	77.9%	70.0%	71.7%	74.7%	72.2%	70.7%	74.4%	73.5%	70.8%	72.7%	71.7%	80.2%	73.4%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	96.3%	94.9%	96.3%	93.2%	88.6%	92.9%	90.6%	93.4%	95.2%	96.4%	93.9%	94.2%	93.6%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%	100.0%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 we...	>45%		57.0%			61.5%			52.0%					52.0%	
Islington Self-Management - Average Increase in PAM Score	>=9														
Haringey Self-Management - Average Increase in PAM Score	>=9														

Community Waiting Times Dashboard

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Aug-22	Sep-22	Oct-22	Avg Wait (Oct)	No. of Pts Seen	% Threshold	Target Weeks	Aug-22	Sep-22	Oct-22	Avg Wait (Oct)	No. of Pts Seen
CAMHS	>95%	8	65.5%	66.1%	54.0%	17.7	100	>95%	2	100.0%	100.0%	84.6%	1.3	13
Child Development Services	>95%	12	80.0%	100.0%	90.0%	5.3	10	>95%	2				-	0
IANDS	>95%	18	81.1%	90.0%	82.5%	12.4	126	>95%	-				-	0
Community Children's Nursing	>95%	2	63.6%	75.7%	76.9%	1.3	65	>95%	1	100.0%	100.0%	100.0%	0.0	1
Community Paediatrics Services	>95%	18	47.8%	72.9%	65.6%	10.2	93	>95%	1				10.2	0
Family Nurse Partnership	>95%	12				-	0	>95%	-				-	0
Haematology Service	>95%	12	94.1%	100.0%	100.0%	0.9	3	>95%	-				-	0
Looked After Children	>95%	4	45.5%	56.3%	87.5%	2.7	16	>95%	-				-	0
Occupational Therapy	>95%	18	28.6%	64.0%	64.7%	16.7	17	>95%	2				-	0
Physiotherapy	>95%	18	100.0%	100.0%	92.9%	9.9	56	>95%	2				-	0
PIPS	>95%	12	93.3%	100.0%	81.8%	6.2	11	>95%	-				-	0
School Nursing	>95%	12	98.7%	88.0%	93.1%	2.7	87	>95%	-				-	0
Speech and Language Therapy	>95%	8	48.0%	59.3%	61.0%	13.0	118	>95%	2	0.0%	0.0%	0.0%	19.1	2
Bladder and Bowel - Children	>95%	12				-	0	>95%	-				-	0
Community Matron	>95%	6	97.2%	100.0%	96.3%	1.0	27	>95%	2				-	0
Adult Wheelchair Service	>95%	8	97.7%	100.0%	100.0%	2.5	36	>95%	2		100.0%	87.5%	0.5	8
Community Rehabilitation (CRT)	>95%	12	84.6%	86.0%	89.1%	8.1	64	>95%	2	56.4%	62.5%	54.5%	7.2	11
ICTT - Other	>95%	12	86.4%	82.2%	53.7%	9.9	216	>95%	2	0.0%	13.0%	30.4%	3.0	23
ICTT - Stroke and Neuro	>95%	12	82.4%	50.0%	26.3%	12.6	19	>95%	2	28.6%	50.0%	50.0%	5.6	8
Home-based Intermediate Care Se...	>95%	6	51.8%	36.0%	37.8%	10.1	45	>95%	2				-	0
Community Bed-based Intermediat...	>95%	6	100.0%	100.0%	100.0%	0.0	2	>95%	2				-	0
Paediatric Wheelchair Service	>95%	8	85.7%	100.0%	100.0%	5.4	7	>95%	-				-	0
Bladder and Bowel - Adult	>95%	12	45.0%	34.4%	45.3%	15.6	150	>95%	2				-	0
Musculoskeletal Service - CATS	>95%	6	29.2%	37.5%	47.1%	7.5	433	>95%	2	50.0%	16.7%	42.9%	3.1	7
Musculoskeletal Service - Routine	>95%	6	35.6%	31.2%	31.7%	14.2	1588	>95%	2	62.9%	65.7%	66.4%	2.3	149
Nutrition and Dietetics	>95%	6	97.2%	96.4%	94.6%	2.5	168	>95%	2	100.0%	100.0%	80.0%	1.0	5
Podiatry (Foot Health)	>95%	6	33.6%	26.7%	22.8%	20.6	496	>95%	2	0.0%	50.0%	50.0%	14.0	4
Lymphodema Care	>95%	6	53.8%	74.4%	85.7%	4.2	21	>95%	-				-	0
Tissue Viability	>95%	6	100.0%	97.3%	100.0%	1.6	44	>95%	-				-	0
Cardiology Service	>95%	6	74.3%	54.5%	90.9%	2.9	33	>95%	2	100.0%		100.0%	0.5	2
Diabetes Service	>95%	6	95.5%	81.9%	95.9%	3.1	74	>95%	-				-	0
Respiratory Service	>95%	6	86.7%	88.0%	98.4%	0.7	63	>95%	2	100.0%			-	0
Spirometry Service	>95%	6	88.9%	100.0%	96.0%	3.1	50	>95%	2				-	0

Children's Community Waits Performance

SERVICE	ROUTINE REFERRALS							URGENT REFERRALS						
	% Threshold	Target Weeks	Aug-22	Sep-22	Oct-22	Avg Wait (Oct)	No. of Pts Seen	% Threshold	Target Weeks	Aug-22	Sep-22	Oct-22	Avg Wait (Oct)	No. of Pts Seen
CAMHS	>95%	8	65.5%	66.1%	54.0%	17.7	100	>95%	2	100.0%	100.0%	84.6%	1.3	13
Community Children's Nursing	>95%	2	63.6%	75.7%	73.2%	1.4	56	>95%	1	100.0%	100.0%	100.0%	0.0	1
Community Paediatrics - Haringey	>95%	18	32.4%	65.9%	56.5%	11.9	69	>95%	1				-	0
Community Paediatrics - Islington	>95%	18	91.7%	93.3%	91.7%	5.4	24	>95%	1				-	0
Family Nurse Partnership - Islington	>95%	12				-	0	>95%	-				-	0
Haematology Service - Islington	>95%	12	94.1%	100.0%	100.0%	0.9	3	>95%	-				-	0
Haringey - SCT	>95%	20	0.0%	0.0%	0.0%	50.3	24	>95%	2				-	0
IANDS - SCT	>95%	20	10.5%	0.0%	7.7%	48.5	13	>95%	-				-	0
IANDS	>95%	18	100.0%	100.0%	92.9%	8.4	14	>95%	-				-	0
Looked After Children - Haringey	>95%	4		37.5%	88.9%	2.9	9	>95%	-				-	0
Looked After Children - Islington	>95%	4	45.5%	75.0%	85.7%	2.3	7	>95%	-				-	0
Occupational Therapy - Barnet	>95%	18	37.5%	13.3%	31.0%	38.5	29	>95%	6				-	0
Occupational Therapy - Haringey	>95%	18	28.6%	64.0%	64.7%	16.7	17	>95%	2				-	0
Occupational Therapy - Islington	>95%	18	16.7%	36.8%	61.9%	17.0	21	>95%	2				-	0
Paediatrics Nutrition and Dietetics - Haringey	>95%	12	66.7%	100.0%	83.3%	8.3	6	>95%	2				-	0
Paediatrics Nutrition and Dietetics - Islington	>95%	12	94.4%	100.0%	100.0%	6.3	14	>95%	2				-	0
Physiotherapy - Barnet	>95%	18	74.1%	63.6%	68.4%	15.0	19	>95%	-				-	0
Physiotherapy - Haringey	>95%	18	100.0%	100.0%	92.9%	9.9	56	>95%	2				-	0
Physiotherapy - Islington	>95%	18	100.0%	100.0%	98.4%	5.8	61	>95%	2				-	0
PIPS	>95%	12	93.3%	100.0%	81.8%	6.2	11	>95%	-				-	0
SALT - Barnet	>95%	18	63.8%	46.2%	24.6%	36.7	69	>95%	6				-	0
SALT - Haringey	>95%	13	42.5%	50.0%	44.1%	16.6	59	>95%	2	0.0%	0.0%	0.0%	19.1	2
SALT - Islington	>95%	13	41.9%	72.0%	76.1%	9.8	46	>95%	-				-	0
SALT - MPC	>95%	18	54.5%	36.4%	77.8%	9.9	9	>95%	-				-	0
School Nursing - Haringey	>95%	12	80.0%	81.1%	86.7%	4.3	30	>95%	-				-	0
School Nursing - Islington	>95%	12	100.0%	94.7%	96.4%	1.9	56	>95%	-				-	0

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Children Community Waiting Times	**Community paediatrics** Waiting times have been impacted by gaps in the medical teams. In Haringey & Islington teams are recruiting to vacant posts. In Islington the skill mix of the team is being reviewed before recruitment. In Haringey following successful recruitment into the named doctor role, the designate role will now be advertised. **Speech and Language Therapy** WH teams continue to use recovery funding to provide additional initial assessments and interventions to help reduce waiting times. All vacant roles in Islington have been recruited to and we are seeing an improvement in waiting times. In Haringey the borough plan for Speech Language and Communication Needs is progressing which will support a reduction of waiting times in the long term. In Barnet work to improve data quality is progressing. The service continues to work with partners on implementation of recommendations from the community services review in NCL – additional investment for some areas will be confirmed in January. **Occupational Therapy** Staffing for OT continues to be a challenge across Children and Young People Services, and the staffing gaps are leading to long waiting times. The OT service in Islington has been unable to fill the clinical lead post after 4 recruitment drives which is placing additional pressure on the service. A range of actions are being taken to address the recruitment challenge including involvement with AHP international recruitment, taking part in recruitment fairs and changing roles. **Looked after children** In Haringey & Islington some additional temporary capacity has supported a reduction in waiting times. Staff absence continues to impact on capacity in Haringey. New registrars in Haringey in October brought additional capacity for assessments. An increase in funding for staffing is proposed as part of the work in response to the NCL Community Service Review. A decision on allocation of funding is expected in December/January. **Social communication** We are working with the ICB and other local providers to agree where additional recurrent funding will be invested to support reduction of waiting times. In the meantime, WH is leading work to provide additional autism assessments across NCL over the next 18 months to help reduce the longest waiting times. In Islington under 5s service we are looking at new model of assessment processes to help further reduce waiting times. **Islington CAMHS** Average waiting times for urgent referrals increased in October with two referrals being seen outside the target of 2 weeks. Average waiting time remains below the target. We have seen a slight decrease in routine waiting times in Community CAMHS. The majority of CAMH services continue to see children and young people well within the 8-week target but the figure in the dashboard includes NDP and the central CAMHS Therapies team which continue to see an increase in referrals and hold the longest waits.	**Named person:** Director of Operations, Children and Young People's Services

Adult Community Waiting Times	**Overall summary:** All services are running with their Business-as-usual models now and most services are progressing positively with their backlogs. There remains a focus of 3 key areas for recovery : MSK, Podiatry, Pulmonary Rehabilitation (PR). MSK : The total number of patients waiting for an MSK appointment in October is now 8437 compared with 9020 in September. *Average waiting time*: CATS – 8.5 weeks in October down from 9 weeks in September. :Routine – 11.9 weeks in October down from 12.7 weeks in August Podiatry : Workforce issues continue to be the main issue with this service. Wait times continue to increase. There is a comprehensive action plan in place to mitigate the risk of the waits growing further which is being monitored very closely. The focus previously was on the waits for follow-ups which has improved, the focus can now be on first appointments.	**Named person:** Director of Operations, Adult Community Services

Meeting title	**Trust Board – public meeting**	**Date: 25.11.2022**
Report title	**Finance Report October (Month 07) 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 £5.05m at the end of October which is £2.09m worse than plan. The planned deficit for October was £2.95m. The year-to-date adverse financial performance to plan is mainly driven by • Non-delivery of savings on Cost Improvement Programmes (CIP) • Unfunded escalation beds • Non-pay overspends within theatres and estates • Elective recovery fund (ERF) underperformance Cash position at the end of October was £77.2m Trust has spent £6.36m on its Capital projects as of the 31st of October 2022. The Trust is currently forecasting to deliver its planned deficit of £112k for 2022-23.	
Purpose:	To discuss October performance.	
Recommendation(s)	To note October financial performance, recognising the need for improve savings delivery.	
Risk Register or Board Assurance Framework	BAF risks Sustainability 1 and Sustainability 2	
Report history	Trust Management Group, November 2022	
Appendices	None	

CFO Message

Finance Report M07

Trust reporting £5.05m deficit at the end of October – £2.09m worse than plan

The Trust is reporting a deficit of £5.05m at the end of October which is £2.09m worse than plan. The planned deficit to end of October was £2.95m.

The year-to-date adverse financial performance is mainly driven by.

- Underperformance of £2.02m against year-to-date Cost Improvement Programmes (CIP) target; The Trust delivered £4.59m savings year to date against a target of £6.61m.
- Enhanced pay rates and temporary staff premiums.
- 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, reactive maintenance costs and energy costs within Estates.
- Elective/Day case performance continues to be below plan. Elective recovery fund (ERF) underperformed in month by £0.05m.

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

Cash of £77.2m at end of October

As at the end of October, the Trust's cash balance stands at £77.2m, a decrease of £4.2m from 31 March 2022, £5.0m higher than September's figure and £4.9m above Plan. The balance has reduced since 31st March as the Trust reports a year-to-date deficit of £5.05m. The favourable variance of cash to plan results from lower than planned capital expenditure in the year to date.

Year to date capital spend of £6.36m

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 (£11.5m) and cash reserves (£13.9m).

Capital expenditure as of 31st October 2022 totals £6.36m, which is £3.65m below plan. This is the continued reflection that the Trust's principal capital projects are yet to get fully underway for this fiscal year.

Better Payment Practice Performance – 91.3% 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 93.8% by volume and 89.5% by value. The BPPC for non-NHS invoices is 94.6% by volume and 91.3% by value.

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 including recovery actions required.

1. Summary of Income & Expenditure Position – Month 07

	In Month			Year to Date			
	Plan	Actual	Variance	Plan	Actual	Variance	Annual Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income							
NHS Clinical Income	28,500	29,121	621	197,513	198,487	974	339,955
High Cost Drugs - Income	909	743	(166)	6,280	6,559	279	10,713
Non-NHS Clinical Income	1,147	1,128	(19)	8,029	7,959	(70)	13,772
Other Non-Patient Income	2,059	2,245	186	14,768	16,288	1,520	25,072
Elective Recovery Fund	656	605	(51)	4,609	3,776	(833)	7,891
	33,272	**33,843**	**571**	**231,199**	**233,069**	**1,870**	**397,403**
Pay							
Agency	0	(1,545)	(1,545)	(77)	(10,426)	(10,349)	(77)
Bank	(402)	(2,598)	(2,195)	(2,974)	(18,713)	(15,739)	(4,811)
Substantive	(22,885)	(19,798)	3,087	(162,674)	(141,275)	21,399	(277,313)
	(23,287)	**(23,941)**	**(654)**	**(165,725)**	**(170,414)**	**(4,689)**	**(282,201)**
Non Pay							
Non-Pay	(7,359)	(7,362)	(3)	(49,410)	(49,417)	(7)	(82,266)
High Cost Drugs - Exp	(711)	(788)	(77)	(5,225)	(5,417)	(193)	(8,779)
	(8,070)	**(8,150)**	**(80)**	**(54,635)**	**(54,835)**	**(200)**	**(91,045)**
EBITDA	**1,915**	**1,752**	**(163)**	**10,839**	**7,820**	**(3,019)**	**24,158**
Post EBITDA							
Depreciation	(1,200)	(1,150)	50	(10,149)	(9,660)	489	(17,801)
Interest Payable	(114)	(75)	39	(692)	(535)	157	(1,288)
Interest Receivable	51	120	69	257	538	281	512
Dividends Payable	(458)	(458)	(0)	(3,206)	(3,208)	(2)	(5,693)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(1,721)	**(1,563)**	**158**	**(13,790)**	**(12,866)**	**924**	**(24,270)**
Reported Surplus/(Deficit)	**194**	**189**	**(5)**	**(2,951)**	**(5,046)**	**(2,094)**	**(112)**

- The Trust is reporting a deficit of £5.05m (excluding donated asset depreciation and impairments) at the end of October which is £2.09m worse than plan.
- The planned deficit to the end of October was £2.95m 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 £5.05m. This is £1.58m higher than the level of non-recurrent support assumed in the plan.
- The normalised position excluding non-recurrent benefits is £10.09m deficit which is £7.14m worse than the plan.

2. Income and Activity Performance

2.1 Income Performance – October

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	1,663	1,660	(3)	11,479	11,256	(223)
Elective	2,243	1,914	(329)	15,490	12,635	(2,854)
Non-Elective	5,110	4,418	(692)	35,282	31,038	(4,244)
Critical care	598	503	(95)	4,129	3,400	(728)
Outpatients	4,399	3,918	(481)	30,379	27,599	(2,780)
Ambulatory	534	586	52	3,688	3,871	183
Direct Access	1,005	1,189	184	6,942	7,891	949
Community	6,337	6,337	0	44,357	44,357	0
Other Clinical income NHS	7,519	9,340	1,820	52,046	62,998	10,952
NHS Clinical Income	**29,410**	**29,864**	**455**	**203,792**	**205,046**	**1,254**
Non NHS Clinical Income	1,147	1,128	(19)	8,029	7,959	(70)
Elective recovery fund (ERF)	656	605	(51)	4,609	3,776	(833)
Income From Patient Care Activities	**31,213**	**31,598**	**385**	**216,431**	**216,781**	**350**
Other Operating Income	**2,059**	**2,245**	**186**	**14,768**	**16,288**	**1,520**
Total	33,272	33,843	571	231,199	233,069	1,870

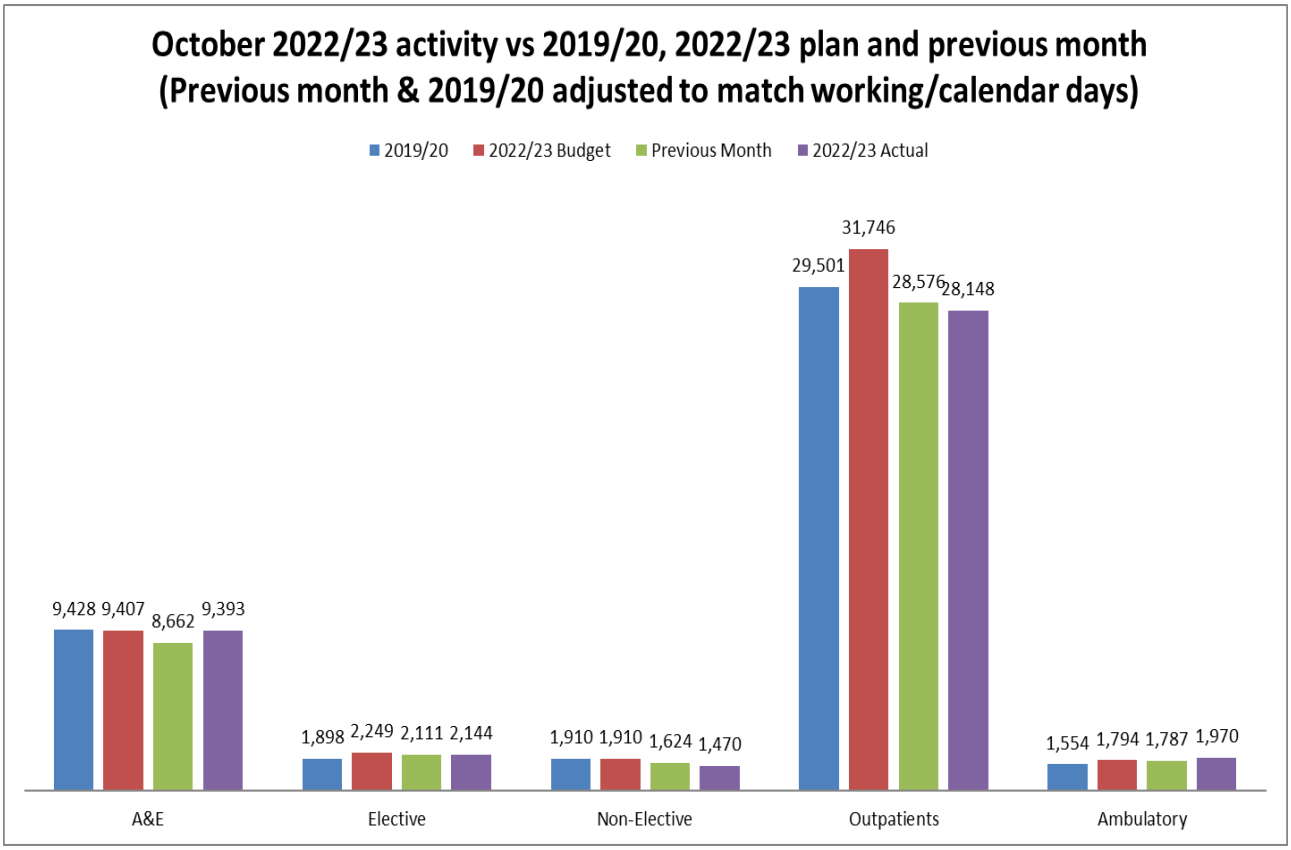
- Income was £0.6m over plan in month and £1.9m YTD.
- In month performance driven by £0.5m NHS clinical income and £0.2m other operating income, offset by £0.1m elective recovery fund (ERF) underperformance.
- NHS clinical income is mainly CCG and NHSE block contract income, with small variable element 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. £0.5m in month favourable position due to additional agreed NHSE dental YTD not in plan.
- ERF is assumed at 100% for April to July. This may be revised in future months after confirmation from NHSE/I on no reduction for Q1 and ongoing calculation/treatment. The in-month £0.1m underperformance is an £0.2m estimate for October and £0.1m positive adjustment for September.
- Other operating £0.2m overperformance is driven by several small variances, the largest being £0.1m Covid vaccine reimbursement, £0.1m education & training and £0.1m non-patient care services to other bodies, offset by £0.1m reversal of IFRS16 accrual.
- Significant underperformance in elective, non-elective, and outpatients, with slight underperformance in A&E and Critical care. Overperformance in ambulatory and direct access.

2.2 Activity Performance – October

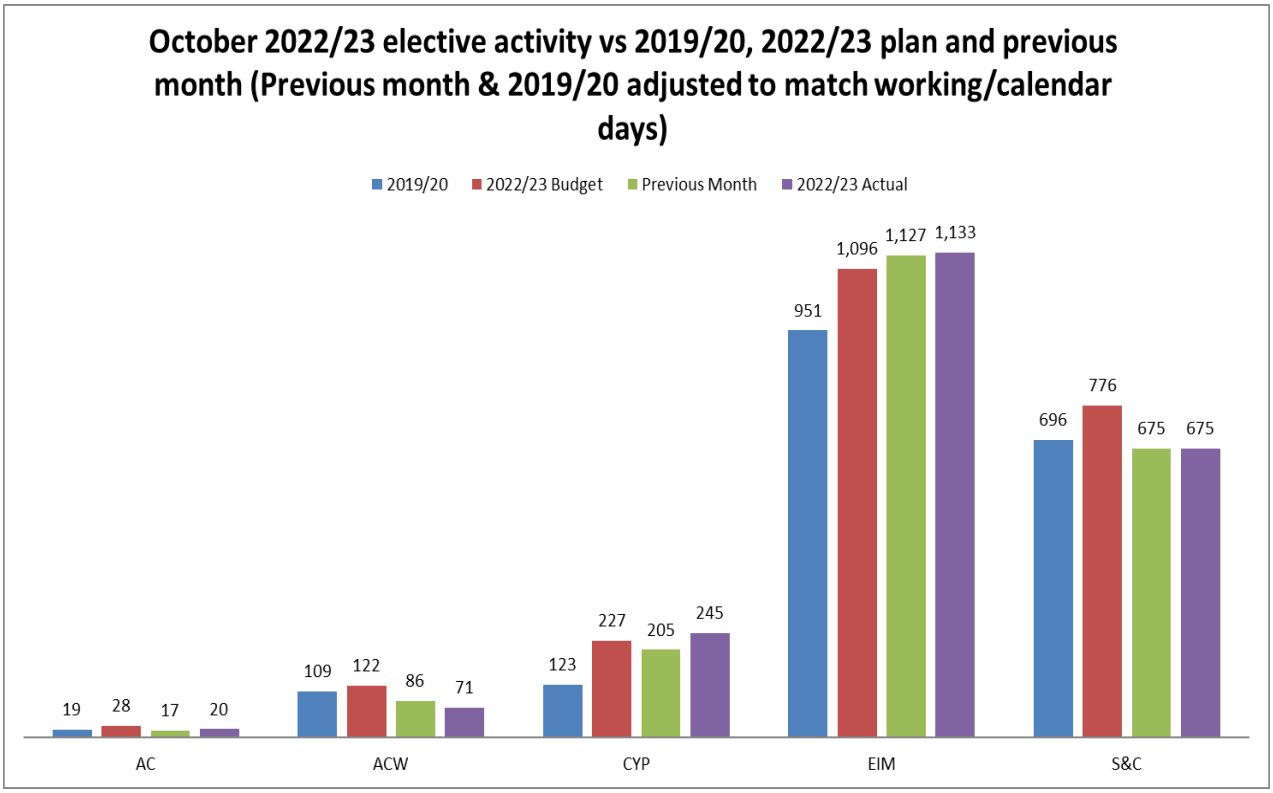
Activity	In Month Activity Plan	In Month Activity Actual	In Month Variance	In month Activity Diff%	YTD Activity Plan	YTD Activity Actual	Activity Diff	YTD Activity Diff%
A&E	9,407	9,393	(14)	(0%)	64,936	62,890	(2,046)	(3%)
Elective	2,249	2,174	(75)	(3%)	15,529	14,204	(1,325)	(9%)
Non-Elective	1,910	1,470	(440)	(23%)	13,183	10,630	(2,553)	(19%)
Critical care	450	395	(55)	(12%)	3,110	2,247	(863)	(28%)
Outpatients	31,746	28,153	(3,594)	(11%)	219,230	196,215	(23,015)	(10%)
Ambulatory	1,794	1,970	176	10%	12,387	13,005	618	5%
Direct Access	85,054	98,556	13,502	16%	587,277	674,221	86,944	15%

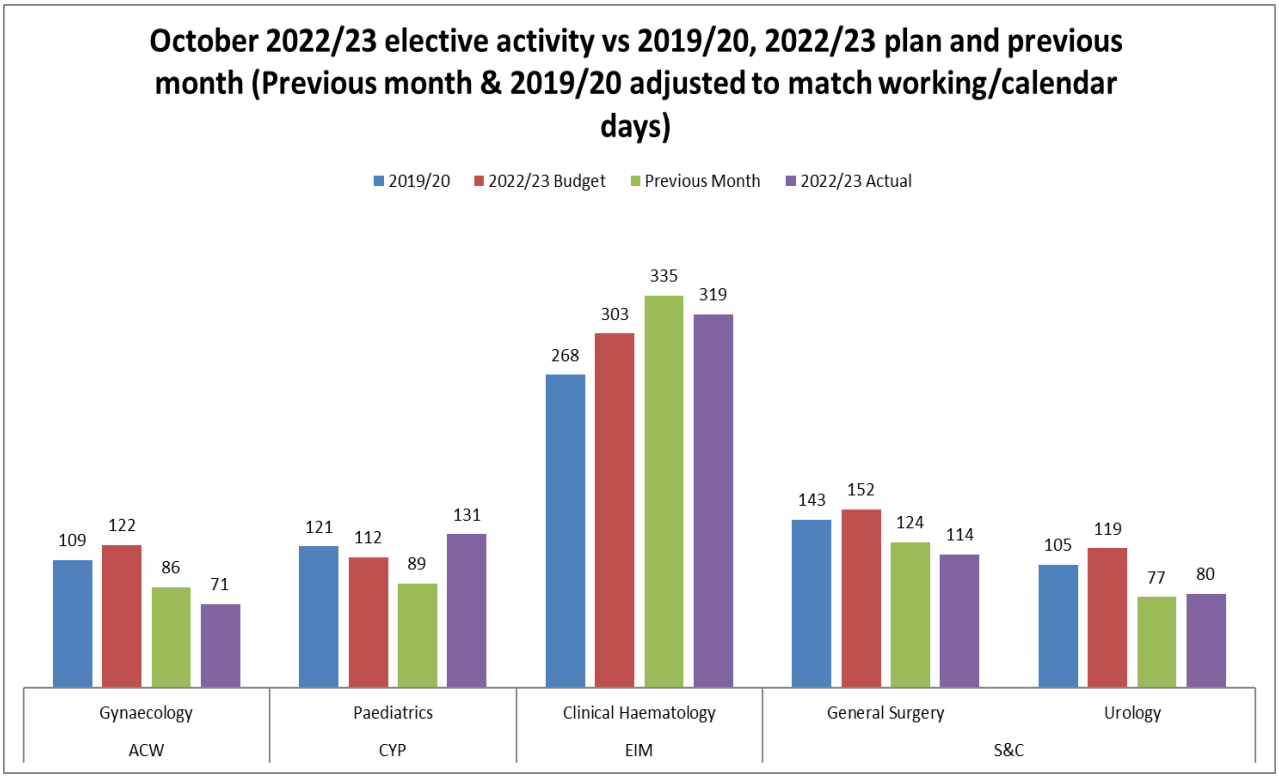
Except for Ambulatory and Direct Access, activity continues to be under plan. Based on this initial early data it strongly suggests that the Trust is at risk of not achieving the 109% activity target needed to achieve 100% of the £8m planned ERF.

Activity decreased compared to previous month adjusted for calendar/working days, except for non-elective activity.

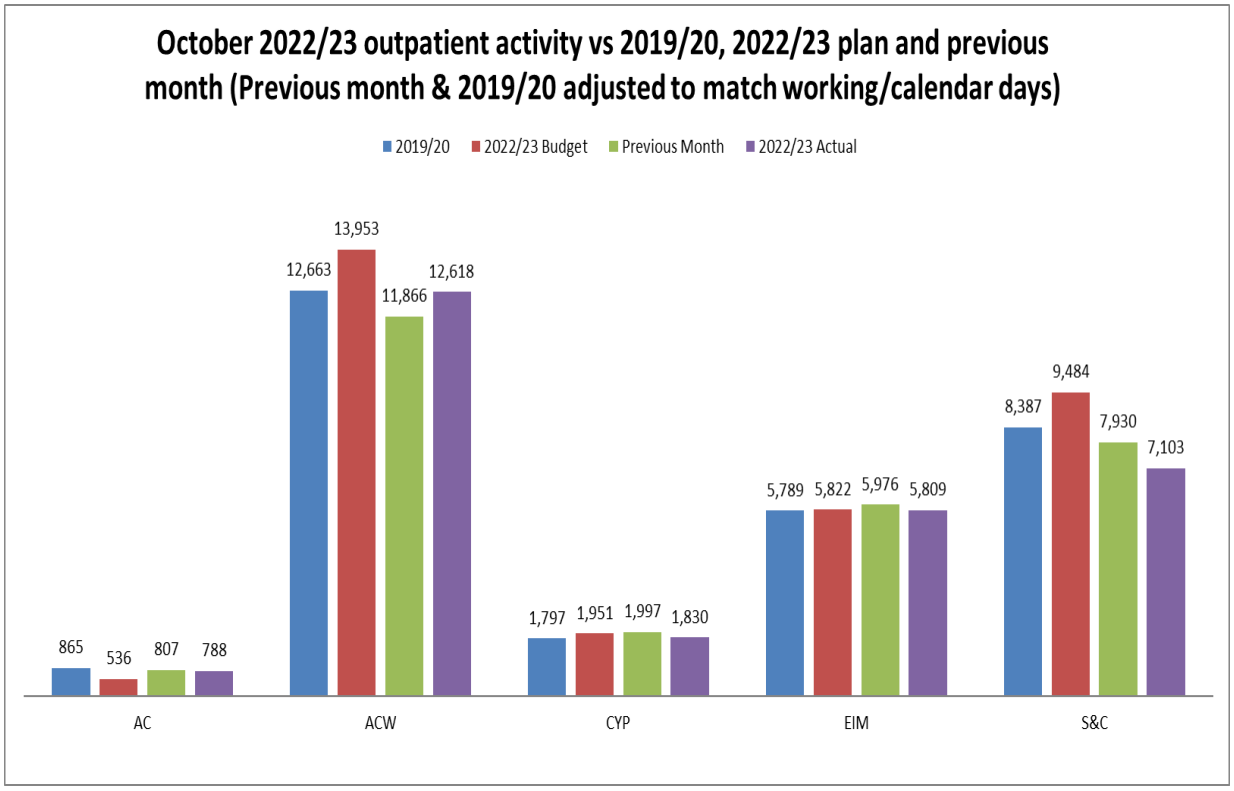


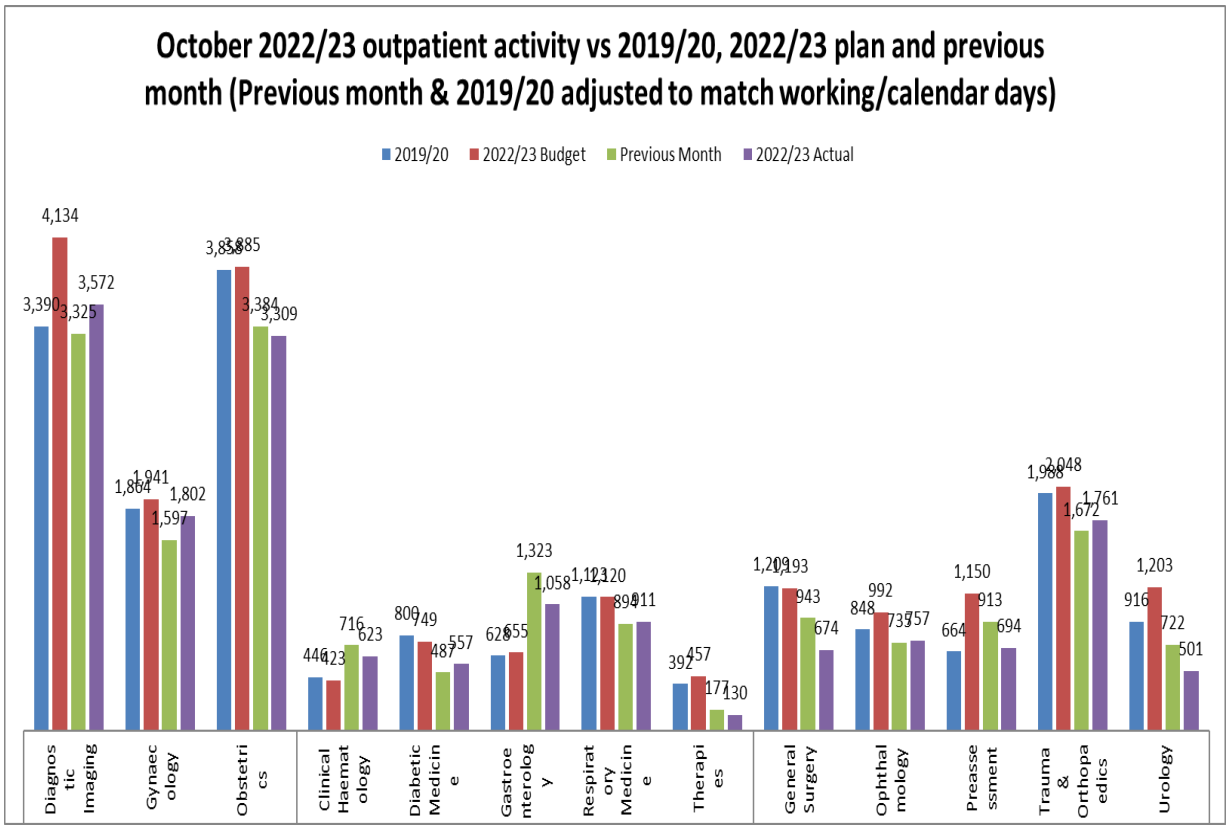
9% underperformance in total elective activity driven mainly by urology (33% under plan), gynaecology (42%), general surgery (25%). Offset by clinical haematology (5% over plan) and paediatrics (17%).





14% underperformance in outpatient activity driven mainly by therapies (72% under plan) urology (58%), diagnostic imaging (14%), ophthalmology (24%), preassessment (40%), gynaecology (7%), respiratory (19%), diabetic medicine (26%), general surgery (44%), trauma & orthopaedics (14%) and obstetrics (15%). Offset by overperformance in gastroenterology (61% over plan) and clinical haematology (47%).





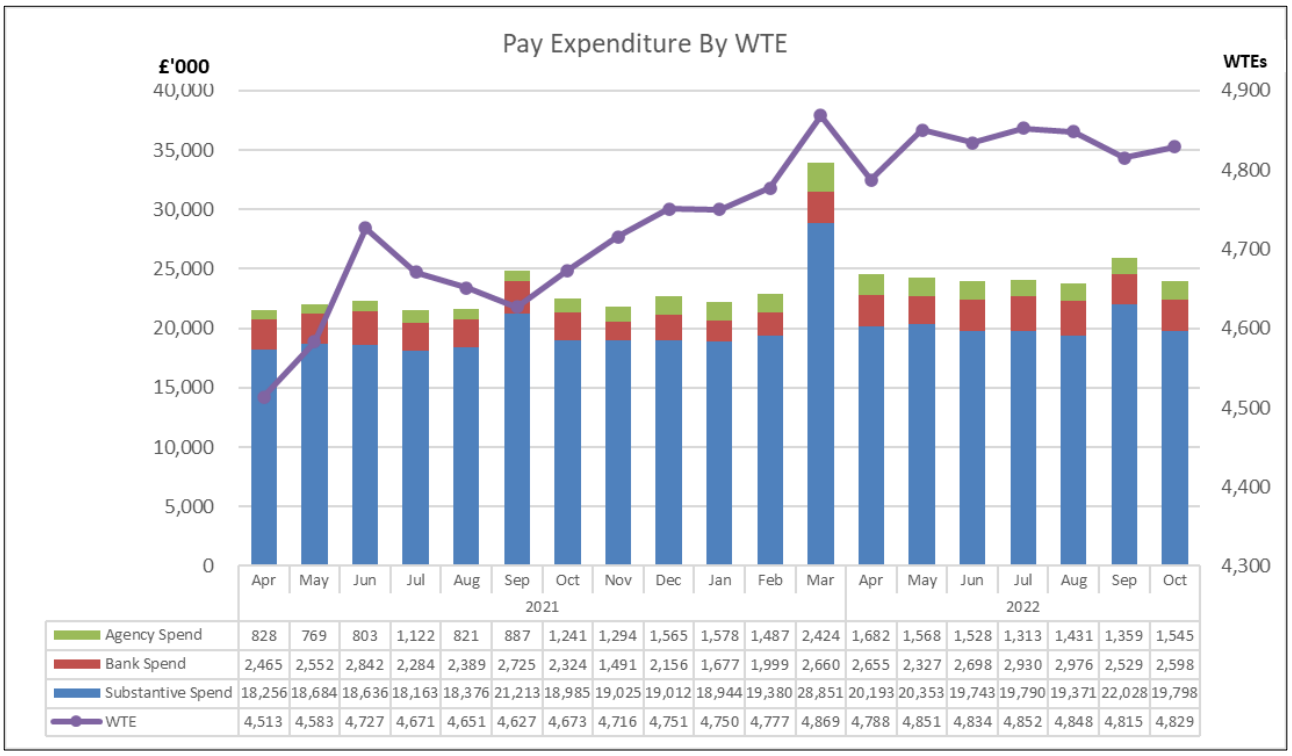
3. Expenditure – Pay & Non-pay

3.1 Pay Expenditure

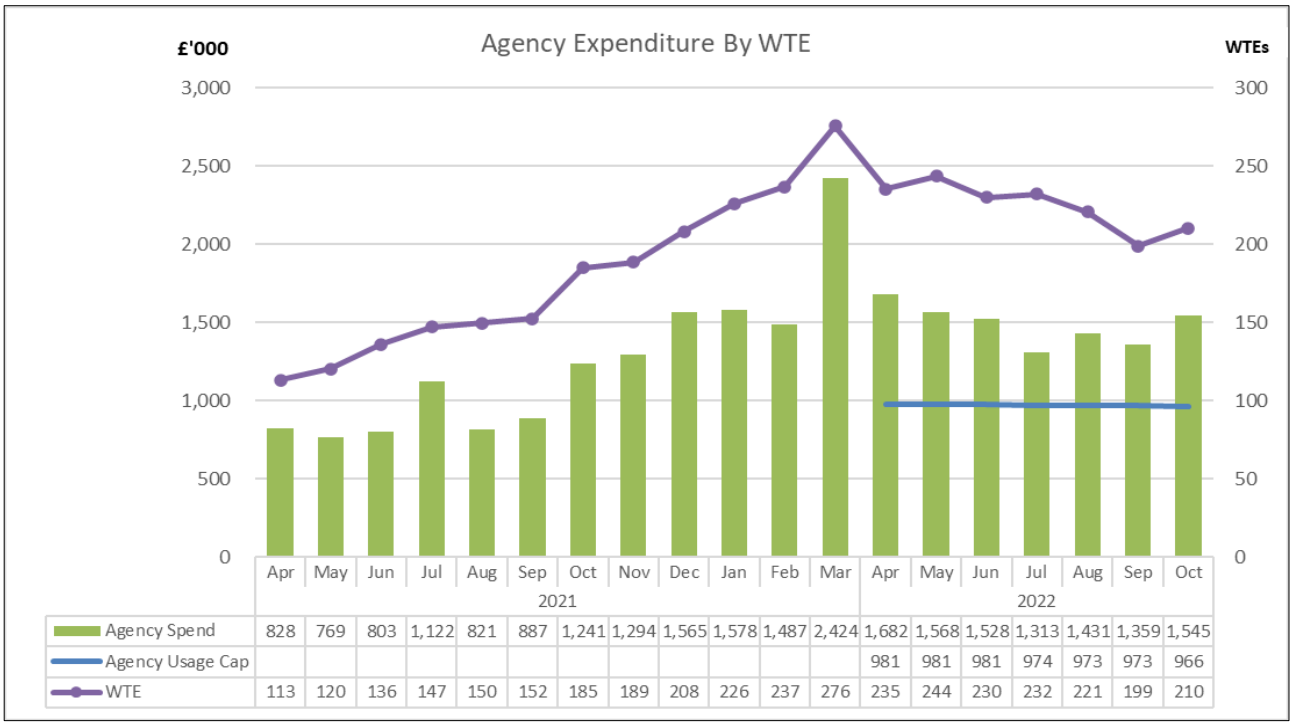
Overall pay is overspent by £4,689k year to date compared to plan. The overspend is mainly driven by unachieved CIPs of £1,988k across all ICSUs, covid requests to cover red/green areas (£1,857k ED), unfunded escalation beds open (£1,861k in Wards and £516k Enhanced Care) and £1,010k in ITU which is related to increased acuity on the wards, and agency staff required to cover staff on limited duties. Part of the unachieved CIPs is currently being offset by vacancies and slippages in some of the planned investments.

Pay expenditure for October was £23,941k which was £2,865k less than previous month. The reduction in pay costs compared to previous month is mainly due to back dated pay arrears for the AFC and medical pay uplift which were paid in September. Previous month, the Trust accrued £718k for the Local CEAs under non-operational pay costs and these costs have now been transferred to operational substantive pay costs.

	2021-22			2022-23							
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Mov^t
Agency	1,170	1,145	1,568	1,678	1,615	1,528	1,313	1,431	1,359	1,545	186
Bank	2,045	2,310	2,644	2,551	2,424	2,586	2,836	2,900	2,723	2,533	(190)
Substantive	18,880	19,178	20,037	19,170	19,366	19,283	19,355	19,179	23,694	20,832	(2,862)
Total Operational Pay	**22,095**	**22,632**	**24,249**	**23,399**	**23,405**	**23,397**	**23,504**	**23,511**	**27,776**	**24,911**	**(2,865)**
Non Operational Pay Costs	103	234	9,686	1,131	843	572	528	267	(1,860)	(970)	890
Total Pay Costs	**22,198**	**22,866**	**33,934**	**24,530**	**24,248**	**23,969**	**24,033**	**23,778**	**25,916**	**23,941**	**(1,975)**



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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
	2021												2022						
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	1,313	1,431	1,359	1,545
Agency Usage Cap													981	981	981	974	973	973	966
WTE	113	120	136	147	150	152	185	189	208	226	237	276	235	244	230	232	221	199	210

**2022-23 agency cap figures 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 £321K overspent year to date compared to plan. Overspends relating to clinical supplies (£1,394k), general supplies (£406k), use of independent sector (£220k), unachieved CIPs, utilities energy costs (£878k) and (£1,998k) reactive maintenance costs due to change of contractor are being offset by slippages in planned investments and non-recurrent benefits released.

Overspends in clinical and general supplies are being driven by increased insulin pumps cost, increased purchases in Endoscopy, unfunded escalation beds, increased usage of apheresis service from NHS Blood and Transport and increased surgical consumables.

In month non-pay expenditure run rate remained in line with prior month when adjusted for non-recurrent benefits which were released.

	2022-22			2022-23							
Non-Pay Costs	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Mov^t**
Supplies & Servs - Clin	2,187	2,917	3,351	2,096	2,547	2,429	2,371	2,489	2,515	2,420	(95)
Supplies & Servs - Gen	228	299	528	219	262	317	337	349	365	231	(133)
Establishment	263	324	276	216	213	217	237	238	276	301	25
Healthcare From Non Nhs	210	268	297	83	226	71	76	57	66	66	1
Premises & Fixed Plant	1,996	2,428	3,857	2,262	1,483	2,651	1,908	1,652	2,225	2,713	488
Ext Cont Staffing & Cons	184	217	97	145	138	120	175	163	346	193	(153)
Miscellaneous	1,599	1,728	6,152	1,679	1,626	1,662	1,812	1,891	1,334	1,449	115
Chairman & Non-Executives	12	12	12	11	11	11	9	12	11	11	
Non-Pay Reserve											
Total Operational Non-Pay Costs	**6,679**	**8,191**	**14,569**	**6,710**	**6,506**	**7,477**	**6,924**	**6,851**	**7,136**	**7,383**	**248**
Non Operational Non-Pay Costs	2,467	876	3,835	305	437	213	(481)	(396)	373	(21)	(394)
Total Pay Costs	**9,146**	**9,068**	**18,404**	**7,016**	**6,943**	**7,690**	**6,444**	**6,455**	**7,508**	**7,362**	**(146)**

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**	**Jul**	**Aug**	**Sep**	**Oct**	**Mov^t**
Ambulance Contract	157	152	144	168	176	208	190	172	131	109	(23)
Other Expenditure	58	81	295	72	51	52	144	103	62	124	61
Audit Fees	9	9	107	8	8	8	8	9	8	8	0
Provision For Bad Debts	100	24	2,124	105	141	19	124	62	101	(80)	(182)
Cnst Premium	837	837	735	827	827	827	827	827	827	827	
Fire Security Equip & Maint	0	15	3	5	11	12	4	6	18	18	(0)
Interpretation/Translation	22	10	10	21	16	9	10	11	10	2	(8)
Membership Subscriptions	126	126	196	128	132	135	139	140	134	103	(30)
Professional Services	203	367	1,525	300	185	294	266	334	(13)	277	290
Research & Development Exp		11	296	1	(1)	(2)	(1)	134	1	(0)	(1)
Security Internal Recharge	20	10	10	10	10	10	10	10	10	5	(5)
Teaching/Training Expenditure	65	86	699	34	65	86	87	79	42	53	10
Travel & Subs-Patients	1	1	8	1	4	4	3	3	2	4	2
Total Non-Pay Costs	**1,599**	**1,728**	**6,152**	**1,679**	**1,626**	**1,662**	**1,812**	**1,891**	**1,334**	**1,449**	**115**

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 October, the Trust is reporting actual delivery of £4.59m year to date of CIP against a target of £6.61m.

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	558	534	(24)	95.7%
CHILDREN & YOUNG PEOPLE	1,839	863	634	(229)	73.5%
EMERGENCY & INTEGRATED MEDICINE	1,653	776	258	(518)	33.3%
SURGERY & CANCER	1,569	736	389	(347)	52.8%
ACW	1,728	809	428	(381)	53.0%
ICSU TOTAL	**7,981**	**3,742**	**2,244**	**(1,498)**	**60.0%**
CORPORATE SERVICES	1,014	478	274	(204)	57.3%
ESTASTES & FACILITIES	1,006	471	133	(338)	28.3%
PROCUREMENT	-	-	20	20	0.0%
CENTRAL	3,829	1,915	1,915	(1)	100.0%
CIP GRAND TOTAL	**13,829**	**6,606**	**4,585**	**(2,021)**	**69.4%**

4.0 Statement of Financial Position (SoFP)

The net balance on the Statement of Final Position as at 31st October 2022 is £228.9m, £4.9m lower than March 2022, as shown in the table below.

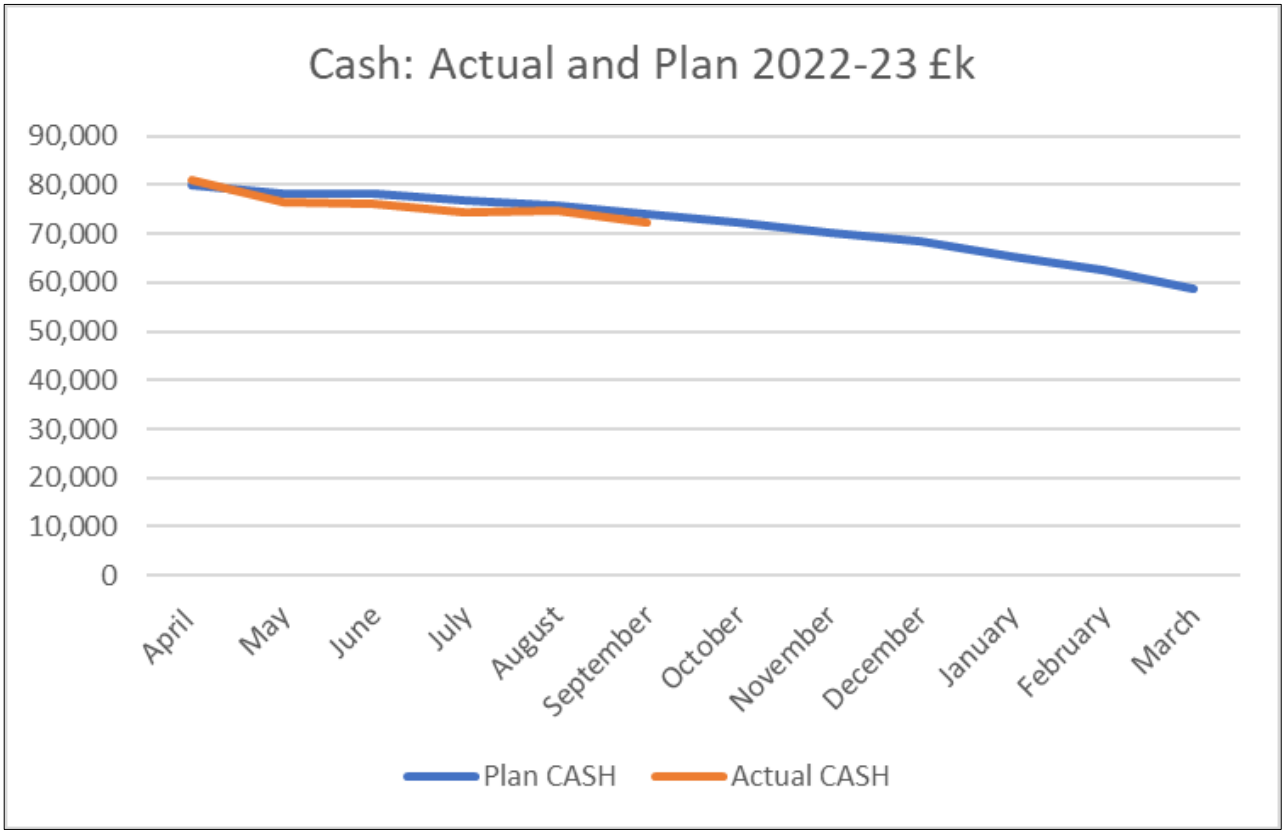
Statement of Financial Position as at 31st October 2022	2021/22 M12 Balance	2022/23 M06 Balance	2022/23 M07 Balance	Movement in Month	MOVEMENT IN YR
	£000	£000	£000	£000	(£000)
NON-CURRENT ASSETS:					
Property, Plant And Equipment	225,710	235,557	235,527	(29)	9,818
Intangible Assets	9,711	8,365	8,145	(219)	(1,566)
Right of Use Assets	0	36,411	35,805	(606)	35,805
Assets Under Construction	20,484	10,723	11,122	399	(9,362)
Trade & Other Rec -Non-Current	415	512	528	16	113
TOTAL NON-CURRENT ASSETS	**256,321**	**291,567**	**291,127**	**(440)**	**34,806**
CURRENT ASSETS:					
Inventories	788	916	1,020	105	232
Trade And Other Receivables	12,742	18,173	17,233	(940)	4,492
Cash And Cash Equivalents	81,416	72,159	77,167	5,008	(4,249)
TOTAL CURRENT ASSETS	**94,946**	**91,248**	**95,421**	**4,173**	**475**
CURRENT LIABILITIES					
Trade And Other Payables	(66,576)	(65,449)	(63,993)	1,456	2,584
Borrowings: Finance Leases	(79)	(136)	(51)	85	28
Borrowings: Right of Use Assets	0	(2,078)	(2,078)	0	(2,078)
Borrowings: Dh Revenue and Capital Loan - Current	(118)	(118)	(122)	(4)	(4)
Provisions for Liabilities and Charges	(704)	(573)	(519)	53	185
Other Liabilities	(1,859)	(4,014)	(9,558)	(5,544)	(7,699)
TOTAL CURRENT LIABILITIES	**(69,337)**	**(72,367)**	**(76,322)**	**(3,955)**	**(6,985)**
NET CURRENT ASSETS / (LIABILITIES)	**25,609**	**18,881**	**19,099**	**218**	**(6,510)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**281,930**	**310,447**	**310,226**	**(221)**	**28,297**
NON-CURRENT LIABILITIES					
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,740)	(1,682)	(1,682)	0	58
Borrowings: Finance Leases	(4,754)	(4,190)	(4,190)	0	564
Borrowings: Right of Use Assets	0	(34,423)	(33,820)	604	(33,820)
Provisions for Liabilities & Charges	(41,622)	(41,622)	(41,622)	0	0
TOTAL NON-CURRENT LIABILITIES	**(48,116)**	**(81,917)**	**(81,314)**	**604**	**(33,198)**
TOTAL ASSETS EMPLOYED	**233,813**	**228,530**	**228,912**	**382**	**(4,902)**
FINANCED BY TAXPAYERS EQUITY					
Public Dividend Capital	113,854	113,854	113,854	0	0
Retained Earnings	21,147	15,863	16,245	382	(4,902)
Revaluation Reserve	98,813	98,813	98,813	(0)	0
TOTAL TAXPAYERS EQUITY	**233,813**	**228,530**	**228,912**	**382**	**(4,902)**

The Trust's overall Receivables decreased by £0.94m to £17.23m in October compared to the prior month. Included within this balance is £6.77m of trade debtors, which have decreased by £2.25m month-on-month. Royal Free continues to form the Trust's most significant debtor, and discussions with RFH continue in order to accelerate payment following the technical issues experienced by that organisation. Their overall balance has decreased by £1.136m compared to September.

IFRS16 was implemented across the NHS on 1st April 2022, and results in an increased range of its leases being recognised as finance leases. This reclassification required the assets, and corresponding finance lease liabilities, to be added to the SoFP. These balances are now shown separately in the summary above, under Right of Use Assets and Right of Use Borrowings respectively. For October, four of the leases were re-measured at 21/22 rental values resulting in a 292k decrease in asset value. The balance of the £606k reduction in value relates to depreciation.

4.1 Cash & Cash Equivalents

As at the end of October, the Trust's cash balance stands at £77.2m – a decrease of £4.2m from 31 March 2022, £5.0m higher than September's figure and £4.9m above Plan. The balance has reduced since 31st March as the Trust reports a year-to-date deficit of £5.1m. 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 favourable variance of cash to plan results from lower than planned capital expenditure in the year to date.



Statement of Cashflows as at 31st October 2022	31st October 2022 (£000)
Cash flows from operating activities	
TB surplus/(deficit)	(4,902)
Less Interest Recvd & Paid	(2)
Less PDC Dividend	3,208
Operating surplus/(deficit)	**(1,696)**
Non-cash income and expense:	
Depreciation and amortisation	9,716
(Increase)/decrease in trade and other receivables	(4,883)
(Increase)/decrease in inventories	(232)
Increase/(decrease) in trade and other payables	(482)
Increase/(decrease) in other liabilities	7,699
Increase/(decrease) in provisions	(185)
Net cash generated from / (used in) operations	**11,632**
Cash flows from investing activities	
Interest received	538
Purchase of intangible assets	(179)
Purchase of property, plant and equipment and investment property	(10,209)
Net cash generated from/(used in) investing activities	**(9,850)**
Cash flows from financing activities	
Public dividend capital received	0
Capital element of finance lease rental payments	(592)
Interest paid	(33)
Interest element of finance lease	(503)
PDC dividend (paid)/refunded	(3,208)
Net cash generated from/(used in) financing activities	**(4,335)**
Increase/(Decrease) in cash and cash equivalents	**(4,249)**
Cash and cash equivalents at start of period	**81,416**
Cash and cash equivalents at end of period	**77,167**

The recent increases in interest rates have resulted in a total of £538k interest being reported for the first seven months of the year, which is £281k in excess of Plan. The Trust continues to monitor the available interest rates and the monthly sum of interest received.

5.0 Capital Expenditure

Capital expenditure as of 31st October 2022 totals £6,360k, which is £3,646k below plan, a reflection that the Trust's principal capital projects for this financial year are yet to get fully underway. A number of projects had significant budgeted spend commencing in October, the non-delivery of which has contributed to an adverse variance. The in-month total is £1,255k.

The overall allocation for the 22/23 financial year is £30,406k including £5,000k for the Targeted Investment Fund project to co-locate Recovery facilities adjacent to Theatres, which was expected to be funded externally. This project is not now expected to proceed in the 2022/23 financial year, and the Trust's forecast outturn has been reduced accordingly.

Meeting title	**Trust Board – public meeting**	**Date: 25.11.2022**
Report title	**2022/23 Quarter two delivery of Corporate Objectives and Quarter three Board Assurance Framework**	**Agenda item: 11**
Director leads	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals, Clare Dollery, Medical Director, and Chinyama Okunuga, Chief Operating Officer (Quality entries); Norma French, Director of Workforce, (People entries); Helen Brown, Chief Executive, and Jonathan Gardner, Director of Strategy and Corporate Affairs (integration entries); and Kevin Curnow, Chief Finance Officer (sustainability entries),	
Report authors	Jonathan Gardner and Swarnjit Singh, Joint Director of Inclusion and Trust Secretary	
Executive summary	**Corporate objectives update** Due to the overlap of corporate objectives and strategic updates, the Board is presented here with one paper highlighting our progress against the corporate objectives for the year, incorporating strategic updates and a Board Assurance Framework update. Board members are asked to note particular progress in the following areas: • Wood Green hub business case is coming to private board this month • Maternity and Neonatal designs have received planning permission and the business case has been discussed at Finance committee • The Community Diagnostic Centre activity is ramping up and phase two has been approved • The business case for the new electronic patient record is progressing. • Continued progress with the partnership with UCLH on various pathways	

	Board Assurance Framework Update The Board Assurance Framework has remained under review by Board and Executive Committees. The main change this quarter is an increase in the Quality 1 entry score to 16 from 12 which was agreed by the Quality Assurance Committee on 9 November.
Purpose	To note and discuss pace of progress, and risk ratings against delivery.
Recommendation	Board members are invited to receive and note the outcomes for the quarter one against performance indicators for the delivery of Whittington Health's corporate objectives in quarter two 2022/23 and to approve the quarter three Board Assurance Framework entries for risks to the delivery of Whittington Health's strategic objectives.
Board Assurance Framework	All entries
Report history	Trust Management Group, Executive team; Quality Assurance Committee, Workforce Assurance Committee, Finance and Business Development Committee
Appendices	1: 2022/23 Q2 Delivery of corporate objectives 2: 2022/23 Q3 Board Assurance Framework

2022/23 objectives
QUARTER TWO
UPDATE
V4

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		0.88 June 2022	
Readmission rate	5.5%	4.61%	
Pressure ulcers grd. 4 and 3	Reduce	Average 11 in q2 Average 12 in q1	
FFT % satisfaction	90%	Average q 2 89%	

Key metrics	Target	Score	RAG
RTT	92%	69.4%	
ED 4hr	95%	71.1%	
Adult community metrics green	Improve		
Child community	Improve		

Key metrics	Target	Score	Direction and RAG
PALS response time	80%	47.1%	
48hrs DN referral	95%	96.3%	
2hr referral	N/A	76.8%	

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	• Introduction of PSIRF (Patient Safety Incident Response Framework) with use of alternative investigation tools focused on identifying and implementing learning quickly. The new Head of Patient of Safety will act as the Patient Safety Specialist, supporting local delivery • Closure of the remaining 10 CQC actions from the 2019 action plan. • Midwifery and Medical recruitment in line with the Ockenden recommendations. • Tendable audit application in place – better uptake is the next step • Effectively embed QI methodology and raise the profile of QI to drive improvements in patient safety and clinical effectiveness. • Advertising for new Lead Medical Examiner, revised learning from deaths policy.
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 are being 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**).**	• Patient Experience Strategy agreed at Quality Assurance Committee with some minor adjustments. • Deconditioning projects show that 77% of patients have their mobility assessed within 48 hours of admission. • Blood transfusion safety training compliance continues to increase, with target of >60% achieved within nursing, midwives and ODP staff. • The Trust held a Prostrate Cancer Conference that was well attended by the community, receiving positive feedback about the usefulness of the event.

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%	13.9%	
Vacancy rate	10%	14.3%	
Appraisal rate	90%	73.9%	
Mandatory training	90%	84.1%	

Key metrics	Target	Score	Direction and RAG
Staff Sickness	3.5%	3.75%	
Likelihood BAME candidate being appointed	1	1.42	
Staff Survey /People Pulse Response rate	20%	*50.9%*	

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 continue to take regular reports to TMG, People Committee, Partnership Group and WAC , TMG and Trust Board. • Public Sector Equality Duty Report Approved by WAC in October • Deep Dive of WRES Indicator 3 completed and follow up actions agreed • Staff Inclusion Open Forum arranged for November • Review of how best to support and embed the See Me First initiative going forward. Two year anniversary reached of See Me First, and being rolled out across the NHS, and beyond. • Development Programme for Bands 2 – 7 from a black, Asian or minority ethnic background launched • Black History Month celebrated across the organisation • Charity approved a further 6 month funding for Staff Psychological Support • Engagement events for new Workforce Strategy undertaken.
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 recruitment service has a Recovery Plan in place and actively monitored on a daily basis. Improvements are being seen in recent weeks • Work on collaborative Bank and rate harmonisation across NCL ongoing. • Trust Board and TMG received Cos of Living update, a number of initiatives are already in place and a series of listening events are scheduled for November. • Health and wellbeing offerings continue to updated on Trust intranet with corporate Communications ensuring wide dissemination. • The Restorative Just Culture Development Group has been established • HCSW Showcase event planned • Broadening our international recruitment offering to midwifery and AHPs • Consultant Future Leader's Programme launched

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.	• We continue to lead on the virtual ward model for the community review in NCL, and that is progressing well. We have additional funding to extend the service even further for the Winter period. • We continue to lead 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	• Further work and analysis required to decide how and if we take forward a major programme on 'make every contact count' • Wood Green hub development was approved by the OSC. The business case is now going to board in November. • 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	• Further details for the UCLH@ oncology model have been worked through. Many other collaborative areas are progressing with UCLH including maternity, general surgery, urology. • The "start well" review continues and we are looking forward to recommendations in due course. • We continue to support multiple streams in the ICB and Provider Alliance. • We currently have the biggest Virtual Ward in the sector. We currently are using 205% of the capacity allocated for WH for the virtual ward by using unused capacity from other providers. • CDC was opened by the Secretary of State at the end of August. Phase 2 approval has been given and work as begin. • 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) Target at end of Q2 38% (£5.2m)	£3.2m Delivered at end of Q2 (62% of target).	
Average beds used	197	223	
Financial position	Annual Plan (£0.1m deficit) Plan to end of Q2 (£3.1m deficit)	£5.2m deficit reported at end of Q2 which is £2.1m worse than plan.	
Capital spend against plan	Annual Plan is £30.4m (£25.4m internally funded and £5.0m PDC).	£5.1m utilised at end of Q2 which is £2.8m below plan.	
Average LOS Non-elective	4	5.5	
Predicted versus actual discharges		119%	

Key metrics	Target	Score	RAG
% super stranded pts	18%	18.5%	
Elective activity against recovery plan	104% of 2019/20	99.5% Q2	
Theatre utilisation	>85%	77.13%	
Virtual vs face to face outpatients	25%	18.2%	
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 £5.2m at the end of Q2 which is £2.1m worse than plan. The planned till end of Q2 was £3.1m.
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 granted. Business case for phase 2 has been written and support is being sought from partners. • Wood Green hub business case going to Board this month
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 Outline Business Case (OBC) for new Electronic Patient Record • Improve & innovate in digital, data, and analytics, using data to transform	• Still further work to do to reconfigure Highgate wing and Jenner • EPR Strategic Outline Case was approved by Board, the OBC will be complete by end of December • 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.
Develop education and research and make the most of our participation in the BRC	• WEC open and in active use – PACES exams booked for next quarter • Research strategy in preparation for board seminar • Orthopaedic department has won the Hospital of the Year Award voted by their trainees

Appendix 2: 2022/23, Q3 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 Q3, 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	4	16				4
Quality 2	4	4	16	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. • 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 basis, 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 reports are 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 • 1st tier – As part of COVID-19, communication issued once a week or more to staff, as required, on adherence to IPC requirements • 1st tier – Zoned areas in healthcare settings to meet IPC needs • 1st tier – COVID-19 operational management is highlighted at monthly Trust Management Group meetings • 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 • 1st tier – TMG confirmed changes to COVID-19 testing in line with guidance so that we are only testing immunocompromised or symptomatic patients and only symptomatic staff • 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	4	5	20				9
People 2	4	4	16	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 ○ Creating a Financial Wellbeing Hub and resources to support staff through the cost of living crisis
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

Key controls	Assurances
	• 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 • 2nd Tier – dedicated ~Caring For Those Who Care staff communication month in September 2022
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
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 – TMG and 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
EDI plan in place	• 1st tier assurance – Partnership Group 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. • Implementing the national Scope for Growth Conversations Framework throughout September 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	Q4 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	4	3	12				8
Integration 2	4	3	12	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 – the Chief Operating Officer is on the NCL Operational Implementation Group • 2nd tier – the Director of Strategy is on the Elective Strategy Group • 2nd tier – the Medical Director is the clinical lead for the Provider Alliance

Key controls	Assurances
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 two 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
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.

Key controls	Assurances
Start well review – CN and CFO are key leads on the review workstreams, Director of Strategy leads an ad hoc review meeting of all the documentation.	• 1st tier – Internal start well review meetings • 1st tier – TMG
Progress Anchor Institution work and population health work – Director of Strategy leading on an 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 • 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

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	4	5	20				8
Sustainability 2	4	4	16	4	4	16	4	4	16				8
Sustainability 3	3	3	9	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
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 have continued and targeted support provided where identified
Development of an estate plan Strong monitoring of fire safety procedures and compliance Capital programme addresses all red risks	• 2nd tier - Estate Strategic Outline Case (SOC) agreed by Trust Board November 2020 • 1st tier – Monthly Private Finance Initiative monitoring group • 1st tier – Monthly Fire safety group

Key controls	Assurances
	• 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 Consultation for Wood Green community hub is complete and approved with the business case to be considered in October 2022	• 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
Implement a revised Digital strategy	• 2nd tier – Implementation of approved Digital strategy is overseen by 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 Q4 for feedback and agreement.	Quarter 4 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))

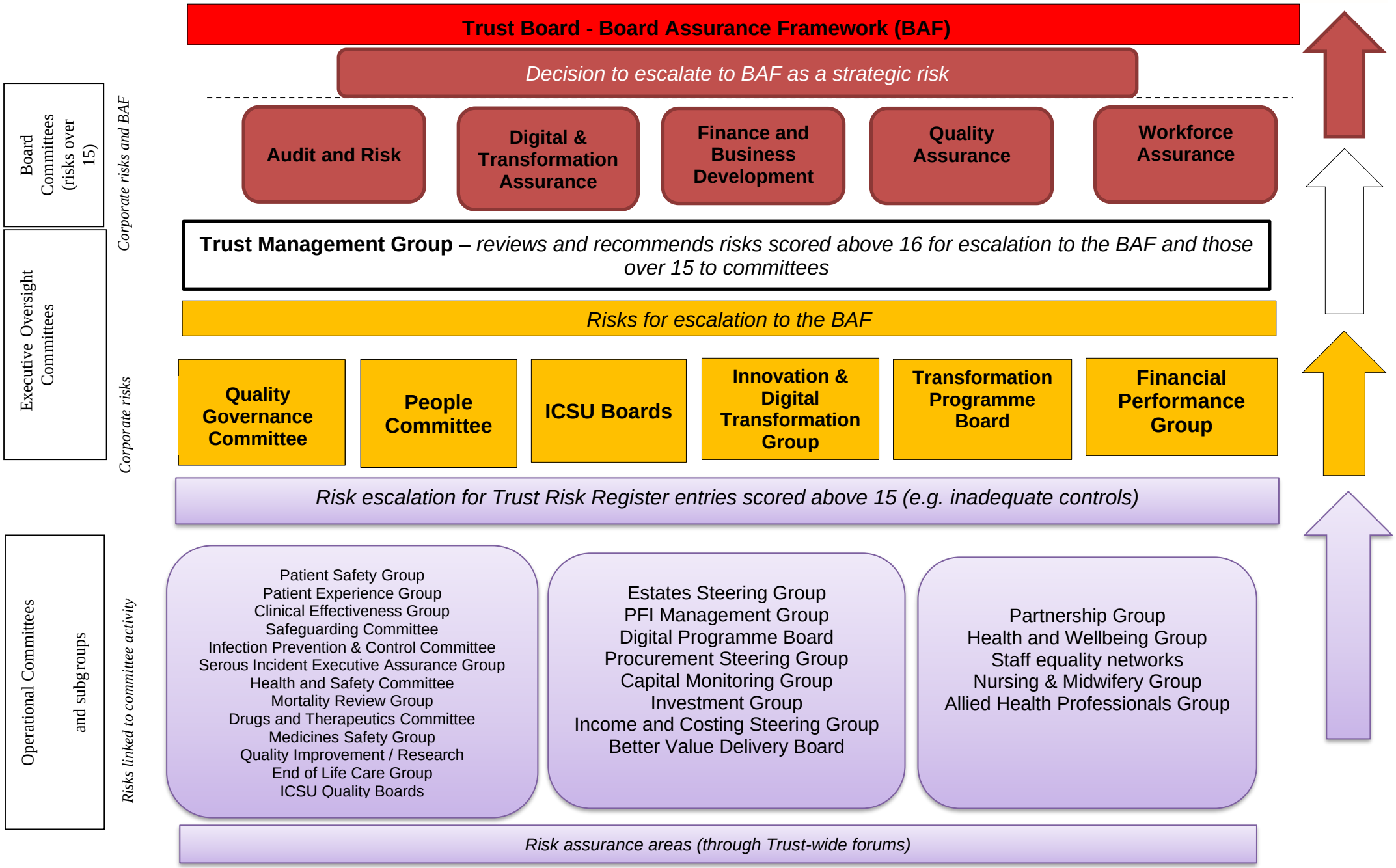
	Likelihood				
	1	**2**	**3**	**4**	**5**
Consequence	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

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: 25 November 2022**
Report title	**Workforce Assurance Committee Chair's report**	**Agenda item: 12**
Committee Chair	Rob Vincent, Non-Executive Director	
Executive director lead	Norma French, Director of Workforce	
Report authors	Marcia Marrast-Lewis, Assistant Trust Secretary	
Executive summary	Trust Board members are presented with the Workforce Assurance Committee Chair's report for the meeting held on 26 October 2022. **Areas of assurance:** • Quarter 1 corporate workforce information report • Nurse Recruitment update • NCL workforce analytics • Deep dive on WRES indicator 3 • 2021/22 Public Sector Equality duty report • Board Assurance Framework – People entries • Risk Register – People entries The Committee also received verbal updates developments on industrial action by NHS unions and on the Restorative Just Culture initiative. There are no items for which the Committee is reporting limited assurance.	
Purpose	Note	
Recommendation(s)	Board members are invited to note the Committee Chair's report, particularly the update on nurse recruitment (appendix 1) and 2021/22 public sector equality duty report (appendix 2).	
BAF	People entries	
Appendices	1: Nurse Recruitment update 2: 2021/22 Public Sector Equality duty report	

Committee Chair's assurance report

Committee name	Workforce Assurance Committee
Date of meeting	26 October 2022
Summary of assurance:	

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

Industrial action

Committee members were apprised of impending industrial action. The Trust had been notified that the Royal College of Nurses, the Chartered Society of Physiotherapists and Unison had undertaken a statutory ballot for industrial strike action. Consultative ballots for strike action were also planned by further trade unions across the NHS. In preparation, Whittington Health had commenced discussions with local staff union representatives, with the North Central London, and the London Social Partnership Forum. Additionally, an industrial action task and finish group had been established to open discussions with operational teams. The Committee noted the importance of facilitating colleagues to take action where they wanted to, but at the same time, continuing to provide safe care for patients.

Restorative Just Culture

The Committee were informed that the first meeting of the Restorative Just Culture Working Group had taken place where the terms of reference and an early resolution process were amended. The next meeting of the group would agree the draft policy and the early resolution process. Further task and finish groups would be set up to cover training and to ensure that frontline managers were trained in the process. An impact measures group was also being set up so that people could take a temperature check which would dispense with the need to wait for the annual outcomes from the Staff Survey or Workforce Race Equality Standard. The task and finish group would agree updated documentation and training.

2022/23 Quarter One workforce report

The Committee received the report which reported on key workforce issues for the first quarter of 2022/23 and noted the following:

- Vacancy rates had increased by 1% from Q4, as had turnover by 0.7%.
- Sickness absence continued to be of concern although the absence rates had reduced.
- Appraisal and mandatory training remained below target but was showing small increases each month. The Elev8 system was in place to facilitate mandatory training and appraisals.
- Formal employee relations cases were not resolved within the 90-day target, and this was attributed to staff turnover within the workforce team and capacity issues.
- At the end of September, the average recruitment time to hire indicator had increased to 84 days against a target of 63. The reasons for this were operational issues with the North London Partners Shared Services which impacted the length of time taken to complete employment checks.

Assurance was provided that the Trust-based workforce team would continue to work with the Shared Service to improve this timeframe.

The Committee discussed sickness absence rates and noted they were likely to increase with Covid-19 and flu over the winter period. It was explained that sickness absence rates due to Covid-19 and flu were currently stable and would continue to be monitored on a daily basis. It was clarified that staff who tested positive for Covid-19 would be required to self-isolate for up to 10 days and could return to work if they tested negative at day 5 or 6. Staff that came into contact Covid-19 would be required to test daily. Staff would also continue to receive lateral flow tests free of charge.

The Committee were assured that remedial measures were in place to address the backlog of employment applications which had a positive impact. The backlog was down to 44, from 382.

The Committee noted that staff turnover was slowly on the increase which was in line with the NHS as a whole and were assured that the rate of staff attrition and recruitment would be closely monitored to ensure that staffing levels remained balanced.

Nurse recruitment
Committee members welcomed an overview of the role and work of the Nurse Recruitment Team which was principally responsible for:

- International recruitment including nurses, midwives and allied health professionals
- UK general recruitment, including graduate schemes
- Healthcare support worker recruitment
- Trainee nursing associates and nursing associates' recruitment
- Return to practice nurse facilitation

The report focussed on international recruitment from which the Committee took good assurance that:

- All international recruitment was conducted through the pan-London International Recruitment Consortium, headed up by Capital Nurse London.
- By the end of the current year, the Trust would have welcomed 85 international nurses.
- An excellent nurse induction programme was in place to provide support as new recruits settled into work at the Trust and life in a new country.
- A pastoral support programme was also in place for which the Trust has received the NHS Pastoral Care Quality Award for International Nurses and Midwives.
- The Team had also worked on the Building Bridges programme, an NHS funded partnership for Refugee Health Professionals living in London. The programme helped refugee doctors to re-qualify to UK standards and secure employment appropriate to their professional qualifications.

The Team had supported four people through the program to achieve professional registration.

The Committee commended the work undertaken by the Nurse Recruitment Team. The Medical Director suggested that a similar approach could be successfully replicated for the recruitment of international medical graduates. Committee members also acknowledged the valuable work undertaken with refugee programmes recommending that it could be linked with the work undertaken by the Trust as an anchor institution.

The Committee noted that the retention rate of international nurses was very high with an attrition rate of less than 7% over the last five years. This was attributed to the quality of work carried out to support the nurses and their families particularly with practical issues around housing.

The Committee extended their appreciation for the report and agreed that a progress update be provided in 12 months' time.

Deep dive on WRES Indicator 3

Committee members discussed the outcome of some high-level analysis of disciplinary cases from April 2021 to March 2022 under WRES indicator 3 – "Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation". The report highlighted specific areas of concern set out below:

- The number of disciplinary cases where the outcome resulted in no case to answer amounted to 8 out of 11 in favour of black and minority ethnic (BME) staff.
- The total number of disciplinary cases where the outcome resulted in no further action was 4, all of which related to BME staff.
- During the reported period, the Estates & Facilities department had the highest number of formal disciplinary cases with a total of 10.

Committee members acknowledged the issues highlighted and welcomed a number of actions which had been implemented to remedy the issues, including:

- Specific work around the culture in the Estates & Facilities department was in place to strengthen senior leadership and address longstanding behavioural concerns.
- The Just Culture initiative's programme of work would bolster the informal part of disciplinary processes.
- There would be training and advice for managers on the benefits of addressing issues early and informally.
- Reviewing the governance arrangements around the disciplinary process. This work would also be captured as a part of the Just Culture programme and in line with the Trust commitment to a culture of openness, learning and restorative practice.

	• A review would also be undertaken in cases where the outcome was “no case to answer” in order to gain further learning and insight to support our Just Culture programme. The Committee supported the continued work with Estates and Facilities and agreed that it was important that the Trust was seen to take corrective action where there were particular issues with management. **2021/22 Public Sector Equality Duty (PSED) report** The Committee received and welcomed the statutory annual report which provided detailed equality information about the Trust's workforce and patient population. The Committee was also informed that the Trust had been awarded Level 3 status as a Disability Confident leader and that work would continue with external partners, to promote the "Ambitious about Autism” and the “autism people in our workforce” initiative. **Board Assurance Framework and Trust Risk Register – People entries** The Committee noted the Board Assurance Framework and Trust Risk Register. **See Me First Presentation** The Committee received a presentation on the “See Me First” initiative which was developed following a number of events including: • an independent workplace culture report carried out by Professor Duncan Lewis which found that there was bullying and harassment in the workplace. • A global pandemic which saw an adverse impact on BME health and social care staff and patients • The murder of George Floyd in the USA in July 2020 • The re-establishment of BME networks at the Trust. • Black History Month 2020 which was themed “each-one-teach-one”. Beverleigh Senior explained that the aim of the initiative was to drive real change in the organisation's culture and to increase the visibility of race equality issues at Whittington Health. The project was officially launched in October of 2020 under the banner of “See Me First” which highlighted the Trusts commitment to zero tolerance of any form of discrimination, and that staff who were subjected to such behaviour were supported to speak up and challenge unacceptable behaviours in a safe way. The Committee noted that the initiative had been successfully adopted by other hospital trusts and healthcare organisations and had been nationally recognised through several prestigious awards.
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

	Chinyama Okunuga, Chief Operating Officer Glenys Thornton, Non-Executive Director **In attendance:** Simon Anjoyeb, Equality Lead 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 Rowena Welsford, Associate Director of Workforce Charlotte Pawsey, Deputy Director of Workforce Catherine McNally, Lead Nurse Clinical Recruitment Deborah Tymms, Assistant Director Human Resources Marcia Marrast-Lewis, Assistant Trust Secretary

Nurse Recruitment Team – Overview 2022

Our Nurse Recruitment team has been in place for almost 4 years and has grown as the need has required us to. We are responsible for:

- International recruitment (Nursing and soon AHP's and Midwives).
- UK recruitment general and Graduates
- Healthcare support worker recruitment
- Trainee Nursing Associates and Nursing Associates recruitment
- Return to Practice Nurse facilitation

For the purpose of this report, we are focusing on our international recruitment (IR).

Currently we have 3 parts to our IR team.

1. HR support fully with agency liaison, compliance, and COS management.
2. Pastoral care support team members.
3. Nursing management and support team

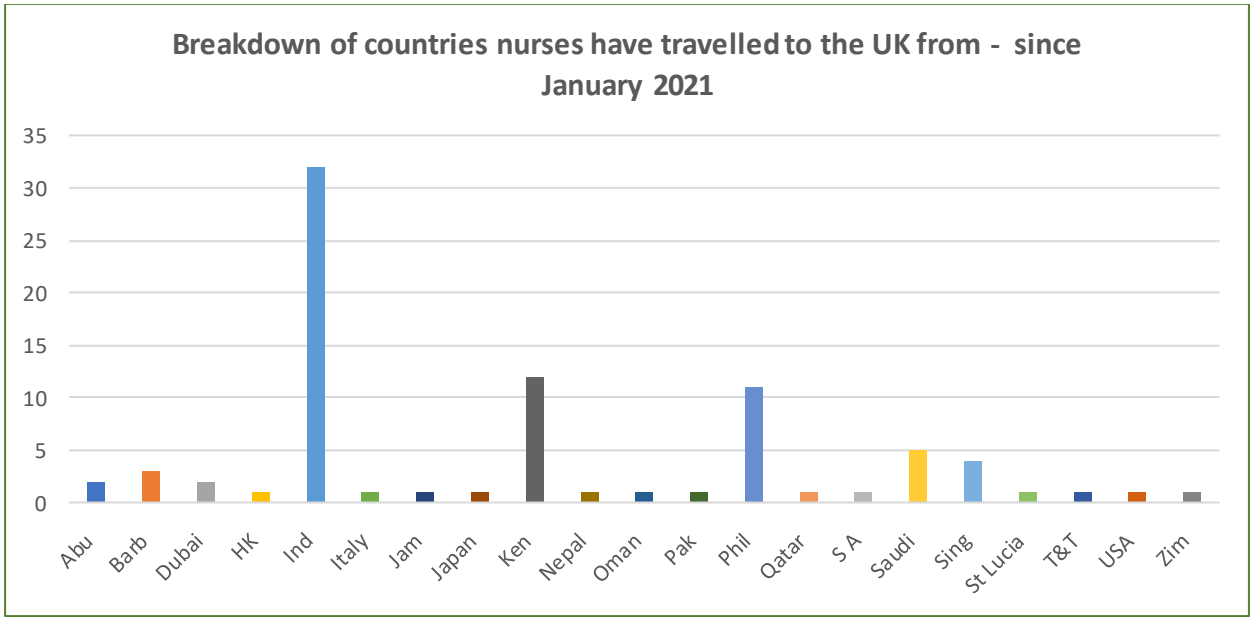
International Recruitment

Key points this year

- **The Team**
  - In September this year we welcomed a new team member in the role of the Clinical Lead Nurse (IR). She will be working to deliver Return to Practice recruitment, supporting the Nursing Associate recruitment and providing our international recruitment team with support and knowledge to successfully onboard our international nurses.

- **International nurses recruited in from January 2022 to date**
  - By the end of this year, we will have welcomed **85** nurses to the Trust
  - As of 28th September, we have received **62** international nurses, including our largest cohort of 12 – who arrived on 26th September.
  - Rest of the world recruitment has increased, providing nurses from a much wider range of countries.

- We started recruiting internationally via the Consortium in the winter of 2020, and nurses began arriving in January 2021 from an ever-increasing variety of countries.



- **International Nurse Induction**
  - Our international nurse induction programme is constantly reviewed and developed to ensure we are providing the best support and induction we can.
    - ASSIST programme
      We now schedule two Assist sessions with Whittington Clinical Health Psychology Team and UCLH for each cohort to provide them with an awareness of stress factors and the tools to reduce stress levels as much as possible. Our international nurses must hit the ground running whilst also having to study, take exams, consider accommodation, and very importantly missing their family and friends.
    - The OSCE team support them throughout their training and factor in debrief sessions with each cohort.
    - NRT include pastoral debriefs, to see where we can improve our support and develop resources further.

- **Keeping in touch with our International Nurses**
  - We now communicate with our international nurses pre-arrival via Teams, so that we can be better acquainted on arrival, and we can respond/reassure much earlier if nurses have questions and/or concerns.
  - We set up different WhatsApp groups with each cohort, so that they easily communicate with appropriate team members when needed, throughout their induction and also before they arrive from their own countries.

- **Providing accommodation support**
  - As we continue to welcome large groups of nurses and other clinical staff, the need to secure accommodation for them also increases.
  - We have been working closely with our provider to ensure we are able to provide initial homes for all our international nurses. We have secured several rooms, solely for the use of the Trust, which we now use on a rotational basis. This ensures our nurses have accommodation for three months before moving on.

- We are also nurturing a new relationship with another local, but smaller provider, to assist where possible.
- We have developed (and continue to develop) a really useful resource pack to assist our nurses to find permanent accommodation after 3 months. A key member of our team supports with guidance and advice regarding permanent accommodation to reduce the stress of having to move as much as possible.

- **Pastoral Care and the Pastoral Care Quality Award.**

  - This year we were one of 3 inaugural trusts to be awarded the **NHS Pastoral Care Quality Award for International Nurses and Midwives**. We are so pleased that out Trust and our pastoral care team have been recognised. We are very proud that Whittington Health is considered to provide a high standard of pastoral care to our international nurses.
  - This a voluntary scheme, that as well as helping to standardise the quality and delivery of pastoral care, this award is an opportunity for trusts to have their work recognised and to demonstrate their commitment to supporting internationally educated nurses and midwives at every stage of recruitment and beyond.
    https://www.england.nhs.uk/nursingmidwifery/international-recruitment/nhs-pastoral-care-quality-award/

  - Additionally, CapitalNurse Consortium developed an informative, welcoming, and friendly pack for international nurses containing an immense amount of useful information about London and living and working in London. The link is included in our offer letter that is emailed to international nurses, and included in our welcome email, sent to nurses' pre-arrival.
    Consortium Handbook for Overseas Nurses Welcome Pack
    https://www.capitalnurselondon.co.uk/resources/

- **OSCE**
  - The management of our OSCE programme was transferred to the Preceptorship Lead Nurse in education. He is working with the OSCE team to deliver innovation in the delivery of the programme following considerable changes to the assessment directed by the NMC.
  - We have seen an increase in the amount of Internationally Educated Nurses (IEN) recruited in the past year. OSCE training has remained challenging to deliver due to Covid restrictions, re-deployment of staff during pandemic waves, changes in the NMC exam assessments and lastly the availability of suitable facilities at the Trust. Since the move to the new Test of Competence (TOC) by the NMC there has been a drop in the number of OSCE candidates passing on their first assessment across most trusts.

- **Retention**

Our retention for International Nurses is excellent, very few IR nurses have left the Trust.

- During financial year 2020/2021
  6.31% of our international nurses left (in the 2nd or 3rd year of their 3-year visa)
- During financial year 2021/2022
  4.3% of our international nurses left (in the 3rd year of their 3-year visa)

NEW VENTURES

- NRT is now supporting the recruitment of midwives and Allied Health Professionals – including assisting with key pastoral activities and accommodation.

- We are working with the Consortium and the London Leadership Academy by encouraging our international nurses to participate in a programme and use a toolkit to support them to develop their careers.
- The Building Bridges programme is an NHS funded partnership for Refugee Health Professionals living in London. We have been fortunate to take part in the programme and currently have four nurses all from Iran out in practice (three within COOP and one within maternity). The aim of the project is to assist the nurses into band 2 roles allowing for experience to be gained with the overall aim being to gain NMC registration with our support.

NHS
Whittington Health
NHS Trust

Whittington Health

2021 – 2022

Public Sector Equality Duty

Compliance Report

Diversity & Inclusion

January 2023

Contents

Item	Page Number
Purpose of the Report	2
The Protected Characteristics	3
About Whittington Health	5
B: Patient and Service Users	10
C: Workforce	24
D: Equality Delivery System (EDS2) Activities	58
Equality objectives	61
Appendix A Equality Objectives	62

A. Context of the report

1.0 Purpose of the Report

1.1 This report presents equality information about the Trust's workforce and patient/service user population and relates to the protected characteristics identified in the Equality Act 2010.
The goal is to set out the how the Trust is meeting the general and specific duties of the PSED in line with the statutory requirements

1.2 The Equality Act 2010 requires the Trust to declare its compliance with the PSED annually. This requires Whittington Health to illustrate compliance with both the general and specific duties of the PSED.

1.3 The report reviews data between 1st April 2021 and 31st March 2022; some datasets require a single snapshot date which will be 31st March 2022.

1.4 The report is split into four main Sections: 'A. Context of the report'; 'B. Patients and Service Users'; 'C. Workforce' and 'D: Equality Delivery System' (EDS2). Information in each section is presented mainly in headings related to the nine protected characteristics. Some sections likely contain significantly less information than others, reflecting the challenges and limitations of collecting information and individual personal rights to choose what to disclose. Where there is limited information, these come with the caveat that it is hard to conclude except give an opinion in places.

1.5 The Equality Act 2010 (the Act) replaced previous anti-discrimination laws with a single Act. It simplified the law, removing inconsistencies to make it easier for people to understand and comply with. The Public Sector Equality Duty (section 149 of the Act) came into force on 5th April 2011.

1.6 The Equality Duty applies to public bodies and others carrying out public functions. It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities, helping them to deliver policies and services which are efficient and effective, accessible to all, and meets different people's needs.

1.7 The specific duties in the regulations strengthen the Equality Duty. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set specific, measurable equality objectives.

1.7 The information published should demonstrate the Trust's regard and support for the achievement of the three aims of the Equality Duty:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it.

1.8 The nine protected characteristics covered by the Equality Duty are:

i. Age
ii. Disability
iii. Gender reassignment
iv. Marriage and civil partnership (elimination of unlawful discrimination only)
v. Pregnancy and maternity
vi. Race (this includes ethnic or national origins, colour or nationality)

vii. Religion or belief (this includes lack of belief)
viii. Sex
ix. Sexual orientation

2.0 The Protected Characteristics

2.1 **Age** – This refers to a person or persons belonging to a particular age group. An age group includes people of the same age and people of a particular range of ages. People who fall into the same age group share the protected characteristic of age.

2.2 **Disability** – In the Act, a person has a disability if they have a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities. For the purposes of the Act, these words have the following meanings:

- *substantial* means more than minor or trivial
- *long-term* means that the effect of the impairment has lasted or is likely to last for at least twelve months or till the end of life (there are special rules covering recurring or fluctuating conditions)
- *normal day-to-day activities* include everyday things like eating, washing, walking and going shopping

There are additional provisions relating to people with progressive conditions. The Act protects people with HIV, cancer or multiple sclerosis from the point of diagnosis. The Act considers people with some visual impairments automatically to be disabled. People with the same disability share the protected characteristic of disability.

2.3 **Gender reassignment** – For the purpose of the Act as where a person has proposed, started or completed a process to change their sex. A transsexual person has the protected characteristic of gender reassignment. A person who has just started the process of changing their sex and another who has completed the process share the characteristic of gender reassignment.

2.4 **Marriage and Civil Partnership** – This refers to people with the common protected characteristic of being married or civil partners. A person that is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person in a dissolved civil partnership is not married or in a civil partnership and therefore does not have this protected characteristic.

2.5 **Pregnancy and maternity** – A woman remains protected in their employment during the period of pregnancy and any statutory maternity leave to which they are entitled. This provision is now separate from protection on the grounds of sex, which is not available to a woman during pregnancy and maternity. It is unlawful to take into account an employee's period of absence due to pregnancy-related illness when making decisions about their employment.

2.6 **Race** – For the purposes of the Act, 'race' includes colour, nationality and ethnic or national origins. People who have or share characteristics of colour, nationality or ethnic or national origins may belong to a particular racial group. Examples: Colour includes being black or white, and nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be 'Black Britons,' which would encompass those people who are both black and who are British citizens.

2.7 **Religion or Belief** – This covers people with religious or philosophical beliefs. To be considered a religion within the meaning of the Act, it must have a clear structure and belief system. The Act includes the following examples: The Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism. To be considered a philosophical belief for the purposes of the Act, it must be:

- genuinely held
- be a belief and not an opinion or viewpoint
- be a belief as to a weighty and substantial aspect of human life and behaviour
- attain a certain level of cogency, seriousness, cohesion and importance
- be worthy of respect in a democratic society, compatible with human dignity and not conflict with the fundamental rights of others

The Act cites as examples of philosophical beliefs, Humanism and Atheism. Adherence to a particular football team would not be a religion or belief. A cult involved in illegal activities would not satisfy these criteria. People of the same or different religions or beliefs share the protected characteristic of religion or belief.

The Act also protects people who do not have a religion or belief (non-belief).

2.8 **Sex** – For the purposes of the Act, sex means being a man or a woman. Men share the sex characteristic with other men and women with other women.

2.9 **Sexual Orientation** – The Act defines a person's sexual orientation towards:

- People of the same sex as them (a person is a gay man or a lesbian).
- People of the opposite sex from them (the person is heterosexual).
- People of both sexes (the person is bisexual).
- People sharing a sexual orientation mean that they are of the same sexual orientation and therefore share the characteristic of sexual orientation.

3.0 About Whittington Health

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

3.2 We provide hospital and community care services to over half a million people living in Islington and Haringey, as well as those living in Barnet, Enfield, Camden and Hackney.

3.3 Whittington Health provided over 40 acute and 60 community health services in 2021/22. In addition, we provide dental services in 10 London boroughs.

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

3.5 Our services and our approach are driven by our vision. We have an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population. We are treating more patients than ever before, and we dedicate our efforts to improving services to deliver the best care for our patients, with a clear focus on integrating care for women, children, and the adult frail.

3.6 Our 2019/24 strategy has four main objectives:

- Deliver outstanding safe, compassionate care in partnership with patients
- Empower, support and develop an engaged staff community
- Integrate care with partners and promote health and wellbeing
- Transform and deliver innovative, financially sustainable services

3.7 The Trust values; the ICARE values developed through staff engagement and consultation continue to be fundamental to everything we do at Whittington Health and form the basis of expected staff behaviours. In the last year, we supplemented the ICARE values with an additional overarching value of equity.

3.8 Our service priorities focus on our population needs: integrating care in all settings with emphasis on women, children and frail adult patients and residents.

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

3.10 As an integrated care organisation, we bring safe and high-quality services closer to home and speed up communication between the community and hospital services,

improving our patients' experience, reducing admissions, and speeding up discharge. Key to our approach is partnering with patients, carers, GPs, social care, mental health and other healthcare providers.

3.11 Our organisation has a highly regarded educational role. We teach undergraduate medical students (as part of University College London Medical School) and nurses and therapists throughout the year, alongside providing a range of educational packages for postgraduate doctors and other healthcare professionals. We also have a growing research arm which is exceeding Clinical Research Network targets.

3.1 Other relevant reports and data

3.1.1 This report feeds into another range of statutory and NHS standards, which look at their subject areas in greater detail than this document.

These include:

- Workforce Disability Equality Standard
- Workforce Race Equality Standard
- Gender Pay Gap reporting.

The Workforce Disability and Equality Standard is available on the Trust's website. The Trust's statutory Gender Pay Gap report is available on the GPG Reporting Service.

3.1.2 When writing this report, data and information from the 2021 Census were unavailable. Where local demographic comparison has been made, the 2011 Census data has been used.

3.2 Trustwide EDI-Related Achievements during 2021/22

The Whittington Health Trust maintain its commitment into making sure that equality is a goal and a decisive factor in delivering excellent patient care and creating a workplace environment that is considerate of our celebrated and diverse workforce. The Trust has adopted various initiatives and projects including :

3.2.1 Supported Internships

Supported internships are a one-year work-based study programme where young people spend most of their time based at an employer.

They provide an important step on the employment journey, helping young people aged 16 to 24 with an Education, Health and Care plan (EHCP) or another form of Special Educational Needs (SEN) support to get the skills they need for work so that they can get into a job.

Using the Project Search model, Ambitious College works with the Whittington Hospital to support interns develop workplace skills. The programme runs from September for one academic year, with interns based at the Whittington five days a week.

Job outcomes:

- 19/20 – 2 out of 3 interns in paid work (the COVID-19 pandemic impacted the scheme)
- 20/21 – 5 interns off-site; the COVID-19 pandemic impacted the scheme (all interns were granted extensions in 21/22)
- 21/22- 9 interns (4 returners) – this was our first full year on-site, and we saw 5 out of 9 young people enter FT paid work, including 1 FT at WH. 1 intern has returned this year for an extension of this programme. 3 are still job seeking with support from supported

employment agency Kaleidoscope Sabre

3.2.2 Disability Confident – Level 3

In December 2021, NHS England and Improvement (NHS E/I) accepted Whittington Health onto a national pilot run by the Nursing Directorate at NHS E/I. The Trust formalised this arrangement with NHS E/I through a Memorandum of Understanding in November 2021.

The focus was on the Disability Confident scheme to encourage employers to think differently about disability and to take action to make improvements to how they recruit, retain and develop people with disabilities.

There were two elements to the pilot. First, NHS organisations assessed current policies, procedures and practices and provided evidence for level three Disability, Confident status. An external disability charity, the Shaw Trust, then validates the assessment.

As part of the Trust's submission, we provided a range of information to be validated, including the Recruitment and Selection Policy, WhitAbility Terms of Reference (disabled staff network) and the North Central London Apprenticeship Policy.

The second element focussed on employability to ensure disabled people secure more paid fixed-term or permanent opportunities.

Whittington Health was successfully awarded level 3 status as a Disability Confident Leader and looks forward to continuing its excellent partnership with two external, third-sector bodies – Ambitious about Autism and the Autism Project – to host internship placements and to help attract and retain disabled people in our workforce.

Talent management

There has been good initiatives in several Integrated Care Service Unit / Directorates to help increase the diversity of their senior staff. In addition, discussions have taken place with the NHS Leadership Academy for Whittington Health to block book 20 places on its development programmes for middle and senior leaders. The programmes involved are Elizabeth Garrett Anderson, Nye Bevan, Rosalind Franklin and Stepping Up. In addition, there may be an opportunity to have places for Whittington Health on the North Central London Integrated Care system's Future Leaders' Programme which is also aimed to increasing the diversity in NCL bodies.

In addition to the above the Trust Mentorship for Black, Asian & ethnic minority staffprogrammeThe plan is underway to enable external mentorshipfor Black Asian and Minority Ethnic colleagues, particularly those in Bands7 & 8A,who would benefit from independent support with recognising their career potentialand with career development planning.

The scheme we have introduced acknowledges mentees in the mentorship programme as partners with their mentors and builds on the ethos of reciprocal mentorship. Alongside the talent management initiative, the scheme act as a deliberate conduit to build inclusion leadership, help shape and develop inclusive and systems-focused talent management and succession planning for Whittington Health as part of the local health and care system. The idea is given a working title of 'Whittington Health –Mentorship for Black, Asian & Ethnic minority (BME) staff programme to support career progression and potential. mentors.

Race Equality Week

The Trust took part in Race Equality Week. which took place this year between 7–13th February 2022. The week is designed to unite organisations and staff in activities that address the barriers to race equality in the workplace. This is the first time the Trust has engaged in the national initiative and several successful staff open forum sessions occurred in support of the event. This year's theme was 'actions not words' and sessions explored important topics such as the benefit of wellbeing, focussing on encouraging take up by Staff from Black, Asian and ethnic minority groups. There was an update on the role and success of See ME First as a Trust engagement initiative which, as a pioneering trust, we have seen spread to 22 other NHS organisations.

Nursing Narratives: Racism and the Pandemic

The Nursing Narratives –Racism and the Pandemic undertaken by academics from Sheffield Hallam University and the Exposed video, which looked at the impact of racism on ethnic minority nurses and care workers during the Covid-19 Pandemic was published in March 2022. A Trust Wide Open Forum screen showing with support from the Trust Clinical Health Psychology Team occurred on the 21st April 2022. The aim was to allow staff and managers to watch and discuss the issues that have come out of the film and explore what action can be taken in support of any negative experience by BME nurses working at the hospital.

Medical Workforce Race Equality

The Medical Workforce Race Equality Standard (MWRES) and 11 indicators were introduced in September 2020 to recognise how the medical workforce differs from the rest of the NHS workforce.

The first MWRES report was published in July 2021. In response, the Trust has created the post of Medical Workforce Race Equality Standard (MWRES. The Trusts is one of the first to introduce the MWRES lead role. Among other focus, the role will emphasise improving the Trust's support and development of International Medical Graduates (IMG's) by setting up and evaluating a suitable induction programme and identifying potential areas of action. It will also include work with clinical leaders to ensure that medical recruitment is fair and equitable by ensuring the principles outlined in the De-biasing Toolkit are embedded at all stages of the recruitment process.

3.2.3 Race, Equality, Diversity, and Inclusion (REDI) Team

In August 2021, The REDI Team was established with the appointment of the Joint Directors of REDI. Tina Jegede and Swarnjit Singh, job share this role. The directors provide strategic direction for the REDI agenda at the Trust.

Both are existing staff members; Tina is also the Nurse Lead for Islington Care Homes, and Swarnjit is the Trust Secretary.

Margo Innocent works as the Staff Engagement and Team Administration Assistant.

Simon Anjoyeb was recruited as the EDI Lead to address the operational aspects of delivering REDI within the organisation. He was in post from April 2022.

Below are some highlights of work that occurred during 2021/22:

- Open Forum sessions were held that were open to staff to attend as an opportunity for staff to receive updates and provide their views on developments within the inclusion agenda. Some topics explored at Open Forum were nursing reports about their experiences and BME staff sharing their experiences working at the Trust.
- The Team have provided support and leadership for the staff networks, especially regarding facilitated time for co-chairs and an annual budget to support network activities.
- The Joint Directors of REDI have been working with organisations across the North Central London ICS. The Joint Directors co-chaired a task and finish group to produce a best-practice recruitment framework across the ICS.
- The REDI team have also participated in many Trust training programmes, for example, International Medical Graduates induction, Allied Health Professional Leadership Development, Corporate Induction and the Trust's Leadership Development Programme.

Other activities/staff engagement initiatives include :

- Review and update of Equality Diversity & Inclusion Policy
- Reviewed of Reasonable Adjustment Process
- Reviewed Equality & Diversity Training
- Reviewed Equality Impact Analysis
- Commitment to the Equality Delivery System
- Introducing pronouns to the staff name badge
- Celebration of World Mental Health Day
- Celebration of Independence Day, i.e., Filipino, Nigeria, etc.

3.2.4 Organisational Development

Following the successful establishment of three additional staff networks (Women's, LGBTQ+ and WhitAbility) to the Trust's existing BAME Network, now known as SRENN, The Trust earmarked resources to improve information on staff needs. In particular for employees with disabilities and long-term conditions (LTC). A specialist disability organisation was commissioned to hold focus groups which were confidential meetings, and those attending confirmed their disability or LTC before being booked into a group. The recommendations in the resulting report are currently being explored and will inform action plans to improve the experience of disabled staff.

The Trust continues its relationship with two organisations for autistic young adults to provide work experience placements across the hospital site to maximise their employability. This year saw a high percentage of interns achieving permanent job offers at the end of their work experience.

In the interests of staff wellbeing, particularly following the unequal impact of covid on different ethnic groups, the Trust commissioned the services of a local culturally sensitive counselling organisation. The organisation has provided both confidential one-to-one services for individuals seeking personal therapy and reflective group sessions to enable people to decompress and support each other in their recent experiences.

Last year, the Trust saw increased mediation requests, including team mediation. Aligned to this approach to reach an agreed resolution between parties, Whittington Health is now implementing Restorative Just Culture (RJC) as its process for managing incidents. Several introductory training sessions have been provided to managers; now looking for more involved training. A development group has been created for representatives across all ICSUs and Directorates to drive this forward.

In support of the Model Employer equality suggested targets, OD ran a pilot BAME Band 2-7 experiential development programme launched with 22 delegates from 54 applicants. Those not on the programme were offered personal development plan coaching resulting in a written summary of the plan. So far, several employees (those in and not in the cohort) have progressed with their development and career progression. This pilot will be evaluated in more detail for a future iteration, likely including neighbouring trusts who have expressed interest in participating, which will widen the opportunity for experiential placements.

A career development workbook was published alongside the Band 2-7 programme. It is available in print and on the Intranet to support coaching and all training programmes, to enable people to work at their own pace through their career development.

3.2.5 See Me First

See ME First is an initiative that aims to promote a more respectful, civil, and inclusive culture within Organisations so that staff have a sense of belonging.

As See ME First approaches its second anniversary on 29th October 2022 and the Whittington Health NHS Trust ICARE values are now underpinned by EQUITY, the message that "….people should not be judged by the colour of their skin but by the content of their character…." is even stronger.

Over 1800 staff have now made their pledge (1:3 staff) and 22 other NHS organisations are 'following our lead' and have either adopted or are looking to adopt the initiative. Islington Council – Social Care are the first Organisation outside of the NHS who are looking to formally launch during October Black History Month. We recently held the inaugural See ME First #StrongerTogether Event where there was representation from 18 of those Organisations who recognise the importance of working together for an inclusive NHS for the betterment of our staff and our patients.

We received the following feedback

"Thank you for inviting us, great to see, See ME First across the UK"

"Thank you for the invite, a worthwhile session"

As a testament to the effect of See ME First, we are now also receiving See ME First Impact Testimonials from staff who have made their pledge and who want to share their experiences and the tangible changes that have taken place.

One See ME First Impact Testimonials reads,

"See ME First is a platform that allows for open and honest discussions even when the topics are difficult, It has particularly given me a voice and has empowered me to help others".

As an entirely staff led initiative, to help raise awareness, raise the profile and to support and facilitate those opening dialogues, we now has See ME First Ambassadors, staff who are actively engaging with other staff across the ICO and spreading the message that a change is long overdue

B. Patients and Service Users

4.0 Patient Equality Information

4.0.1 There are two sets of patient equality information that are available. Firstly, data relates to who is using our services, and secondly, data relates to the patient experience while they are under our care. Some data is unavailable to be analysed as it is not routinely collected via Medway or Rio, our patient management systems. This information could be held in patients' written medical or nursing notes. The issue has been reported to the Chief Nursing Information Officer, who will act on this as part of our ongoing work to digitalise patient records.

The available data shows service usage for patients that were outpatients, inpatients, and using emergency services and community services during 2021/22.

4.0.2 Age

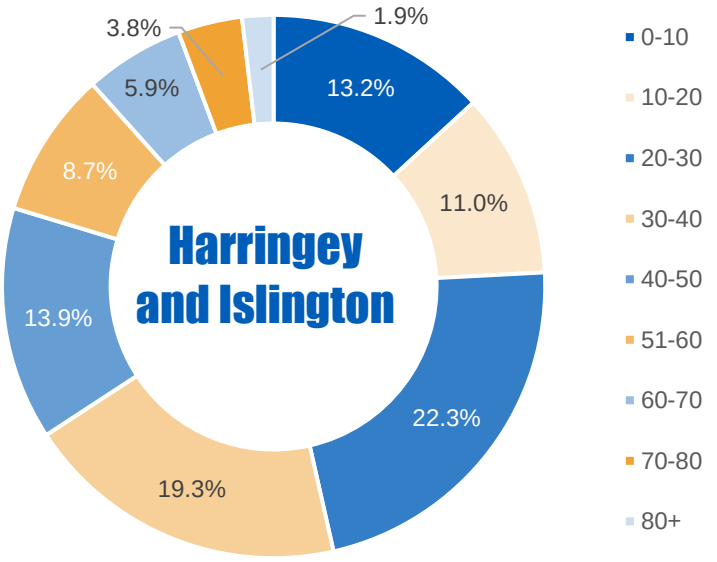


Chart 1 (left) shows the representation of the local population of Haringey and Islington broken down by age group. The local breakdown of the local population helps provide a point of comparison when looking at patient and service use data.

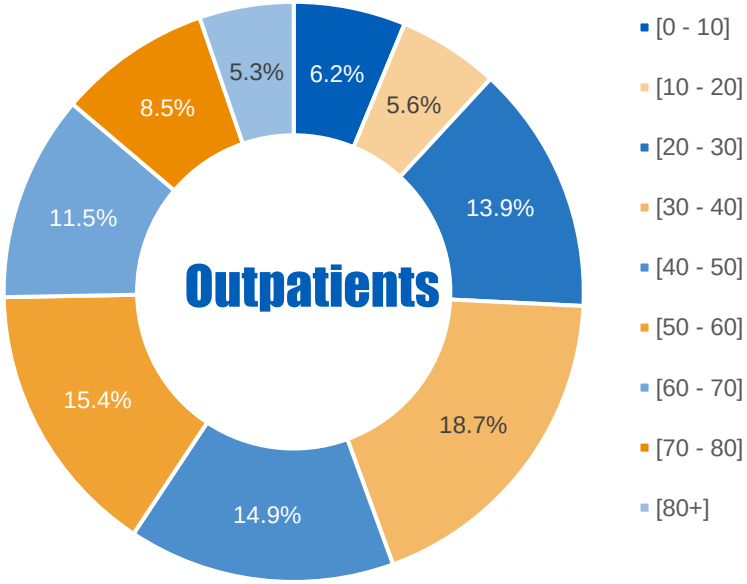


Chart 2 (left) represents outpatient service use by age group. In outpatient services, most patients are 20-70 years of age.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 0-40 and a higher-than-expected representation for those aged 40+. Patients aged 70-80 are represented in outpatients 2.2 times more than the local population, and patients aged 80+ are represented 2.7 times more.

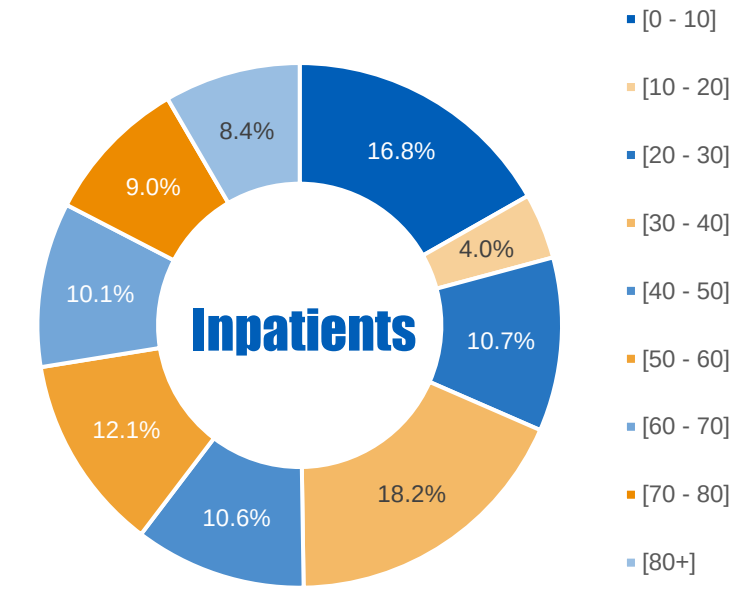


Chart 3 (left) represents inpatient service use by age group. In inpatient services, most service usage is from patients aged 0-10 and 20-70.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 10-50 and a higher-than-expected representation for those aged 0-10 and 50+. Patients aged 70-80 are represented in inpatients 2.4 times more than the local community, and patients aged 80+ are represented 4.4 times more.

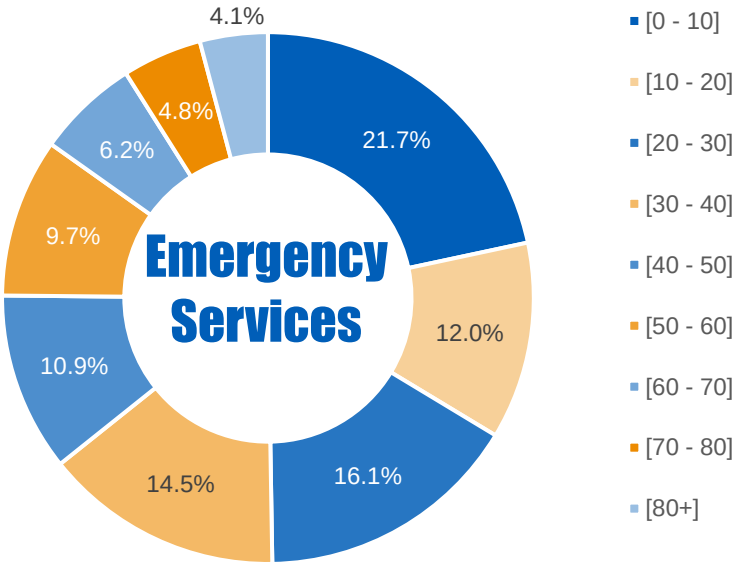


Chart 4 (left) represents patient use of emergency services by age groups. For these services, most service usage is from patients aged 0-50.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 30-50 and a higher-than-expected representation for those aged 0-10 and 50+. However, most age groups, whilst higher, are broadly in line with the local demographic.

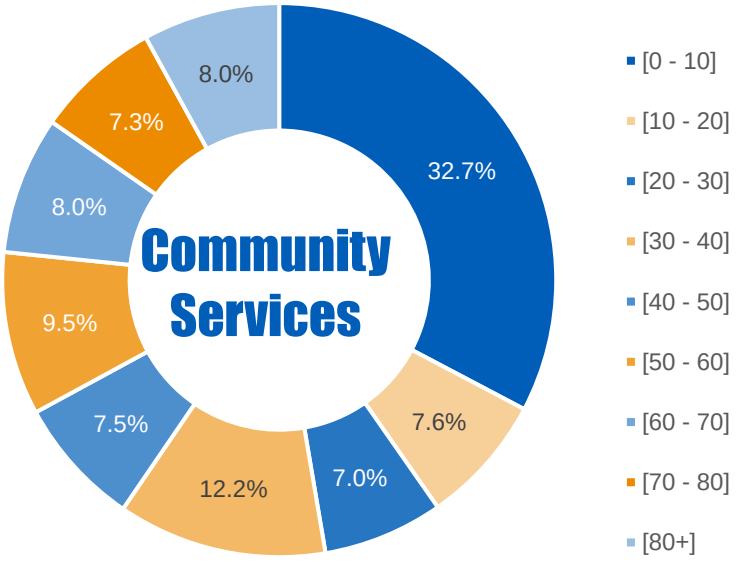


Chart 5 (left) represents patient use of community services by age group. The groups with the greatest representation in community services are 0-10, 30-40 and 50-60.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 10-50 and a higher-than-expected representation for those aged 0-10 and 50+. Patients 80+ have a 4.2 times greater representation in services compared to the local population

4.0.3 Disability

This information is not routinely collected through Medway or Rio, our patient information management systems.

4.0.4 Gender Reassignment

This information is not routinely collected through Medway or Rio, our patient information management systems.

4.0.5 Marriage and Civil Partnership

This section reviews patient attendance data by marital status who attended emergency services or were inpatients and outpatients. This information is unavailable for community patients as it is not routinely collected in Rio.

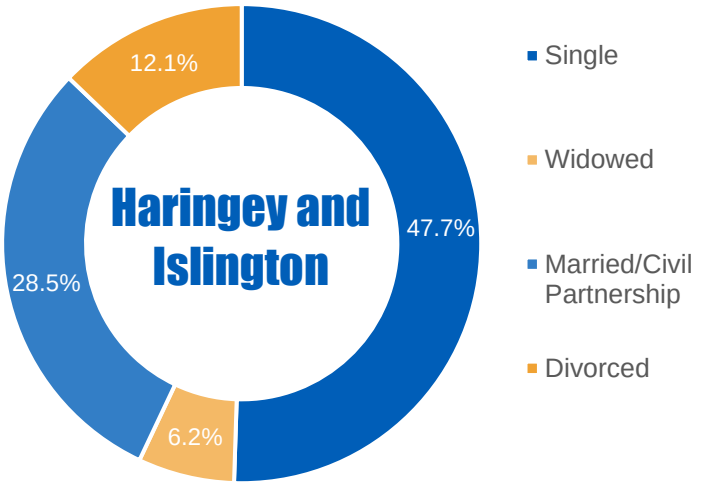


Chart 6 (left) represents the local population of Haringey and Islington broken down by marital status. The breakdown helps provide a point of comparison when looking at patient and service use data.

The categories have been adjusted to align with the Trust's Patient Management System categorisation to allow for direct comparison.

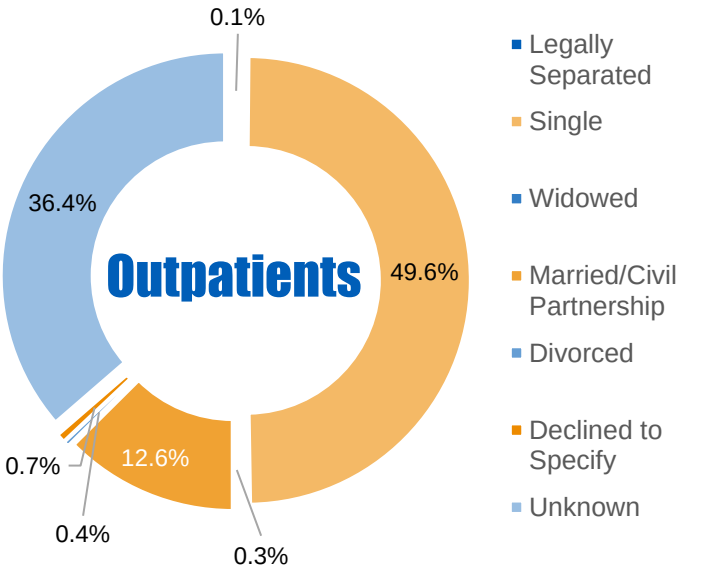


Chart 7 (left) represents patients that attended outpatient services broken down by marital status. Overall, the largest groups to have attended outpatient services are single and patients where their status is unknown.

Compared to Haringey and Islington's local population, there is a much lower representation of patients who are either married or in a civil partnership attending outpatient services. However, it should be noted that over a third of patients' marital status is unknown; the true reflection of the patient demographic for marriage and civil partnership using outpatient services cannot be seen.

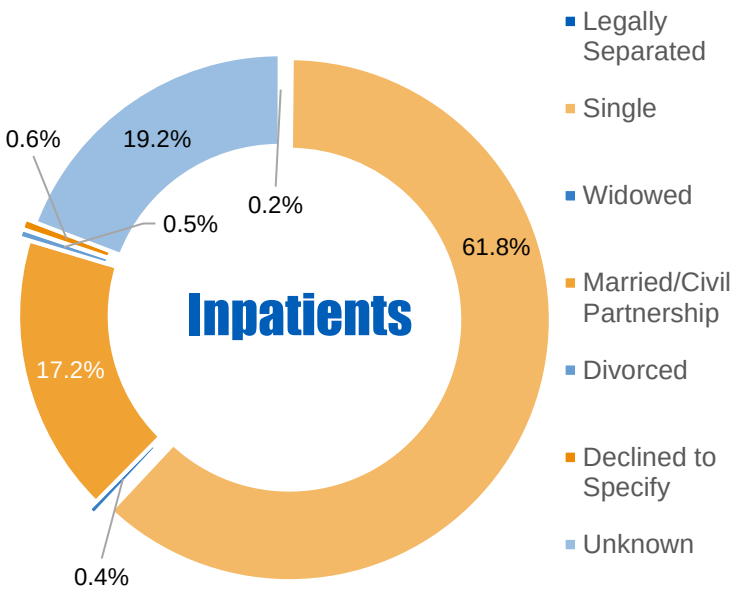


Chart 8 (left) represents patients that attended inpatient services broken down by marital status. Overall, the largest groups to have attended inpatient services are single and patients where their status is unknown, followed by those who are married or in a civil partnership.

Compared to Haringey and Islington's local population, there is a much lower representation of patients who are either married or in a civil partnership attending inpatient services. However, it should be noted that nearly a fifth of the patient's marital status is unknown; the true reflection of the patient demographic for marriage and civil partnership using inpatient services cannot be seen.

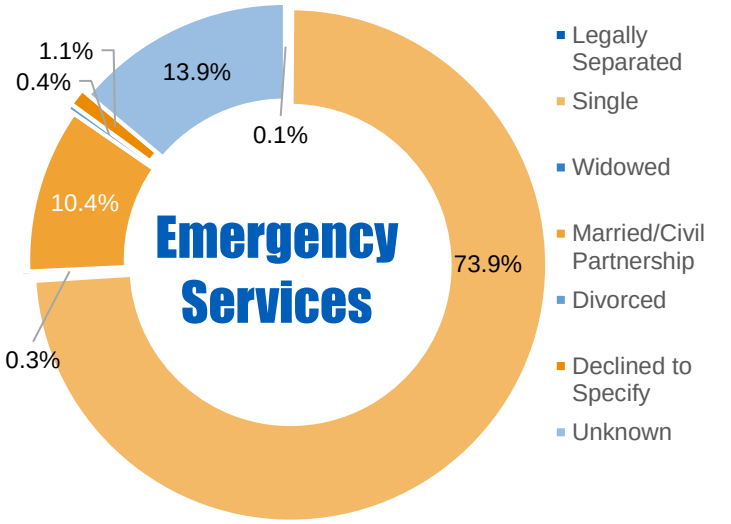


Chart 9 (left) represents patients that attended emergency services broken down by marital status. Overall, the largest groups to have attended emergency services are single and patients where their status is unknown, followed by those who are married or in a civil partnership.

Compared to the local population of Haringey and Islington, nearly all groups have a much lower representation (except single patients).

4.0.6 Pregnancy and Maternity

This information is not routinely collected through Medway or Rio, our patient information management systems.

4.0.7 Race (this includes ethnic or national origins, colour or nationality)

For all areas, the predominant race is White British, and the proportion of white patients is lower than that of the local population.

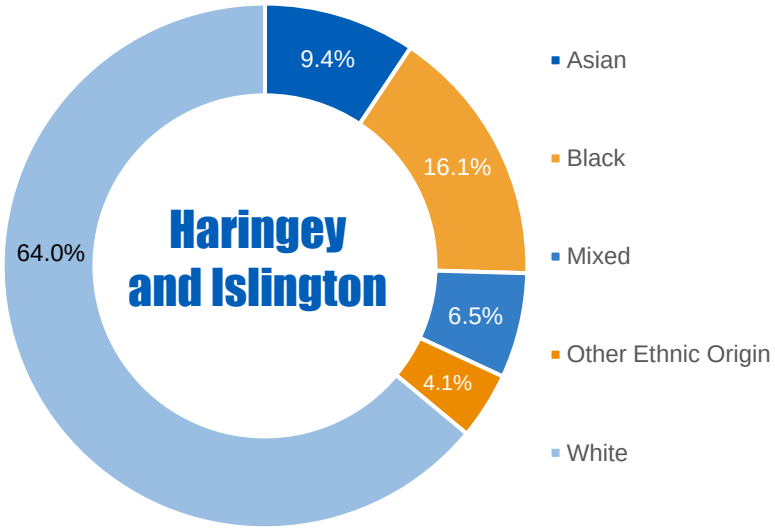


Chart 10 (left) shows the representation of ethnic categories in the local population of Haringey and Islington. The local demographic data will help aid comparison when looking at the use of Trust services by patients.

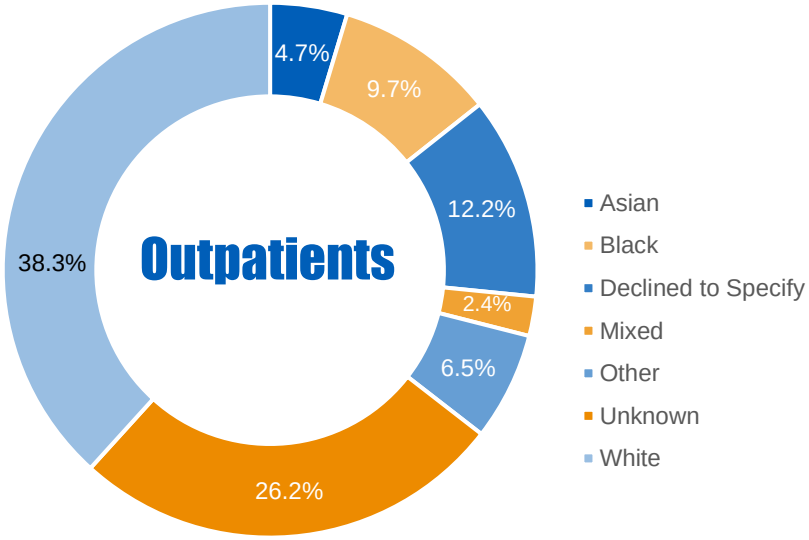


Chart 11 (left) represents patients that attended outpatient services broken down by ethnic categories. Overall, the largest groups to have attended inpatient services are White, followed by patients whose ethnic category is unknown.

When comparing to the local population of Haringey and Islington, there is a lower representation in most groups (nearly half as much) using outpatient services. For 'other' patients, there is a greater representation using outpatient services (nearly a third more).

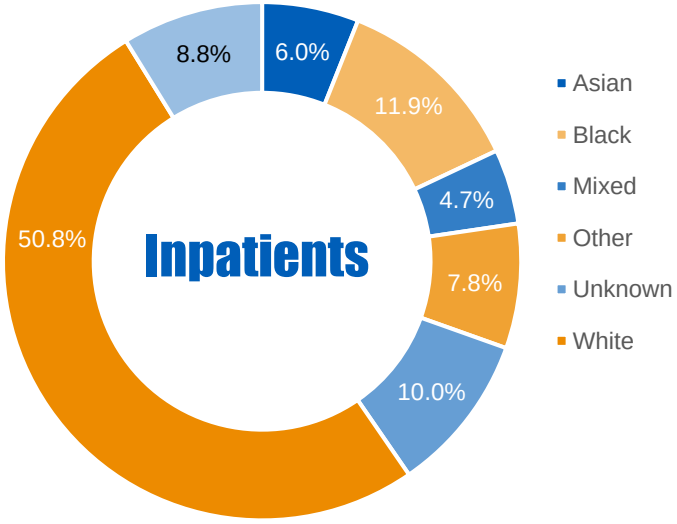


Chart 12 (left) represents patients that attended inpatient services broken down by ethnic categories. The largest groups to use inpatient services are White and Black patients.

Compared to the local population of Haringey and Islington, most groups have a lower representation (Asian, Black, and Mixed, about a third less). There is a greater representation of patients in the 'other' category (nearly twice more).

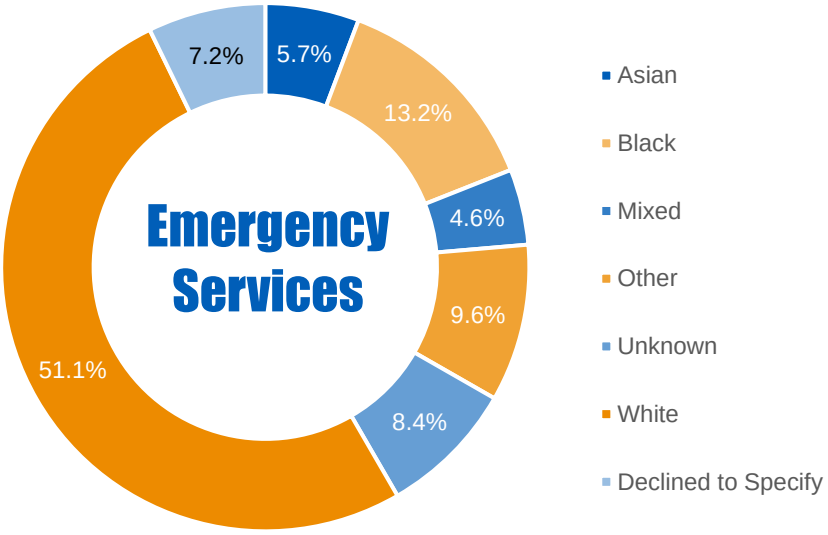


Chart 13 (left) represents patients using emergency services at the Trust. The largest groups to use these services are White and Black patients.

When comparing to the local population, there is a lower representation in most groups; the exception to this is patients in the 'other' category, where there is a greater representation

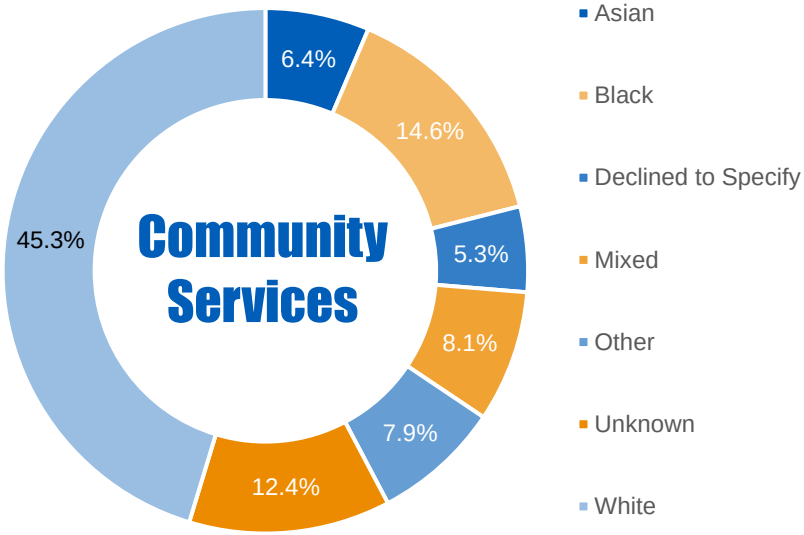


Chart 14 (left) represents patients using community services at the Trust. Overall, the largest groups to use these services are White, Black, and patients whose ethnic category is unknown.

When comparing to the local population, there is a lower representation in most groups; the exception to this is patients in the 'Other' category, where there is a greater representation

4.0.8 Religion or belief

It is difficult to comment accurately on patients' religion or belief representation, as over 50% of patients' demographic data in all services is unknown. Where religion or belief is known, 10-20% register as having no religion, and 13-6-18.6% are Christian or of a Christian denomination. Patients with 50 different religions or beliefs attended Whittington Health last year. This information is not routinely collected on Rio, so it is impossible to comment about community patients.

Table 1 (below) shows the limited data available from the service use of patients at the Trust.

Religion	Haringey and Islington	Outpatients	Inpatients	Emergency Services
Buddhist	1.1%	0.2%		0.2%
Christian	42.8%	13.6%	18.5%	14.4%
Declined to specify		2.4%	2.5%	4.3%
Hindu	1.4%	0.5%	0.5%	0.3%
Jewish	2.1%	0.8%	1.3%	0.5%
Muslim	12.1%	4.5%	5.3%	5.6%
No Religion	27.4%	10.0%	12.7%	20.2%
Other	0.5%	0.3%	0.4%	0.2%
Sikh	0.3%	0.1%	0.1%	0.1%
Unknown	12.4%	67.7%	58.8%	54.2%

4.0.9 Sex

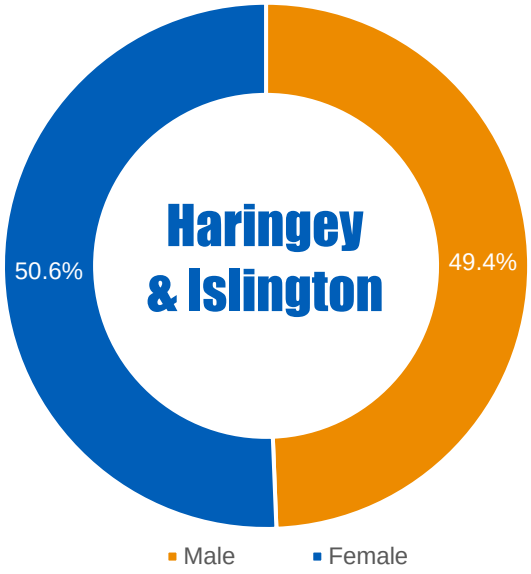


Chart 15 (left) shows the representation of sex in the local population of Haringey and Islington.

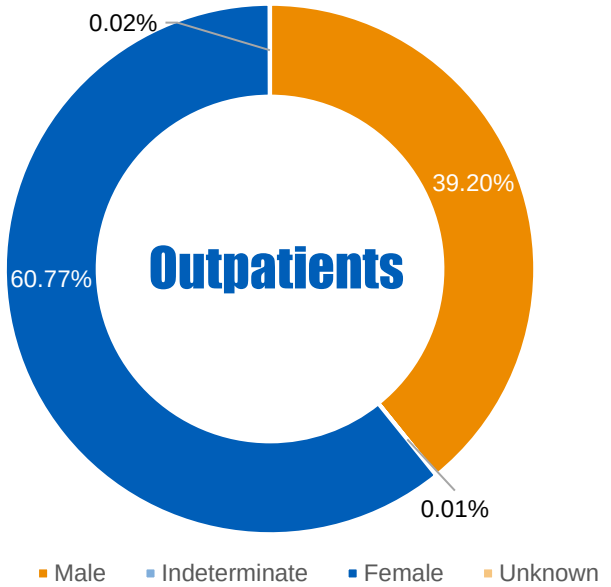


Chart 16 (left) represents the sex of patients using outpatient services. Overall, there are more women than men who have attended outpatient appointments.

Compared to Haringey and Islington's local population, more women and fewer men attend outpatient services.

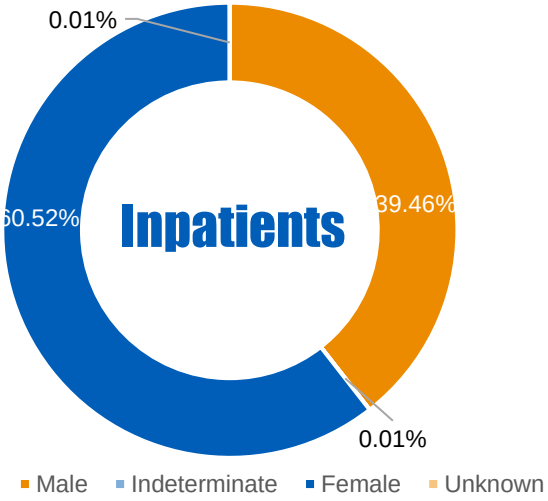


Chart 17 (left) represents the sex breakdown in patients attending inpatient services at the Trust.

Compared to Haringey and Islington's local population, more women and fewer men attend outpatient services.

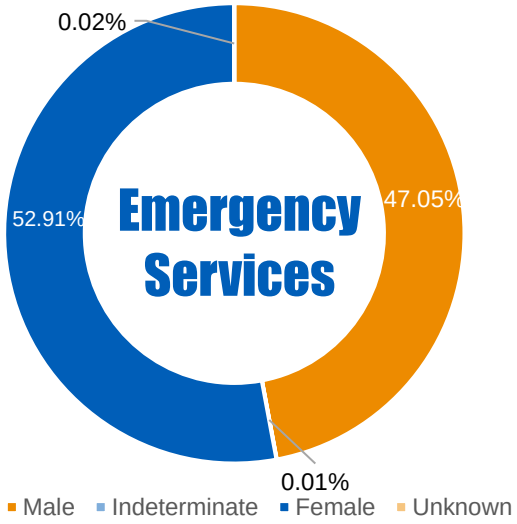


Chart 18 (left) represents the sex breakdown in patients attending emergency services at the Trust.

Compared to the local population of Haringey and Islington, the representation is broadly similar for male and female patients.

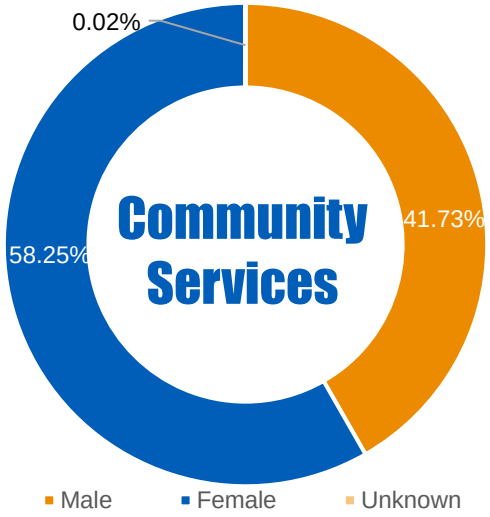


Chart 19 (left) represents the sex breakdown in patients attending community services at the Trust.

Compared to the local population of Haringey and Islington, the representation there are proportionally more female and fewer male patients.

4.0.10 Sexual orientation

This information is not routinely collected through Medway or Rio, our patient information management systems.

4.1 Complaints

This section highlights information about patients that have raised concerns or complaints by our Complaints Department or PALS Team. Not all protected characteristics are reported on in this section:

4.1.1 Age (Profile of complainants)

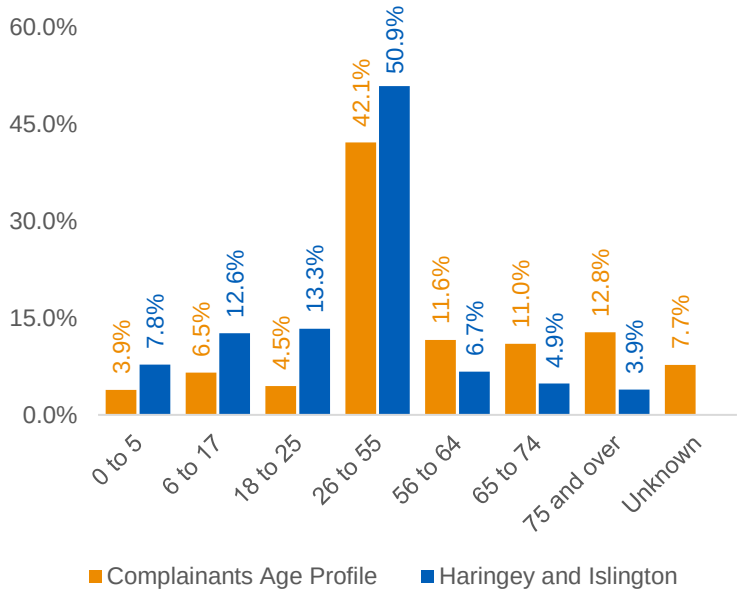


Chart 20 (left) shows the age profile of those raising complaints/concerns during 21/22. The local population of Haringey and Islington is included for comparison.

The group raising the majority of complaints and concerns are those aged 26-55 – however, this is the largest group, so it is not surprising. From 0-55, there is a lower proportion of people raising complaints and concerns compared to the local demographic; however, from 56+, there is a greater proportion than the local demographic. Data for service use representation is incompatible with the complainant's data profile; therefore, no meaningful comparison can be made.

4.1.2 Race (this includes ethnic or national origins, colour or nationality)

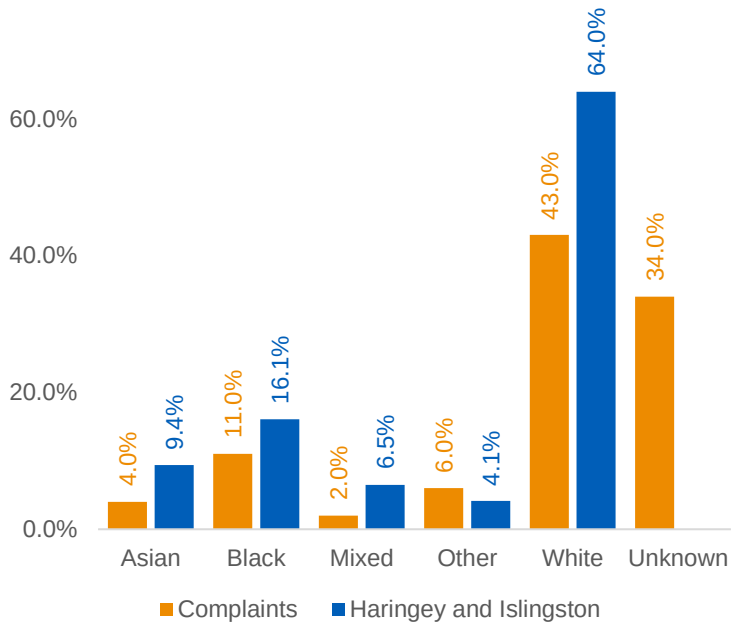


Chart 21 (left) shows the number of complaints/concerns raised during 21/22 broken down by race. The local population of Haringey and Islington is included for comparison.

The groups that have raised the majority of complaints and concerns are white, and where their race is unknown. For those raising complaints/concerns, the representation is lower than the local profile, except for the Other group (slightly higher). When comparing to service use data, none of the known groups would suggest an overrepresentation in complaints. However, with over a third of complaints, the race category is unknown; this may not be an accurate assessment.

4.1.3 Sex

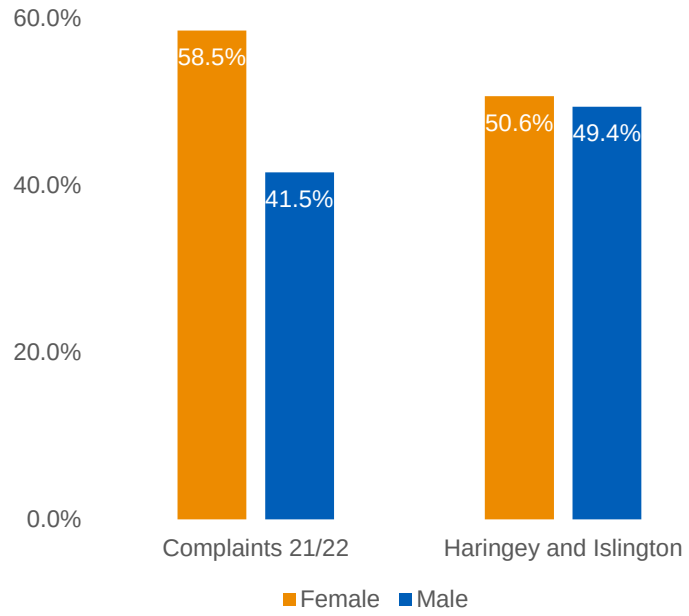


Chart 22 (left) shows the breakdown of the number of complaints/concerns raised by sex, the demographic information for Haringey and Islington has been included for comparison.

Females have raised most complaints, proportionally higher than the local population. Compared to service use data, the gender breakdown of complaints is broadly in line, except in Emergency services, where women are slightly overrepresented and men under in complaints/concerns data.

4.3 Serious Incidents

Serious Incidents in health care are adverse events where the consequences to patients, families and carers, staff or organisations are so significant that the potential for learning is so great that a heightened level of response is justified.

Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death and injury resulting in serious harm. This includes those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

During 2021/22, there were 30 serious incidents; this section explores the demographical breakdown of these incidents. Please note that some incidents will involve multiple people, and only the protected characteristics that can be reported are listed below.

4.3.1 Age

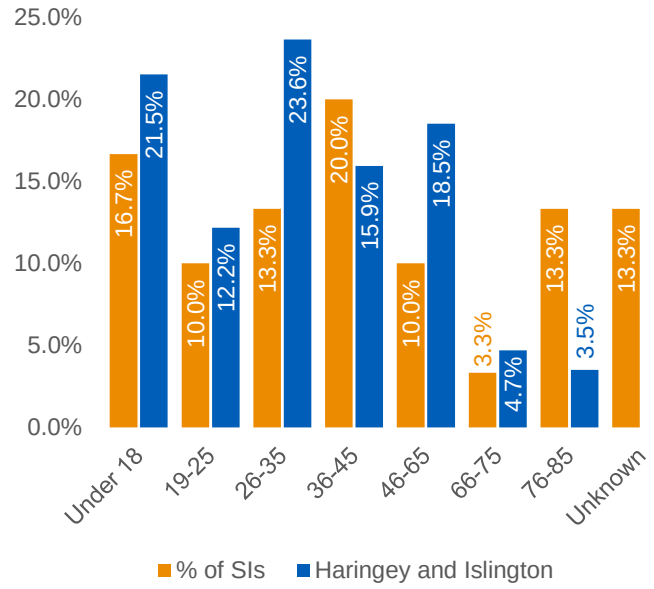


Chart 23 (left) shows the representation of age in serious incidents; comparable demographical data for Haringey and Islington is also included to aid comparison.

When comparing the local demographic data to Trust data about serious incidents, most groups are not overrepresented except for groups 36-45 and 76-85. Data from service use is not compatible with the serious incident data; therefore, a meaningful comparison cannot be made.

4.3.2 Disability

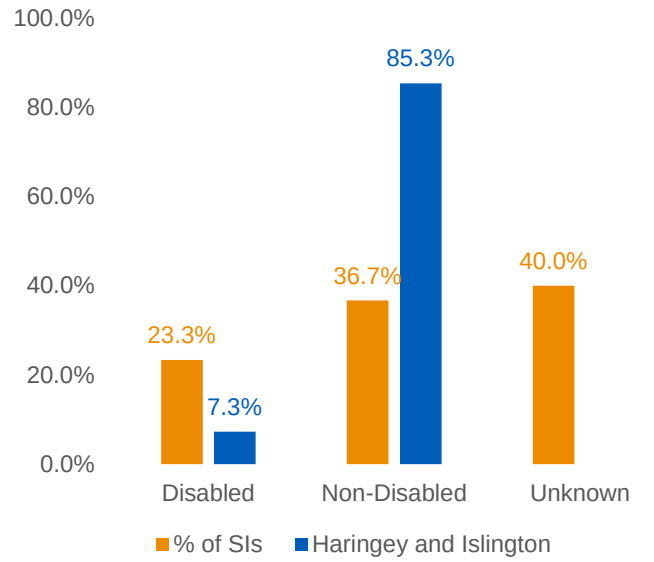


Chart 24 (left) shows the representation of disability in reported serious incidents, the demographic data relating to the local population have been included to aid comparison.

Disabled patients are overrepresented in the Trust's reported serious incidents data compared to the local demographic data by nearly three times more. Non-disabled representation is just under half the representation of the local population. There is no service use data on disability to compare serious incidents.

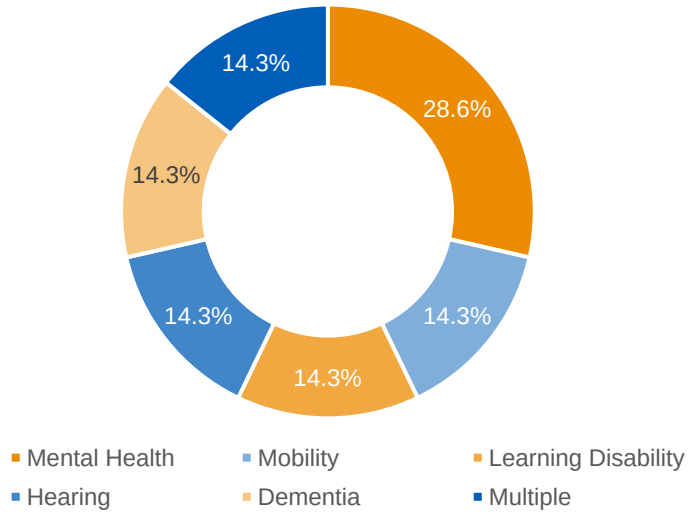


Chart 25 (left) provides a further breakdown of the health conditions of the disabled patients featured in (Chart 24 above).

The group with the highest level of representation are patients with mental health conditions.

4.3.3 Race (this includes ethnic or national origins, colour or nationality)

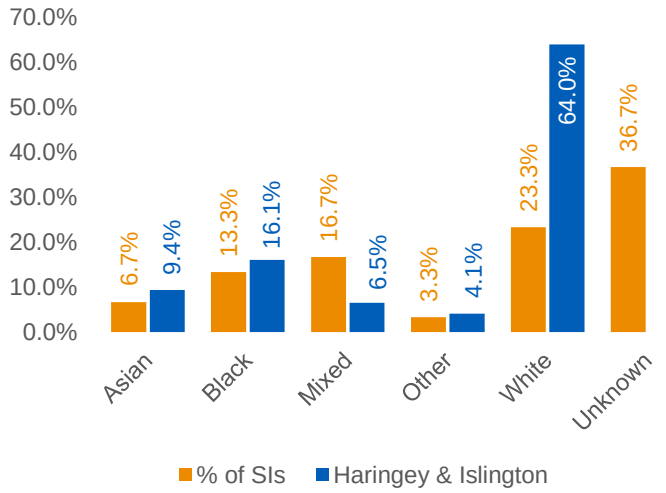


Chart 26 (left) shows the representation of race in serious incidents; the local population demographic data is included to aid comparison.

The Mixed group has a higher representation in the Trust's serious incidence data than the local population. All other groups have lower representation; however, with over 36% of serious incidents being unknown, this may not be an accurate assessment.

Compared to service use data, the mixed group has a greater representation, the Black group has a higher representation of serious incidents than inpatient and community services, and the Asian group has a greater representation (serious incidents) than community services.

4.3.4 Sex

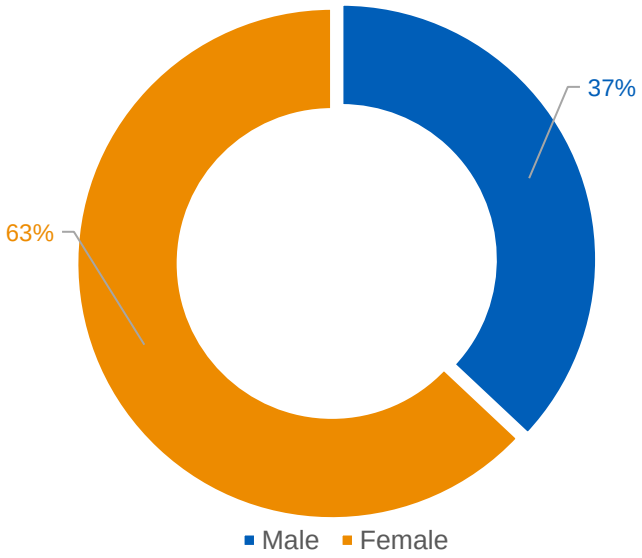


Chart 27 (left) shows the representation of sex in serious incidents.

Females are overrepresented in serious incidents compared to the local population, and males are underrepresented.

Compared to service use data, the gender breakdown of complaints is broadly in line, except in Emergency services, where women are slightly overrepresented and men under in serious incidents data.

4.3 Patient language and communication services

The trust uses interpreter and translation services to meet our diverse patient base's language and communication needs across all sites. The Trust has access to a range of in-house interpreters that meet most of the interpreting requests. Where the in-house interpreters cannot meet a request, requests are sent to the external provider, The Big Word, to meet.

During 2021/22, the top ten languages used throughout our acute and community services were:

1 Turkish
2 Spanish
3 Bengali
4 Arabic
5 Albanian
6 Somali
7 Polish
8 Portuguese
9 Farsi/Persian
10 Romanian

During 2021/22, the Trust received 425 British Sign Language interpreting requests, of which 240 came from acute services and 185 from community services. Our in-house interpreters completed 308 (72.5%) sessions, 65 (15.3%) sessions were covered by our external supplier and 52 (12.2%) were not covered, usually leading to a rebooking.

4.4 Summary of observations from patient data

4.4.1 Age

Overall, the greatest attendees to all our services are from age groups 0-10 and 50+; compared to the local demographic, we see a high representation of patients aged 70+ in our outpatient, inpatient, and community services.

Patients aged 56+ appear to raise a higher-than-expected number of complaints. Patients aged 36-45 and 76-85 appear to be proportionally overrepresented in serious incidents.

4.4.2 Disability

Data collection appears not to be routinely collected in many factors that relate to the patient journey in all Trust services.

Compared to local demographic data, disabled patients are overrepresented in serious incidents. However, with 40% of serious incidents where the patient's disability status is unknown, this may not be an accurate picture.

4.4.3 Gender Reassignment

Data is not collected for this protected characteristic related to the patient journey in all Trust services.

4.4.4 Marriage and Civil Partnership

Data collection is only available for service use for this protected characteristic. However, it is not collected in community services. A high level of unknowns within the datasets impacts the data quality.

4.4.5 Pregnancy and Maternity

Data is not collected for this protected characteristic related to the patient journey in all Trust services.

4.4.6 Race (this includes ethnic or national origins, colour or nationality)

Compared to the local demographics, most groups have a lower-than-expected representation in service use data for most services; the only exception is for patients in the 'Other' ethnic category.

For complaints data, over a third of complainants' ethnic category was unknown, impacting data quality. The only group that demonstrated an overrepresentation in the process was patients from the 'Other' ethnic category.

Most groups have a lower-than-expected representation in serious incident data, except for the Mixed ethnic category. However, 36.7% of the patient's ethnic category is unknown, impacting data quality.

4.4.7 Religion or Belief

For service use, an extremely high number of patients use our services where their religion or belief is unknown (circa 60%). Religion or belief is not collected in community services.

4.4.8 Sex

For the majority of Trust services, compared to the local demographic, there is a greater proportion of female patients; this ultimately means a lower-than-expected number of male patients are using Trust services. The exception is within Emergency Services, where representation is broadly equal to the local population. This same trend follows into representation in complaints/concerns and serious incidents; however, representation in these processes is broadly in line with service use.

4.4.9 Sexual Orientation

Data is not collected for this protected characteristic related to the patient journey in all Trust services.

C. Workforce

5.0 Workforce Representation

The following information is displayed in order of protected characteristics.

5.0.1 Age

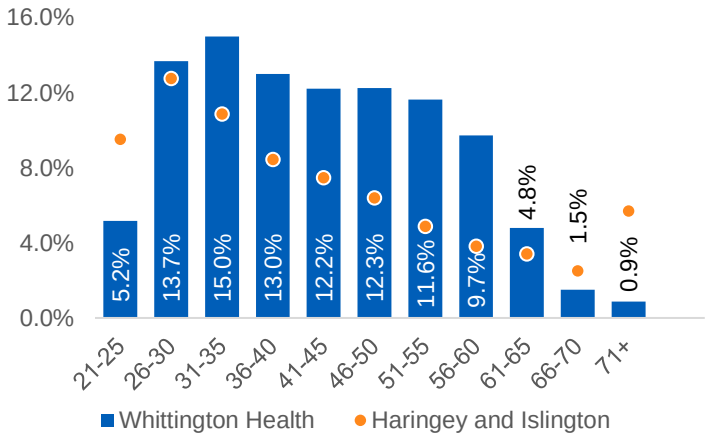
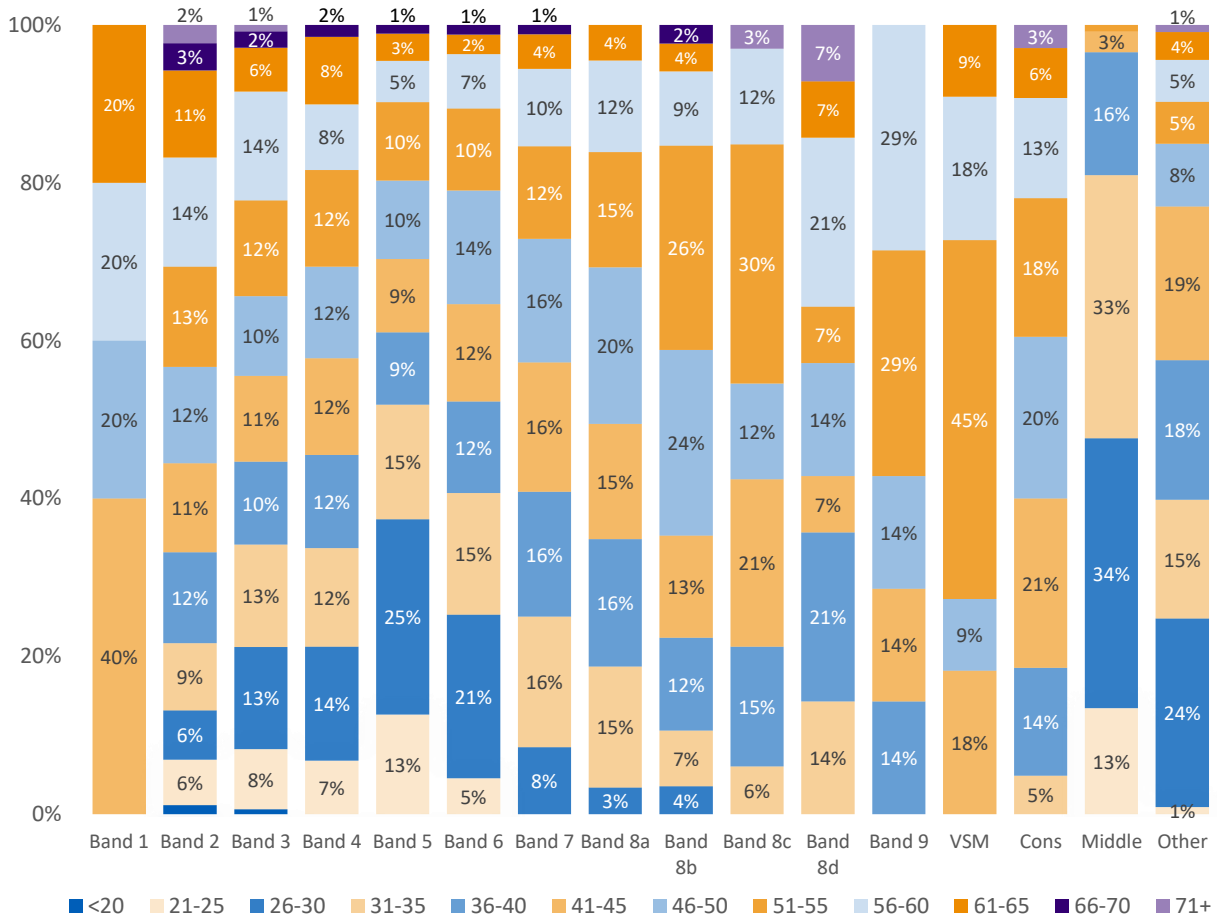


Chart 28 (left) shows the age profile of the Trust's workforce and the profile of residents of Haringey and Islington.

The chart shows the biggest proportion of the workforce is aged between 26-55; each category represents 12-15% of staff. The chart also demonstrates that the Trust has a good representation of staff aged 26-65 compared to the local population. There is also a lower representation of staff aged 21-25 and 66+ compared to the local population.

Chart 29 (below) shows the breakdown by pay band of the Trust's workforce by age.



Pay band or grade	*Age groups that have the highest representation in pay band or grade*
Band 1	*41-50*
Band 2	*26-65*
Band 3	*26-60*
Band 4	*26-55*
Band 5	*21-55*
Band 6	*26-55*
Band 7	*31-55*
Band 8a	*31-55*
Band 8b	*36-55*
Band 8c	*41-55*
Band 8d	*36-40, 46-50 and 56-60*
Band 9	*51-60*
VSM	*51-60*
Medical – consultants	*41-55*
Medical – middle grade	*26-35*
Medical - other	*26-45*

Table 2 (left) highlights what age groups have the greatest representation of pay bands and grades.

Typically, we will see the greatest concentration of younger workers in bands 2-6 and medical roles classified as other or middle grade.

Conversely, older workers have high levels of representation in more senior roles (band 8 a-d, 9, VSM and medical consultants). However, older workers are represented throughout all pay bands and grades.

Table 3 (below) compares the representation of the age group in the workforce to the actual representation in the band/grade. Higher means greater than workforce representation, lower representation is lower than workforce representation, and equal representation is equal to workforce representation.

Age group	*Higher representation*	*Equal representation*	*Lower representation*	*No representation*
<20	Bands 2 and 3	None	None	Bands 4-9, VSM and medical grades
21-25	Bands 2-5, medical- middle	Band 6	Medical – other	Bands 7-9, VSM and medical consultants
26-30	Bands 5-6, medical middle and other	None	Bands 2-4, 7-8b.	Bands 8c-9, VSM and medical consultants
31-35	Bands 5-8a and medical middle and other	Band 8d	Bands 2-4, 8b-c and medical consultants	Band 9 and VSM
36-40	Bands 7-8a, 8c-9 and all medical roles	Bands 2, 4 and 8b	Bands 3, 5 and 6	VSM
41-45	Bands 1,7, 8c, VSM medical consultant and other	8a	Bands 2-6, 8b, 8d-9 and medical middle	None
46-50	Bands 1-6, 8b, 8d-9 and medical consultants	None	Bands 2-5, 8c, VSM and medical consultants	None
51-55	Bands 2, 8a-c, 9 VSM and medical consultants	Bands 3-4	Bands 5-7, 8d and medical middle & other	None
56-60	1-3, 7-8a, 8c-9, VSM and medical consultants	8b	Bands 4-6 and medical - other	Medical middle
61-65	Bands 1-4, 8d, VSM and medical consultants	None	Bands 5-8b and medical - other	Bands 8c, 9 and medical middle
66-70	Bands 2-4 and 8b	Band 5-7	None	Bands 8a, 8c-9, VSM, all medical
71+	Bands 2-3, 8c-d and medical consultants and other	None	None	Bands 4-8b, 9, VSM and medical middle

5.0.2 Disability

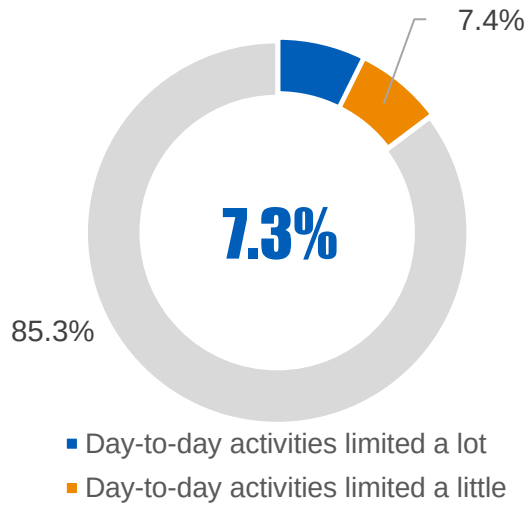


Chart 30 (left) represents the local population of Haringey and Islington by health status.

The categories asked in the Census are not entirely compatible with data held on our Electronic Staff Record system. However, at least 7.3% of local residents are likely to have a disability. However, there are approximately 5% fewer staff within the Trust than in the local community.

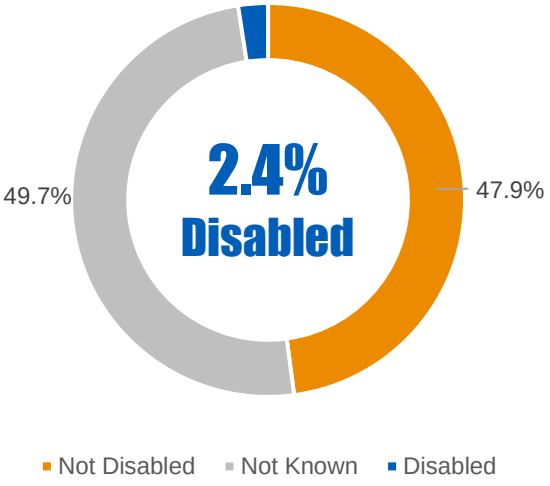


Chart 31 (left) represents the Trust's workforce. 2.4% of staff have declared that they have a disability; this is the same as last year. One of the Trust's priorities is to improve the data on the Electronic Staff Records system about diversity data, as 48% of the workforce's disability status is unknown.

In the 2021 NHS Staff Survey, 17% of respondents highlighted that they have a disability. This means there is a 15% difference between the NHS Staff Survey and local ESR data.

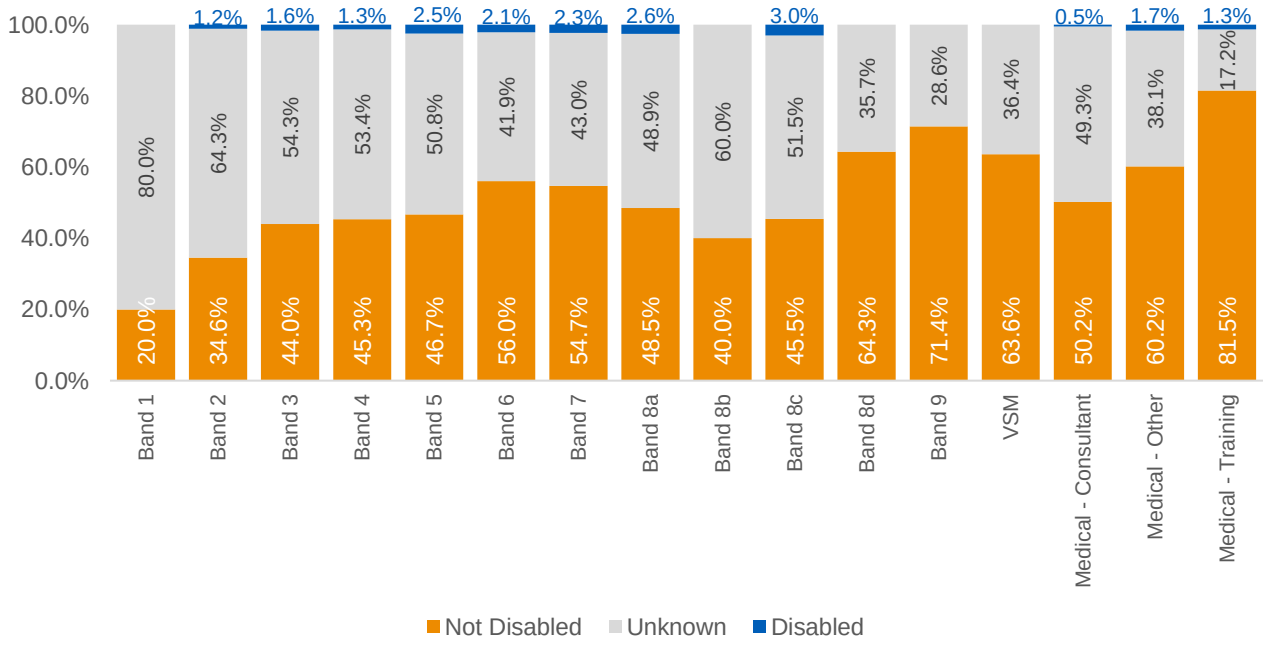


Chart 32 (above) shows the pay bands and grades broken down by disability status. There is not sufficient data to draw firm and accurate conclusions.

However, from the available data, when comparing disabled staff in pay bands and groups compared to overall workforce representation, we can see that:

- In bands 2-4 – there is a slight underrepresentation of disabled staff
- In bands 5-8a and 8c, there is a slightly higher than expected representation of disabled staff.
- In bands 8b, 8d-9, and VSM, staff have not declared their disability status.
- All medical roles have an under-representation of staff that have declared they are disabled.
- There is a high level of staff whose disability status is either unknown or elected not to share their status.

5.0.3 Gender Reassignment

Nationally, it is impossible to record gender reassignment/identity on Electronic Staff Records; this is currently under review. Until national updates are made to the ESR system, it will not be possible to report on this protected characteristic.

5.0.4 Marriage and civil partnership

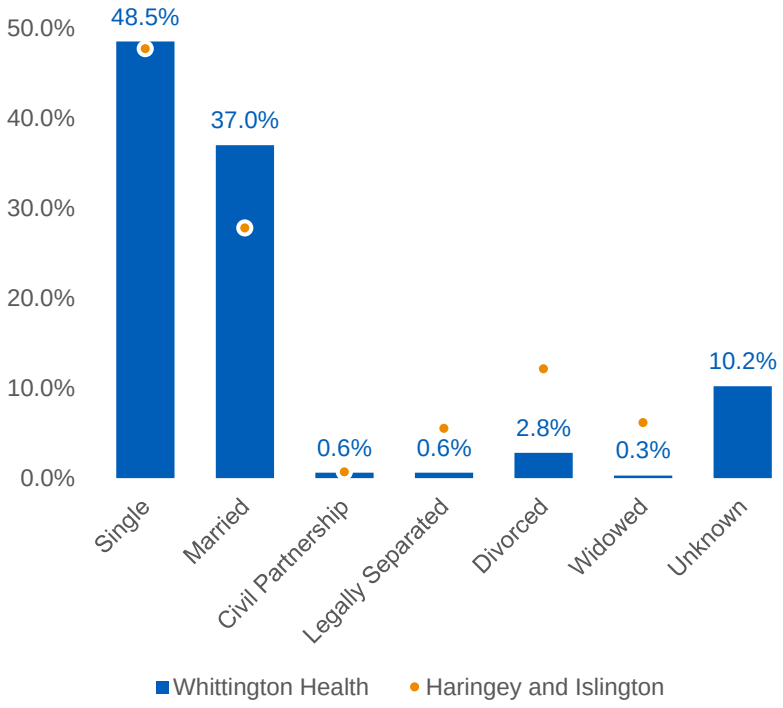


Chart 33 (left) shows the Trust's workforce broken down by marital status compared to the residents of Haringey and Islington.

The Trust's workforce has proportionally more people that are either married or single compared to the local population. There are slightly fewer staff than the population in a civil partnership, and all other categories (except unknown) have a greater representation in the local community than in the workforce.

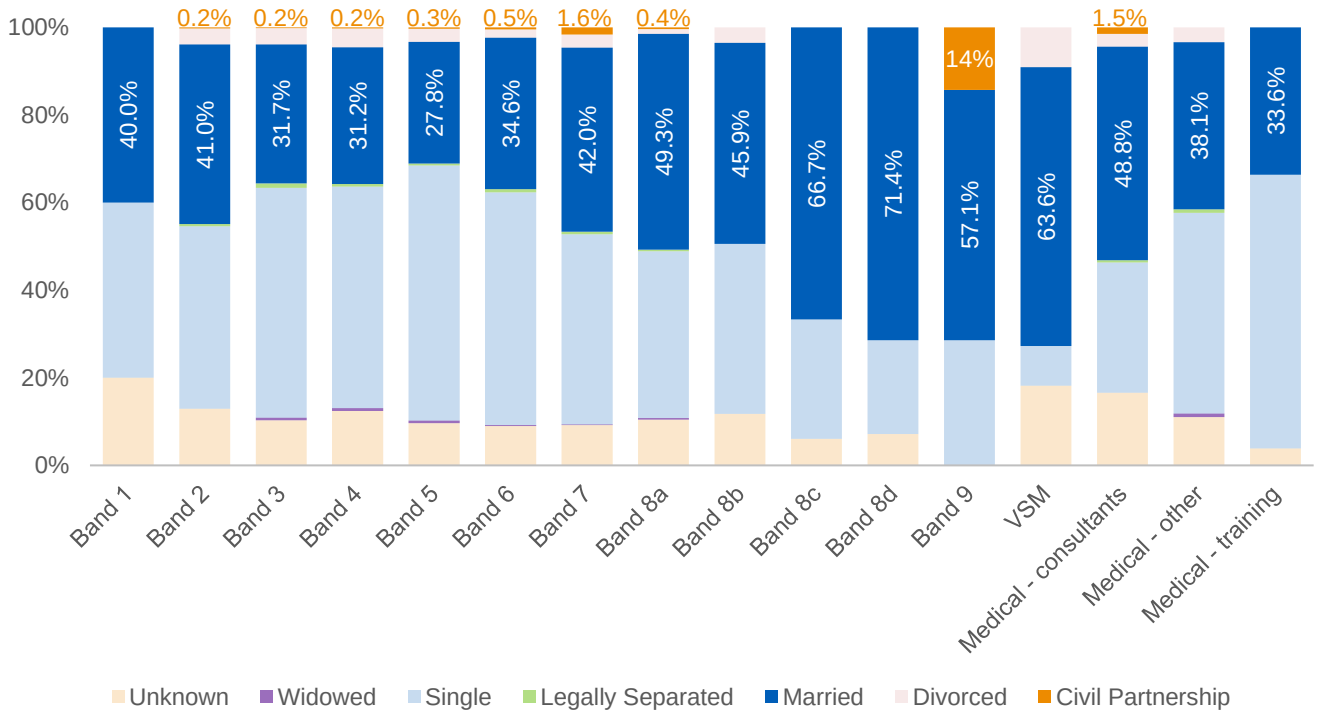


Chart 34 (above) shows pay bands and grades by marital status. Please note only the categories married and civil partnership have been labelled and will be commented on.

When comparing the breakdown provided in chart 33 to the overall workforce representation:

- For the characteristic of marriage: there is a greater than expected representation in bands 1-2, 7-9, VSM and medical consultants and other. There is a lower-than-expected representation in bands 3-6 and medical in training.
- For the characteristic of civil partnership: there is a greater than expected representation in bands 7, 9 and medical consultants. All other bands have either a lower-than-expected representation or no representation.

5.0.5 Pregnancy and maternity

One hundred twenty-seven women were recorded on ESR as being on maternity leave as a snapshot on 31st March 2022. This represents just 0.03% of the female population of the Trust. It is impossible to know the number of all women in the Trust who are pregnant because there is no requirement to record it until the Maternity Certificate can be issued after 20 weeks of pregnancy. ESR will only record those who have completed and submitted their certificates.

5.0.6 Race (this includes ethnic or national origins, colour or nationality)

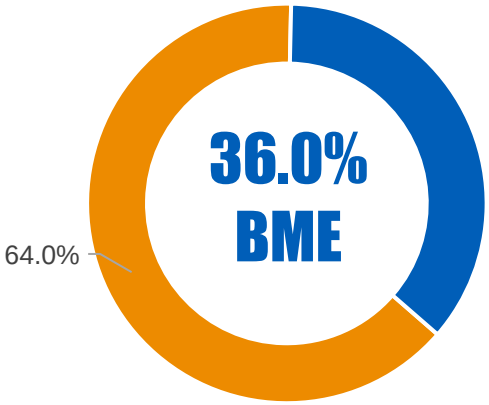


Chart 35 shows the representation of the population of Haringey and Islington broken down by ethnicity.

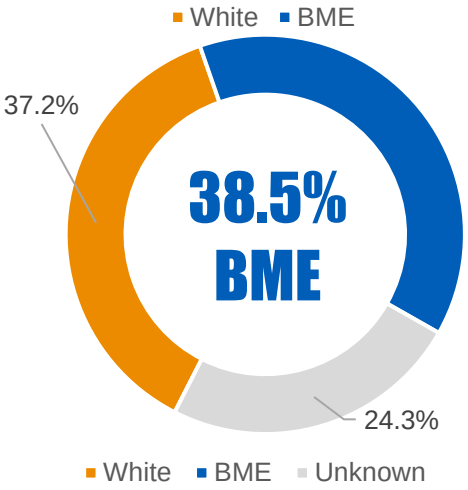


Chart 36 (left) represents the Trust's workforce by ethnicity.

Compared to the local population (chart 35), there is a greater representation of BME staff and fewer white staff. However, about one-quarter of the workforce's ethnicity is not known.

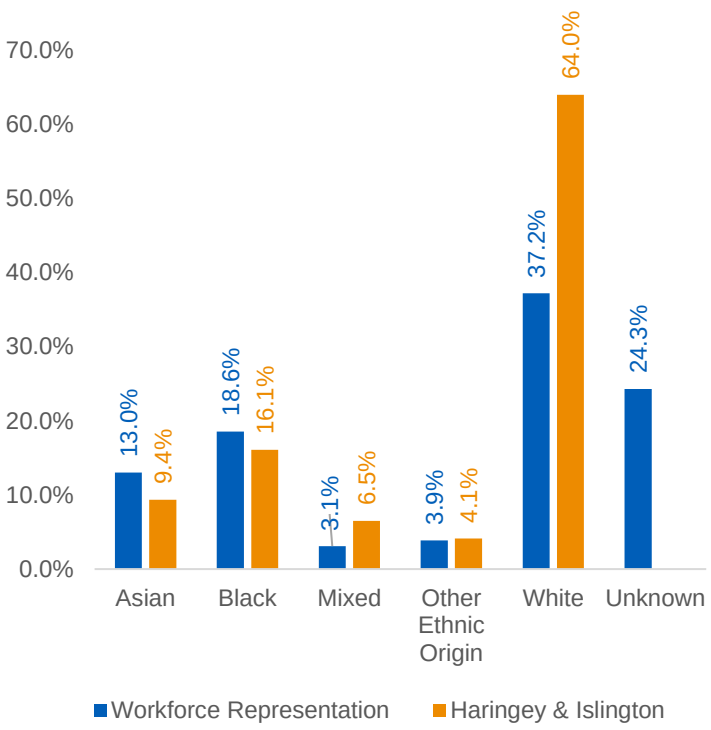


Chart 37 (left) breaks down the representation of the BME category into smaller ethnic groups for the workforce at the Trust and the local population of Haringey and Islington.

Compared to the local population, the workforce has a higher-than-expected representation of Asian and Black staff, a lower-than-expected representation of mixed and White staff, and about the same representation of staff in the other ethnic origin category.

With nearly a quarter of the workforce's ethnic origin being unknown, the available data may not represent an accurate picture of the racial demographic breakdown of the workforce.

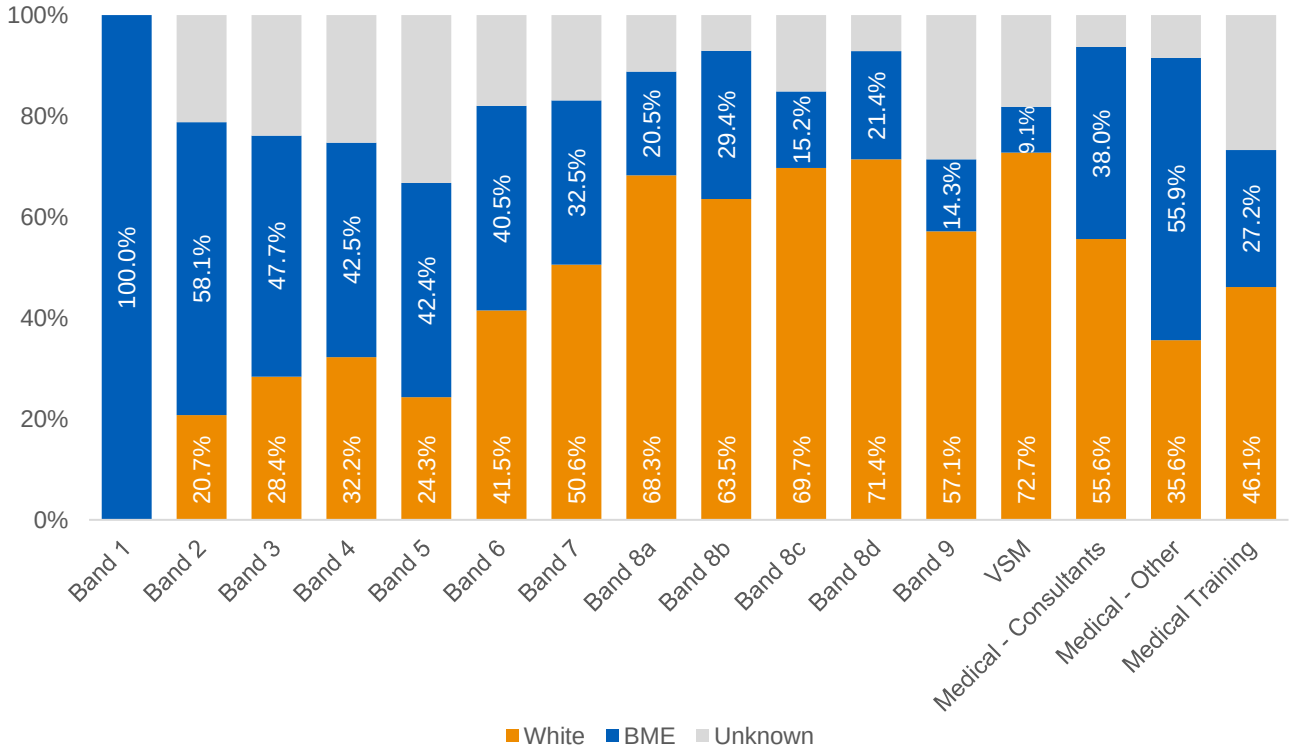


Chart 38 (above) shows the breakdown by pay band of the Trust's workforce by ethnicity. Although there is a 1% difference in the number of BME to white staff, the career path is notably different, with most BME staff represented up to Band 5, and white staff are in the majority from Band 6 onwards.

Most notably, there is a smaller-than-expected representation of BME staff from bands 7-9, VSM and medical consultant and training grades. BME staff have a greater representation than expected in bands 1-6 and medical - other.

However, nearly a quarter of staff have not declared their ethnicity, so the accurate picture of representation throughout the bands and grades will not be known until declaration improves.

5.0.7 Religion or belief

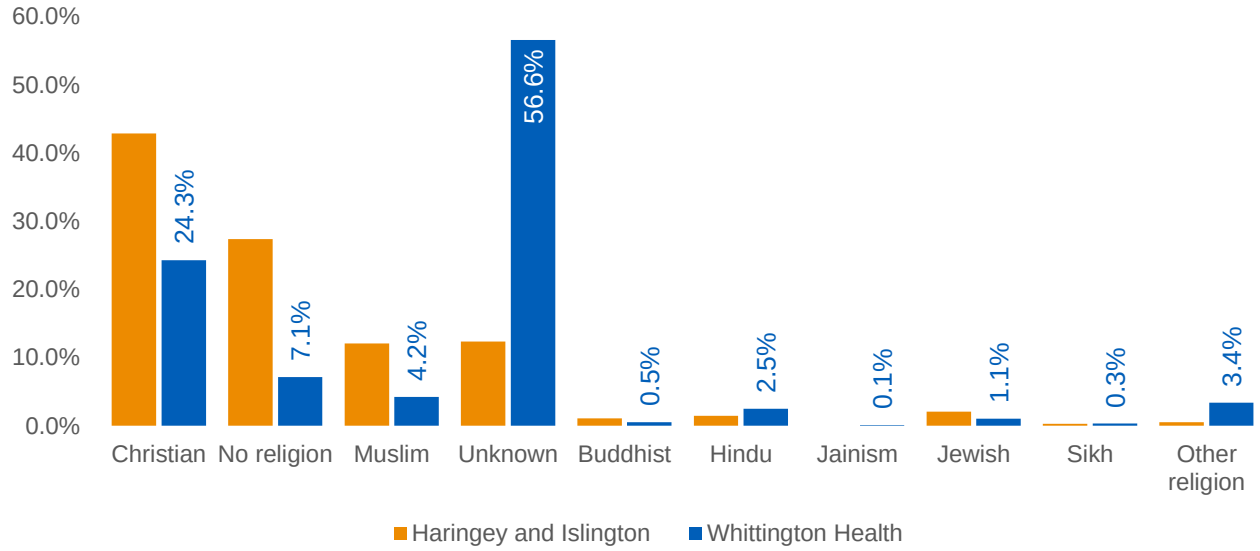


Chart 39 (above) shows the representation of religion and belief of the population of Haringey and Islington and the Trust's workforce. Within the Trust, the greatest representation is staff whose religion or belief is unknown/staff have elected not to share that information; the second largest group is Christian, and the third largest group are staff with no religion or belief.

When comparing the workforce to the local population, there is equal representation of Sikhs. There is a lower representation of Christians (-18.6%), those with no religion (-20.2%), Muslims (-7.8%), Buddhists (-0.6%) and Jews (-1.0%); conversely, there is a greater representation in the workforce of those where their religion or belief is unknown or where staff have elected not to share this information (+44.2%), Hindus (+1.0%), other religion (+2.9%). Jainism is not recorded as a separate religion in the 2011 Census.

Table 4 (below) represents the religion or belief broken down by pay band or grade, the items highlighted in green illustrate a higher-than-expected representation compared to the overall workforce.

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9
Atheism	0.5%	2.5%	4.1%	3.6%	4.3%	9.2%	8.8%	8.9%	20.0%	20.0%	9.1%
Buddhism	0.3%	0.8%	0.2%	0.3%	0.49%	0.4%					
Christianity	25.2%	26.8%	24.1%	19.3%	27.7%	26.7%	26.4%	25.7%	20.0%	33.3%	18.2%
Hinduism	1.9%	1.7%	1.3%	1.2%	1.1%	2.2%	3.0%	2.0%			9.1%
Islam	3.8%	5.7%	3.6%	3.2%	3.2%	3.5%	2.4%	3.0%	5.7%		
Jainism	0.3%		0.2%		0.1%	0.1%			2.9%		
Judaism		0.2%	0.2%	0.5%	1.3%	1.3%	1.0%	2.0%			
Other	2.7%	3.4%	4.3%	2.6%	2.7%	3.5%	5.1%	4.0%	5.7%	20.0%	
Sikhism		0.4%		0.2%	0.1%	0.6%			2.9%		
Declined to answer	7.8%	11.0%	16.6%	5.1%	11.0%	15.5%	25.3%	22.8%	14.3%	6.7%	9.1%
Unknown	57.6%	47.5%	45.4%	64.0%	48.0%	37.0%	28.0%	31.7%	28.6%	20.0%	54.5%

	VSM	Medical - Consultant	Medical - Other	Medical - Trainee
Atheism	7.1%	12.9%	4.8%	33.0%
Buddhism		1.4%	1.2%	1.4%
Christianity	28.6%	21.7%	15.7%	15.4%
Hinduism		7.4%	10.8%	8.2%
Islam		6.5%	19.3%	7.5%
Jainism				
Judaism		4.1%	1.2%	3.2%
Other		1.4%	2.4%	4.7%
Sikhism		1.4%	1.2%	0.7%
Declined to answer	14.3%	13.8%	16.9%	17.9%
Unknown	50.0%	29.5%	26.5%	7.9%

With high levels of staff with either unknown or declined to specify (56.6%), no meaningful conclusions can be made about the representation of religion or belief in pay bands or grades.

5.0.8 Sex

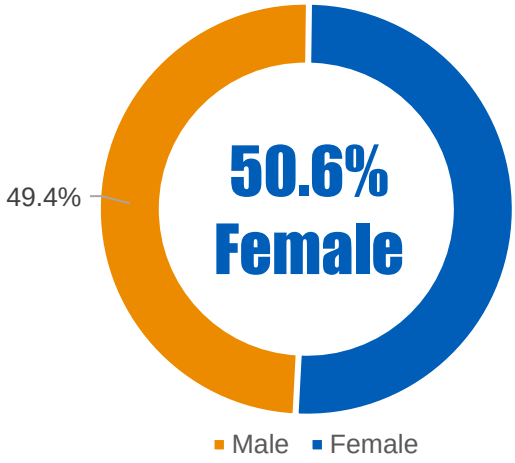


Chart 40 (left) shows the breakdown of the population of Haringey and Islington by sex. 49.4% of the population is male, and 50.6% is female.

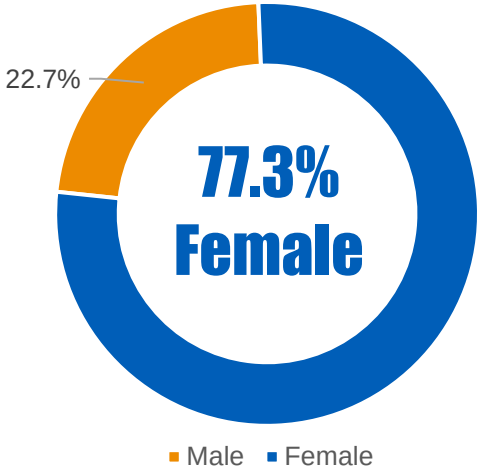


Chart 41 (left) shows the breakdown of the Trust's workforce by sex. Whilst the representation in the Trust does not reflect the local population, it does mirror the national NHS pattern of 77% female and 23% male.

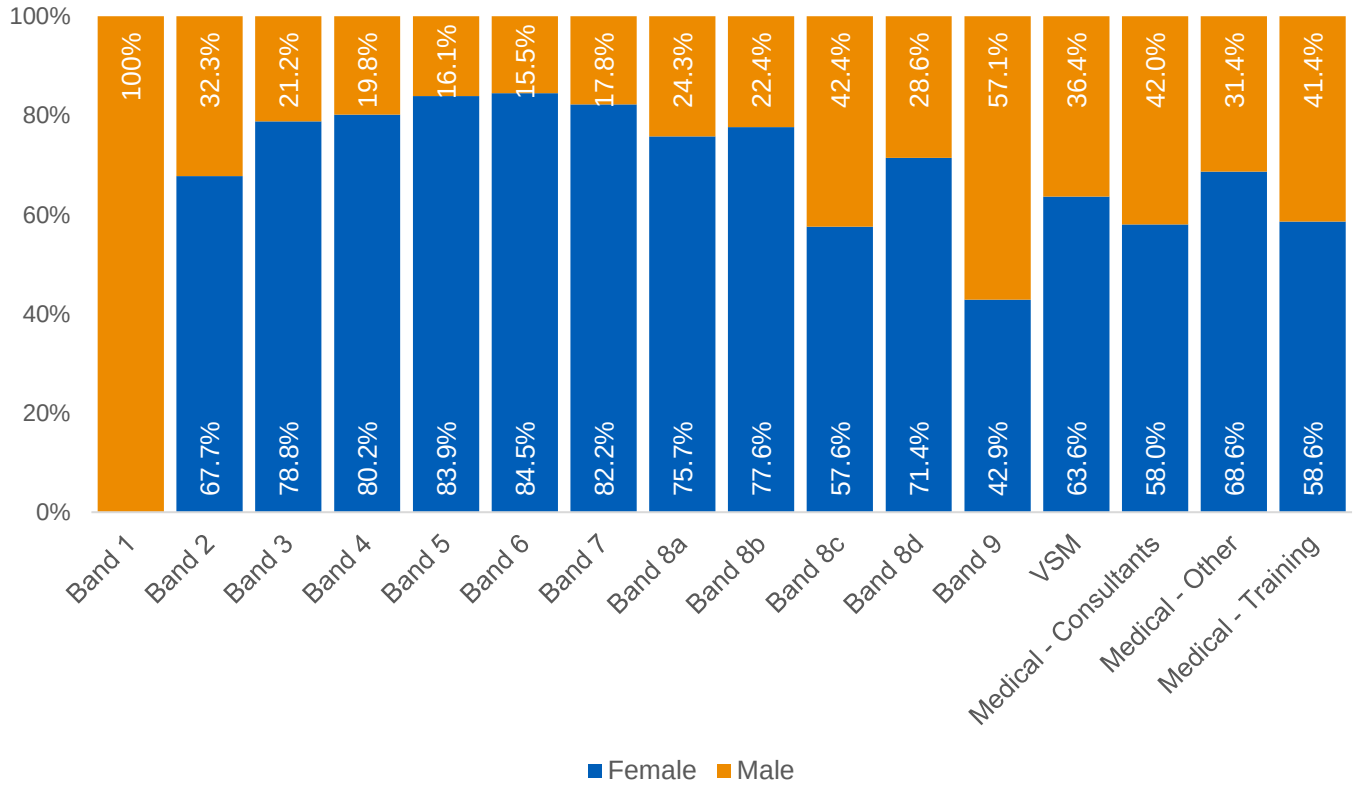


Chart 42 (above) shows the breakdown of pay bands and grades by sex; male and female staff are well represented across all bands and grades.

Compared to the workforce representation, women have a lower-than-expected representation in senior and very senior manager roles and all medical roles. Women also have a higher-than-expected representation in bands 3-7. Male staff have a higher-than-expected representation in all medial roles, VSM and bands 8c-9; however, there is a lower-than-expected representation in bands 3-7.

Table 5 (below) highlights the 2021/22 Gender Pay Gap Report; the report is available on the Gender Pay Gap Reporting Service. Lower representation in senior manager bands and medical grades may impact the gender pay gap at the Trust.

GPG Factor	Observation
Women's hourly pay	Median hourly pay is 6.5% lower than men's Mean hourly pay is 7.6% lower than men's
Pay quarters – female representation	Lowest quarter – 76% Lower middle quarter – 79.9% Upper middle quarter – 78.8% Upper quarter – 71.2%
Women's bonus Pay	Median bonus pay is 32.5% lower than men's Mean bonus pay is 2.2% lower than men's 1.6% of women and 2.7% of men received bonus payments

5.0.9 Sexual orientation

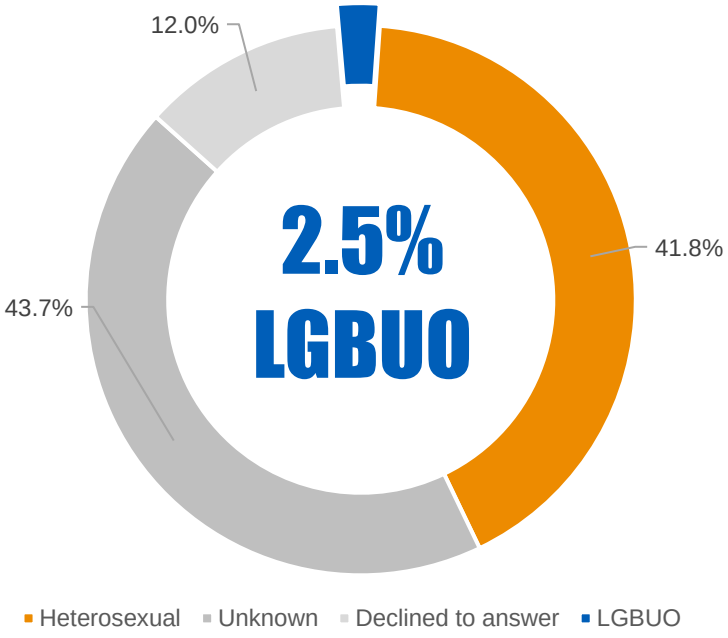


Chart 43 (left) represents the Trust's workforce by sexual orientation. In the 2011 Census, data about sexual orientation was not collected.

Because the level of declaration for sexual orientation is very low throughout the organisation, Lesbian, Gay, Bisexual, Undecided and Other Sexual Orientation Not Listed categories have been aggregated (LGBUO). However, as the declaration rates are so low, it is impossible to draw meaningful conclusions, as we do not have an accurate picture of the demographic profile for this protected characteristic.

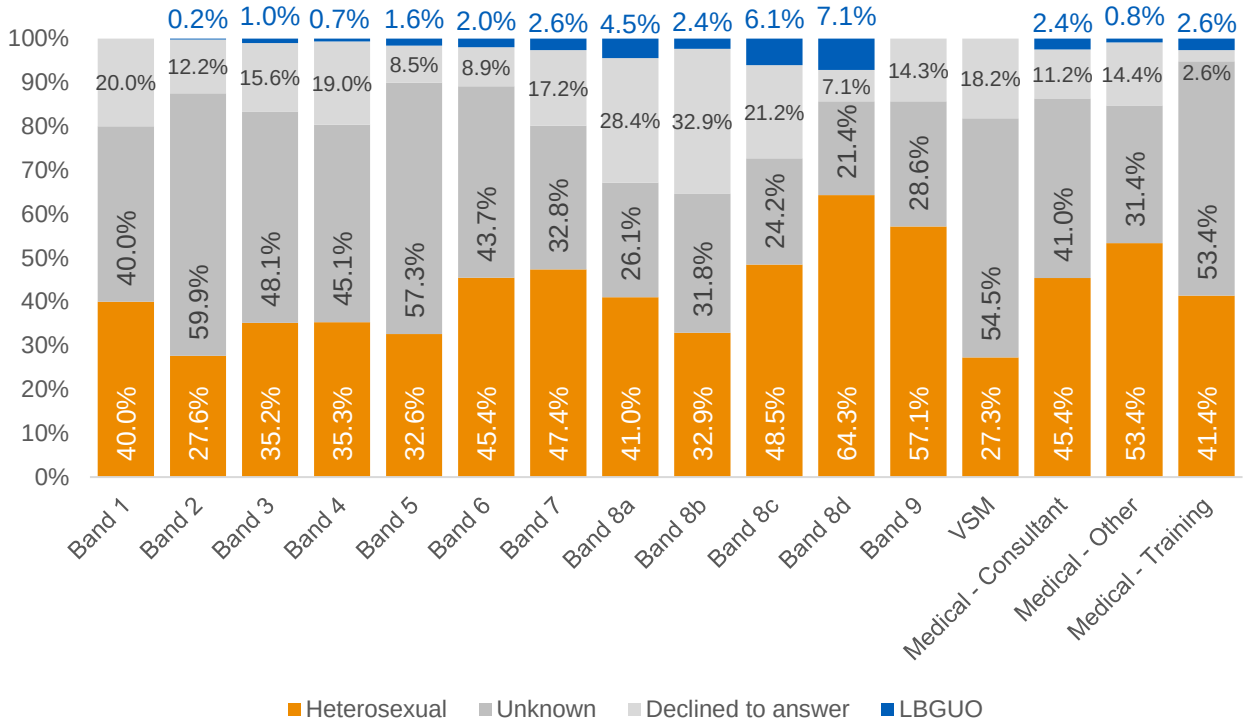


Chart 44 (above) shows the workforce broken down by pay band/grade and sexual orientation.

Many staff have either declined to provide their sexual orientation or that it is simply unknown.

Comparing the representation in pay bands and grades to the overall workforce. LGBUO staff have good (higher than expected) representation in bands 5-8d, medical consultant and training; there is lower than expected representation in bands 2-4 and medical other; and no representation in band nine and VSM.

Heterosexual staff are well represented throughout most pay bands and grades; in most cases have a greater representation in the band/grade compared to the overall representation in the workforce. The bands and grades with a lower-than-expected representation are bands 2-5, 8b and VSM.

5.1 Recruitment

This section reviews recruitment data from 2021/22; it breaks down the representation of protected characteristics through three stages of recruitment – application, shortlisting, and appointment. To aid comparison, data relating to workforce representation is also included.

During 2021/22, there were:

- 12,269 applications received
- 6,924 applicants that were shortlisted to progress to interview
- 935 applicants were appointed

5.1.1 Age

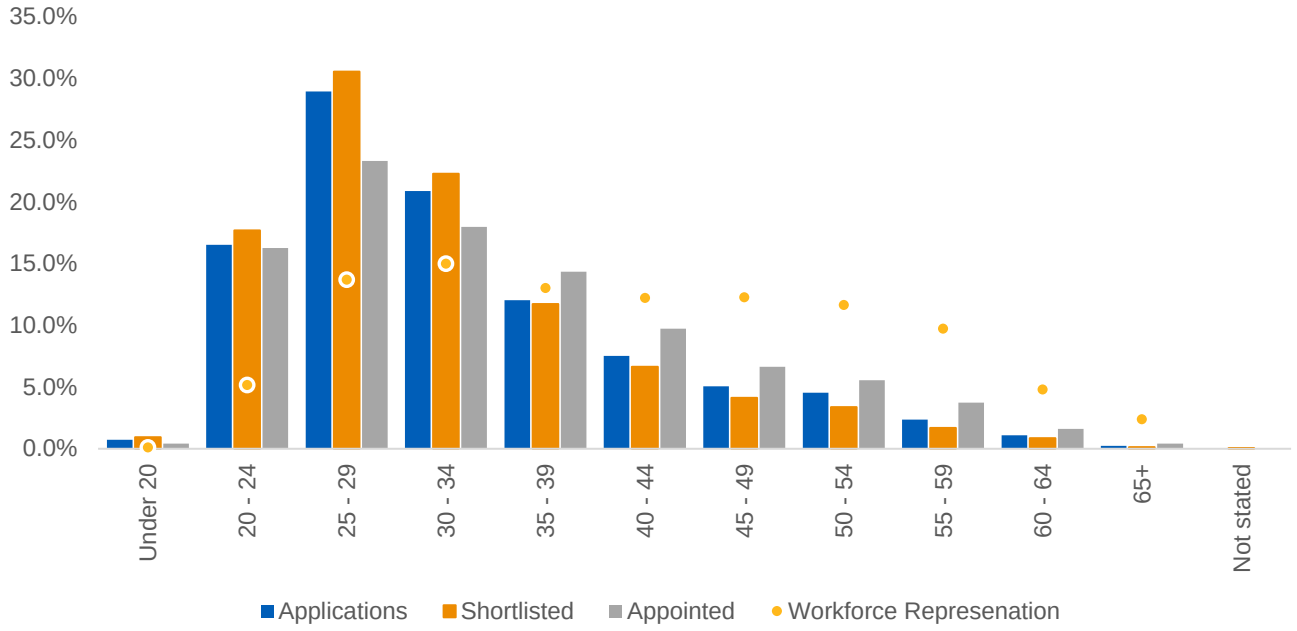


Chart 45 (above) shows the representation throughout the recruitment stages broken down by age; the workforce representation data has also been included to aid comparison.

Compared to the overall workforce representation, there is a greater proportion of applicants aged 20-34 in the recruitment processes; conversely, there is a broadly lower-than-expected representation for those under 20 and 35+.

There is an overall trend of younger applicants (under 20 to 34) having a greater proportional representation when progressing from the application to shortlisting stage but a lower representation from shortlisting to the appointment stage. In all cases, the representation at the appointment stage is lower than at the application stage.

For applicants aged 35+, in all cases, when progressing from the application to shortlisting stage, there is a lower proportional representation; however, at the appointment stage, there is a greater proportional representation. In all cases, the representation at the appointment stage is more significant than at the application stage.

5.1.2 Disability

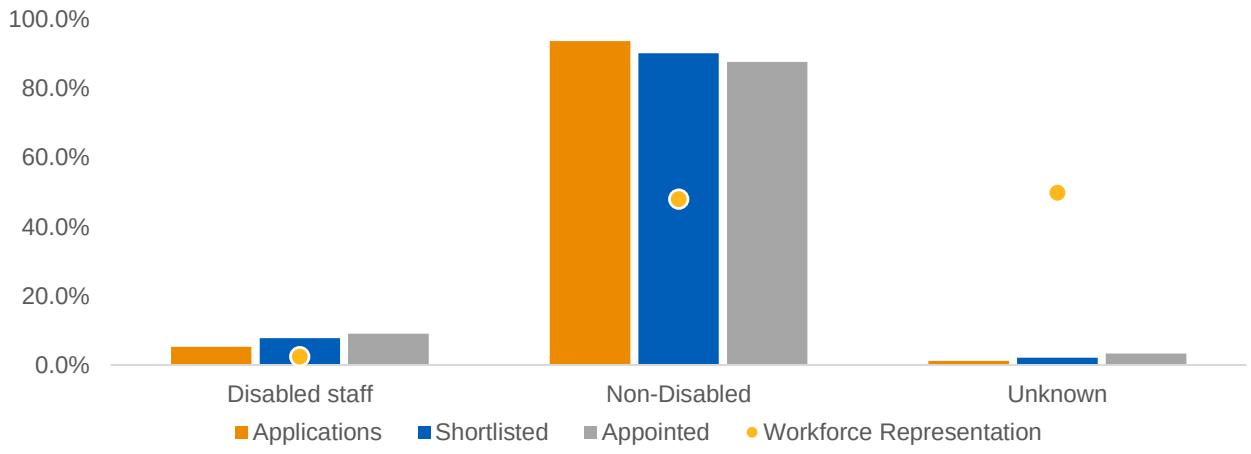


Chart 46 (above) shows the representation throughout the recruitment stages broken down by disability; the workforce representation data has also been included to aid comparison.

Compared to the overall workforce representation, there is a greater proportion of disabled and non-disabled applicants in the recruitment processes; conversely, there is a proportional lower representation where the applicant's disability status is unknown. Should the trend of representation of disabled applicants continue, the Trust should ultimately see a greater representation of disabled staff in the workforce.

Overall, there is a staggered proportional increase in disabled applicants as they progress through the recruitment stages; the opposite is true for non-disabled applicants.

5.1.3 Marriage and civil partnership

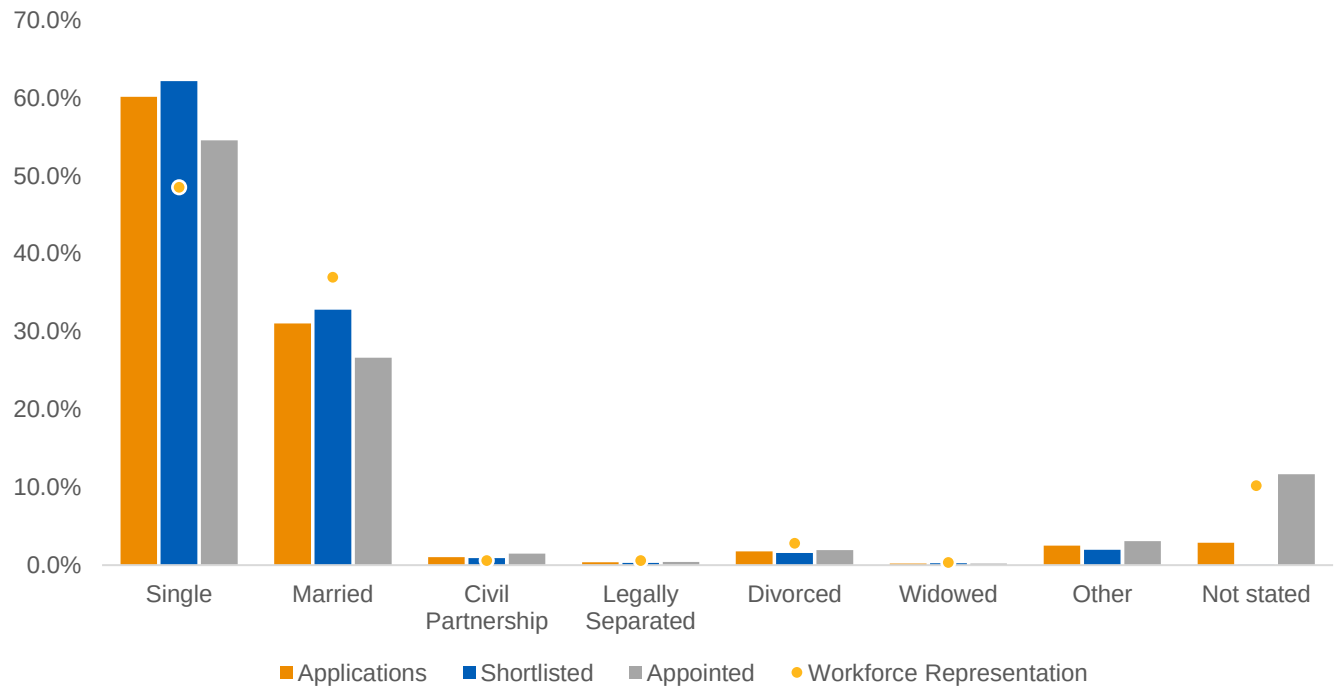


Chart 47 (above) shows the representation throughout the recruitment stages broken down by the applicants' marriage or civil partnership status; the workforce representation data has also been included to aid comparison.

Compared to the overall workforce representation, there is a greater proportion of applicants in a civil partnership in the recruitment processes; conversely, there is a lower proportional representation where the applicants are married.

For married applicants, proportional representation increases when progressing from application to the shortlisted stage, which then drops to the appointment stage. There is a lower representation of married applicants appointed than in the application stage.

For applicants in a civil partnership, there is a slight decrease from application to the shortlisted stage, which increases when progressing to the appointment stage. There is a great representation of applicants in a civil partnership that has been appointed compared to the application stage.

5.1.4 Race (this includes ethnic or national origins, nationality, or colour)

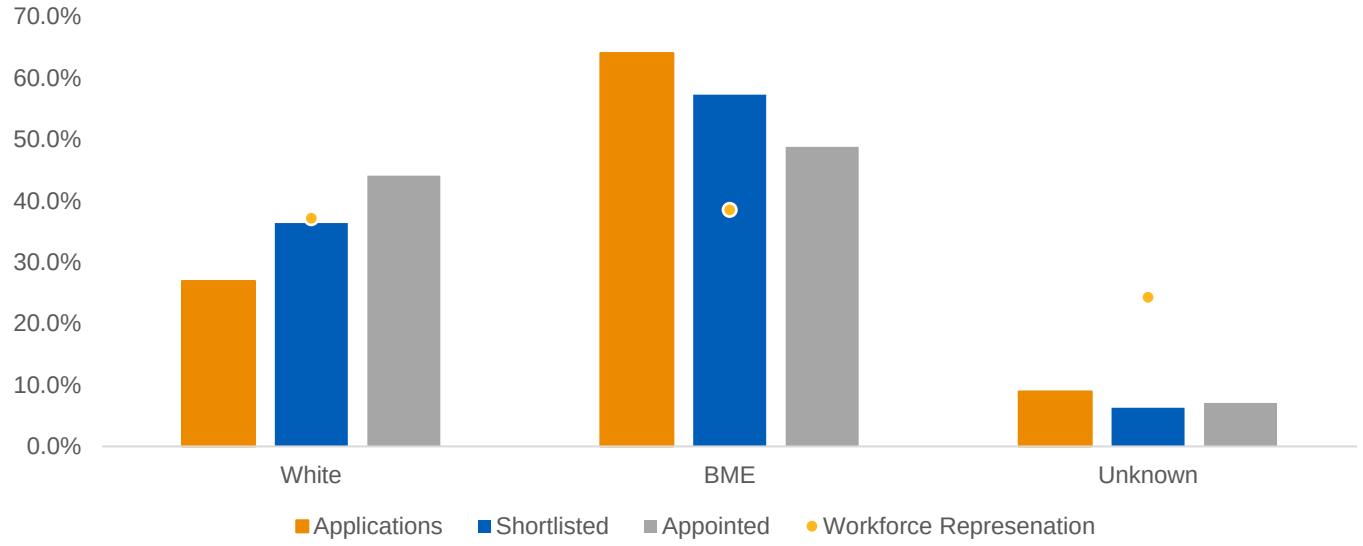


Chart 48 (above) shows the representation throughout the recruitment stages broken down by the applicants' race; the workforce representation data has also been included to aid comparison.

Compared to the overall workforce representation, BME applicants have a greater proportional representation at all stages of recruitment. However, when progressing throughout the stages of recruitment, the representation of BME applicants reduces at each stage. However, there is a lower proportional representation of BME applicants appointed compared to the application stage.

Compared to the overall workforce, there is a lower representation of white applicants at the application and shortlisted stages but a great representation at the appointment stage. When progressing throughout the three stages, the representation of white applicants increases, and there is a greater representation of white applicants appointed than in the application stage.

5.1.5 Religion or belief

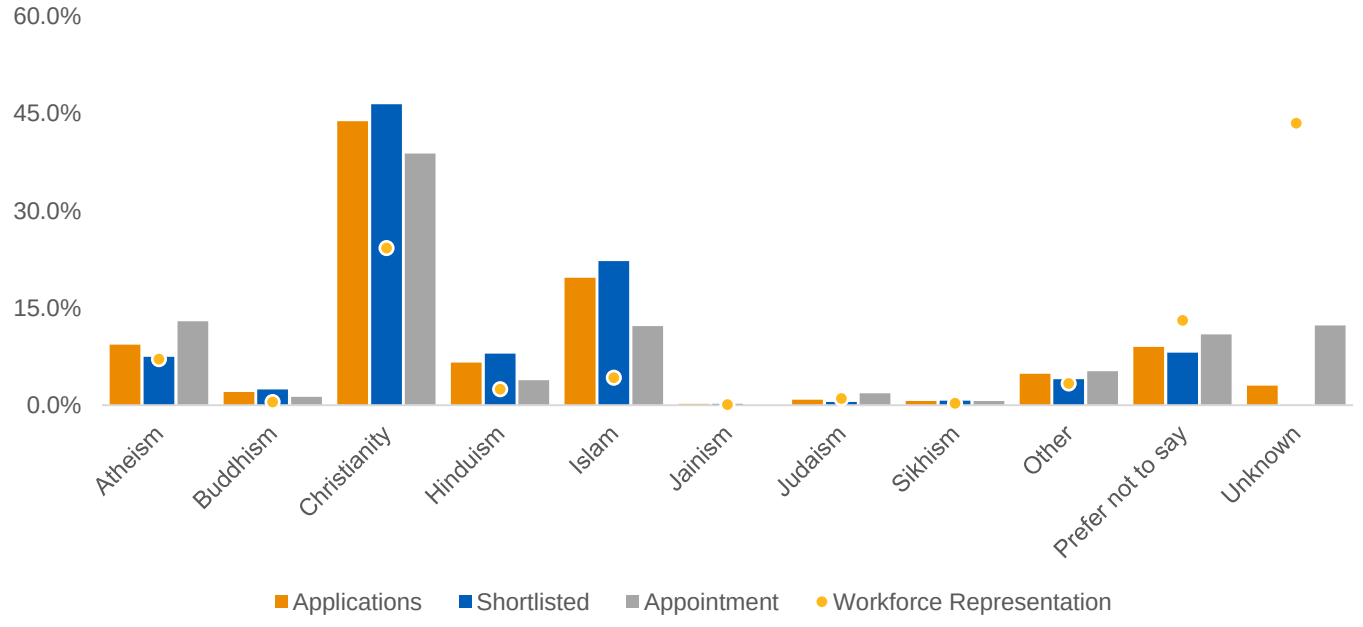


Chart 49 (above) shows the representation of religion or belief in the recruitment process; overall workforce representation has been included to aid comparison.

Compared to the workforce representation, there is an overall greater representation of Atheists, Christians, Hindus, Muslims, Sikhs, Others, and those that have declined to share their religion or belief. There is a lower-than-expected representation of Buddhists, Hindus and those whose religion or belief is unknown; for Jewish candidates, there is a lower-than-expected representation at application and shortlisted stages but a greater-than-expected representation at appointment.

When progressing from shortlisted to the appointment stage, Atheist, Jewish, unknown and prefer not to say applicants saw an increased representation, whilst all other groups saw a degradation; applicants that are either Hindu or Muslim saw the largest proportional decreases.

When comparing the appointment stage, Atheists, Jewish and Other groups saw a representation greater than at the application stage.

5.1.6 Sex

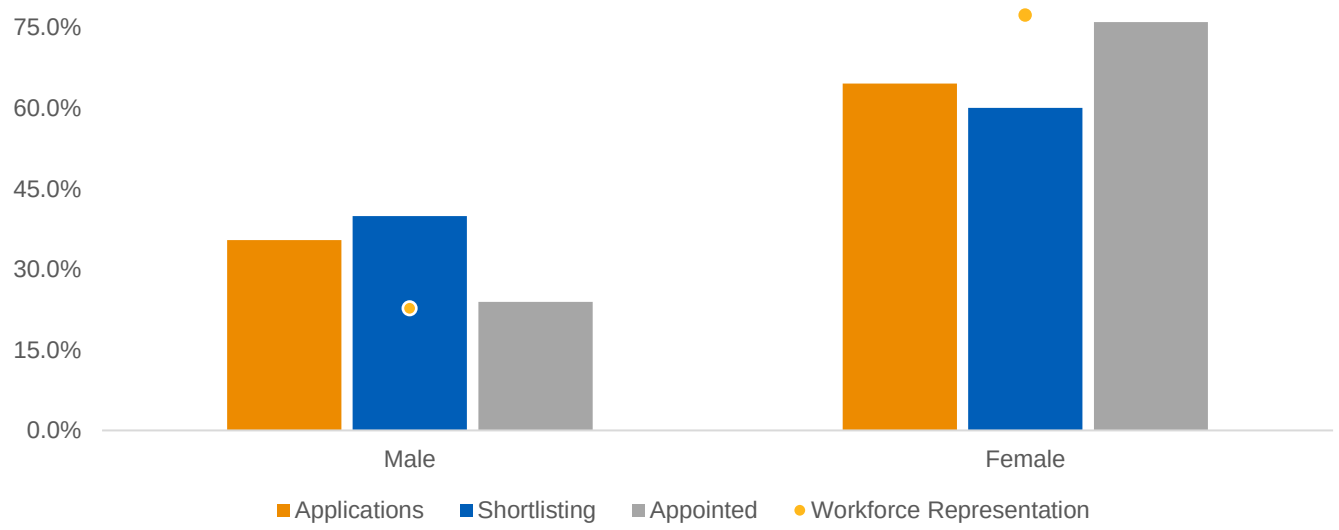


Chart 50 (above) shows the representation of sex throughout the recruitment process; the workforce representation has been included to aid comparison.

Compared to the workforce representation, fewer female applicants are represented in the Trust's recruitment processes, and more male applicants are represented in the recruitment processes.

When progressing through the stages of recruitment, the proportional representation of female applicants decreased from the application to the shortlisting stage and increased from shortlisting to the appointment stage. Male candidates follow the opposite trend.

When comparing proportional representation at appointment from application stages, female applicants have a greater representation, and male applicants have are lower.

5.1.7 Sexual Orientation

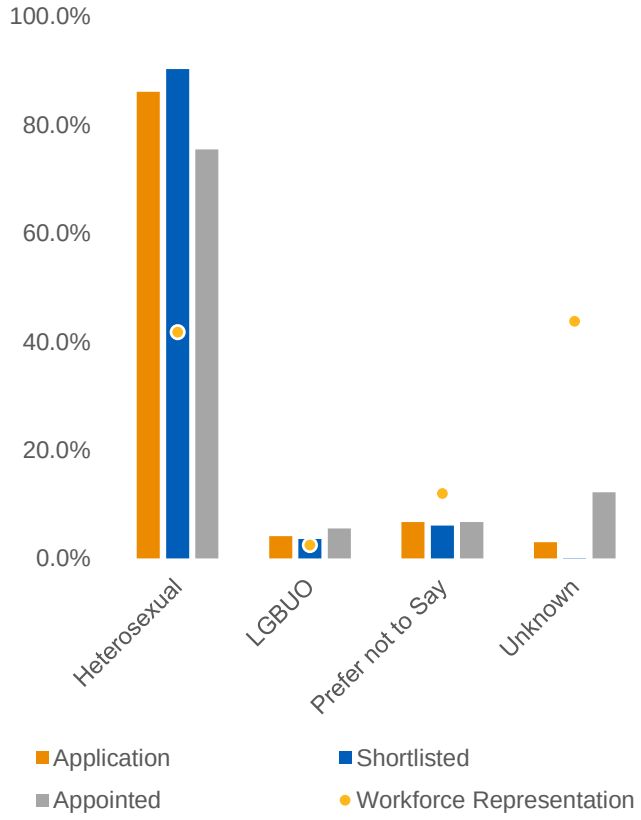


Chart 51 (left) shows the representation of sexual orientation in the Trust's recruitment processes; the workforce representation data is included for comparison.

Compared to the workforce representation, there is a greater representation of candidates that are LGBUO, fewer that are heterosexual, prefer not to say and are unknown.

Looking at progression through the stages, LGBUO candidates see an initial decrease in representation from the application to shortlisting stages; then, it increases from shortlisting to the appointment stages. The opposite trend is true for heterosexual applicants.

When comparing representation from appointment to the application stage, there is a greater representation of LGBUO applicants and a lower representation of heterosexual applicants.

5.2 Employee Relations Processes

During 2021/22, there were 28 disciplinary cases; 11 involved clinical staff, eight involved non-clinical staff and 9 were unknown. Looking at the staff that had been through a disciplinary process by pay band, 9 cases were in bands 1-4, 9 cases were in bands 5-7, 1 case was in band 8a-b, and 9 cases were unknown.

The next sections review the demographical breakdown in representation compared to the workforce. Not all protected characteristics are recorded against the employee relations case; as such, only those characteristics with useful data are included in this report.

5.2.1 Disability

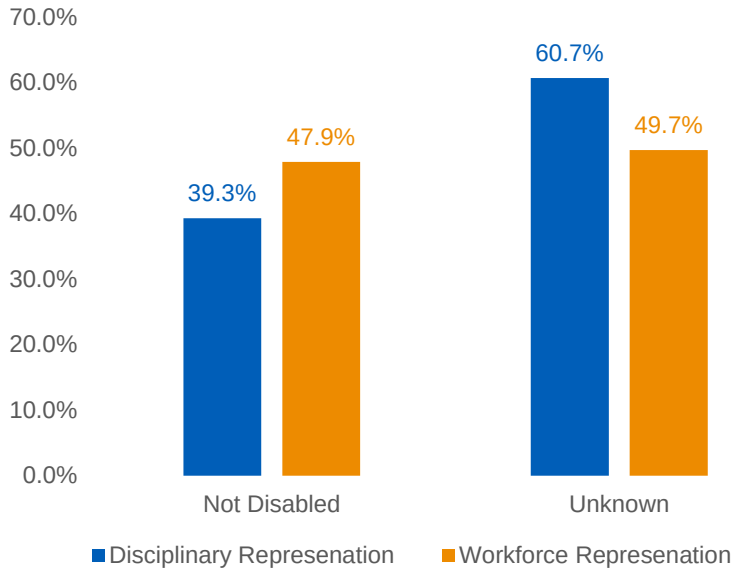


Chart 52 (left) shows the representation within disciplinary procedures compared to the representation in the overall workforce.

No disabled staff have been through the disciplinary process in 2021-22.

However, compared to representation in the general workforce, non-disabled staff have a lower-than-expected representation in disciplinary procedures; staff whose disability status is unknown is higher.

5.2.2 Race (this includes ethnic or national origins, colour or nationality)

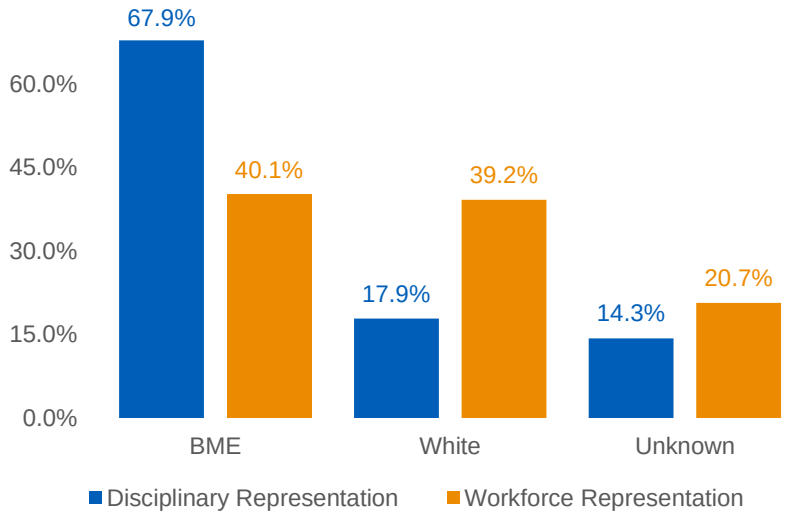


Chart 53 (left) shows the representation in the disciplinary procedures by ethnicity; workforce representation is also included for comparison.

Compared to the workforce representation, BME staff are overrepresented; white staff are underrepresented in disciplinary procedures.

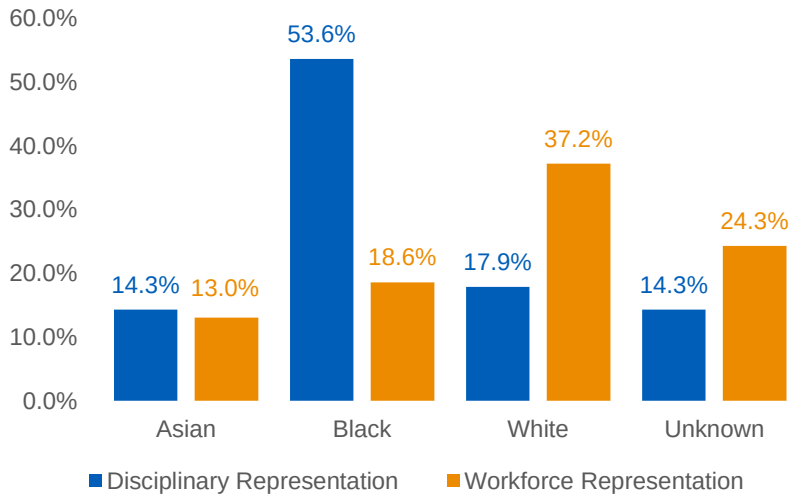


Chart 54 (left) further breaks down the BME category in the representation in the disciplinary procedures; workforce representation is included for comparison.

Staff from black groups are overrepresented in disciplinary procedures; Asian staff have broadly similar representation, and white staff have a lower-than-expected representation compared to the overall workforce.

5.2.3 Sex

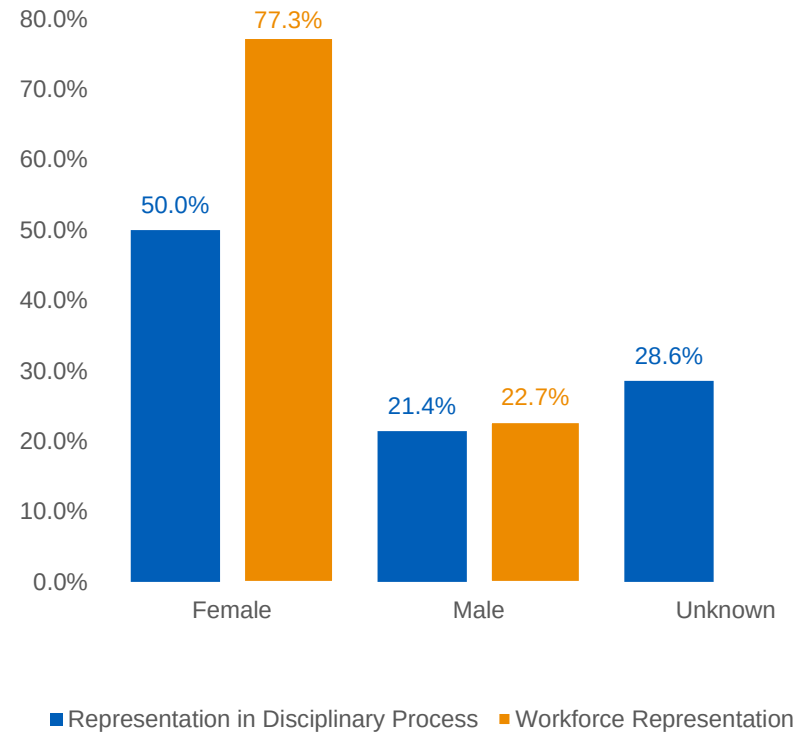


Chart 55 (left) shows the representation of sex in the disciplinary procedures; workforce representation data is included for comparison.

Compared to the workforce, female staff have a lower-than-expected representation in disciplinary procedures, while male staff have about the same representation. For nearly 30% of those going through the disciplinary process, their sex was not recorded.

5.2.4 Sexual Orientation

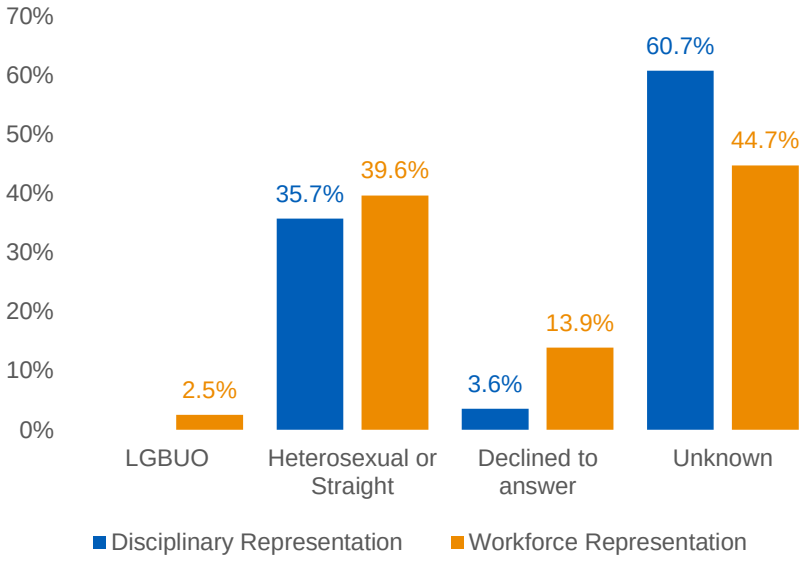


Chart 56 (left) shows the representation of sexual orientation in the disciplinary procedures; workforce representation data is included for comparison.

There were no Lesbian, Gay, Bisexual, Undecided or Other staff that have been through disciplinary procedures, heterosexual staff have about equal representation, and there is an overrepresentation of staff whose sexual orientation is unknown.

5.3 Non-Mandatory Training and Continued Professional Development

Opportunities for non-mandatory training and CPD can lead to staff career development and play an important metric when measuring inclusion.

During 2021/22, a total of 1,382 undertook training that was either non-mandatory or related to continued professional development. This section will review the demographic breakdown of the staff that undertook training. Not all the data for the protected characteristics were available at the time of writing this report.

5.3.1 Race (this includes ethnic or national origins, colour or nationality)

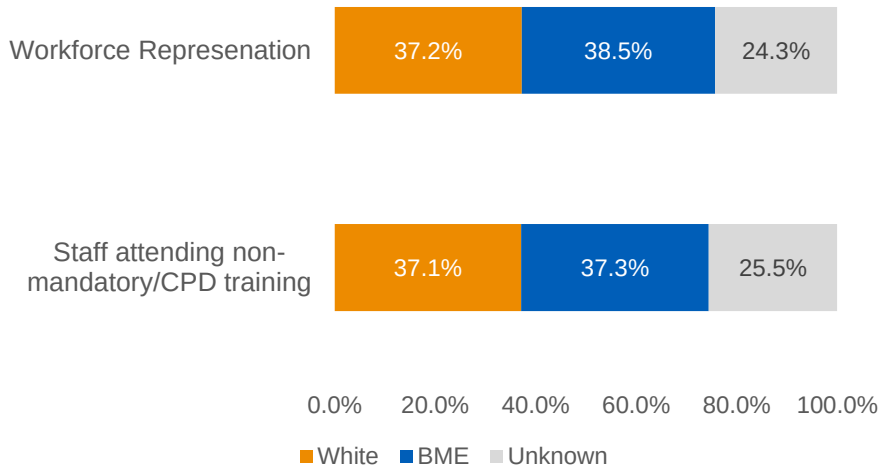


Chart 57 (left) shows the breakdown of staff that accessed non-mandatory training or CPD broken down by race; overall workforce representation has been included to aid comparison.

Compared to the overall workforce representation, all groups access this type of training proportionally.

5.3.2 Sexual Orientation

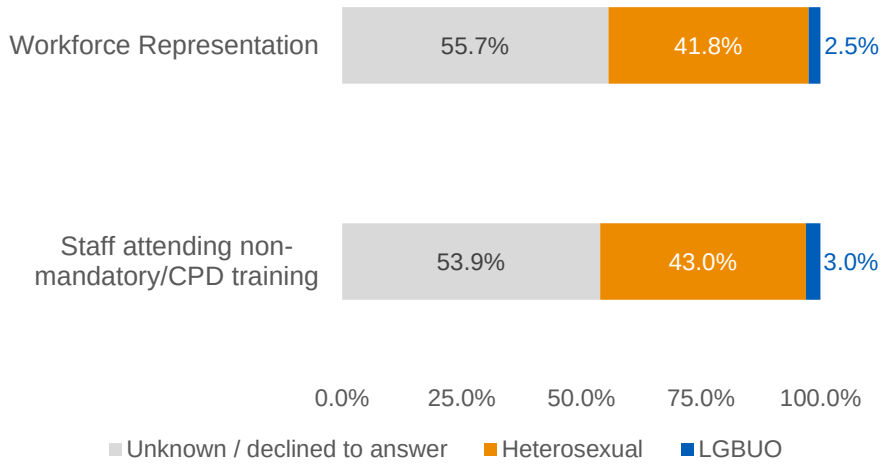


Chart 58 (left) shows the breakdown of staff that accessed non-mandatory training or CPD; the workforce representation has been included to aid comparison.

Compared to the workforce representation, all groups that undertook this type of training are broadly in line. However, it should be noted that LGBUO staff have a slightly higher-than-expected representation.

5.4 Leavers

During 2021/22, a total of 937 staff left the organisation. This section will review in greater detail the demographic breakdown of staff that left the Trust.

5.4.1 Age

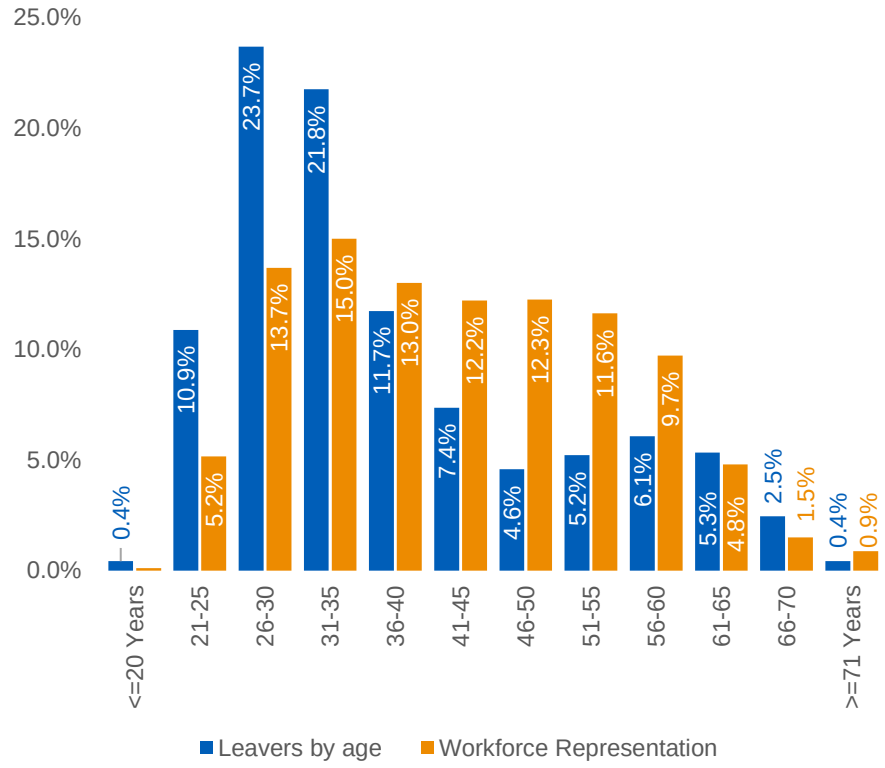


Chart 59 (left) shows the representation of staff that have left Whittington Health by age; the overall workforce representation has been included to aid comparison.

Most staff that have left the Trust are aged between 21 and 35.

Compared to the overall workforce representation, a greater than expected proportion of staff aged <20-35 and 61-70 have left the organisation. For all other age groups, fewer staff have left the organisation.

5.4.2 Disability

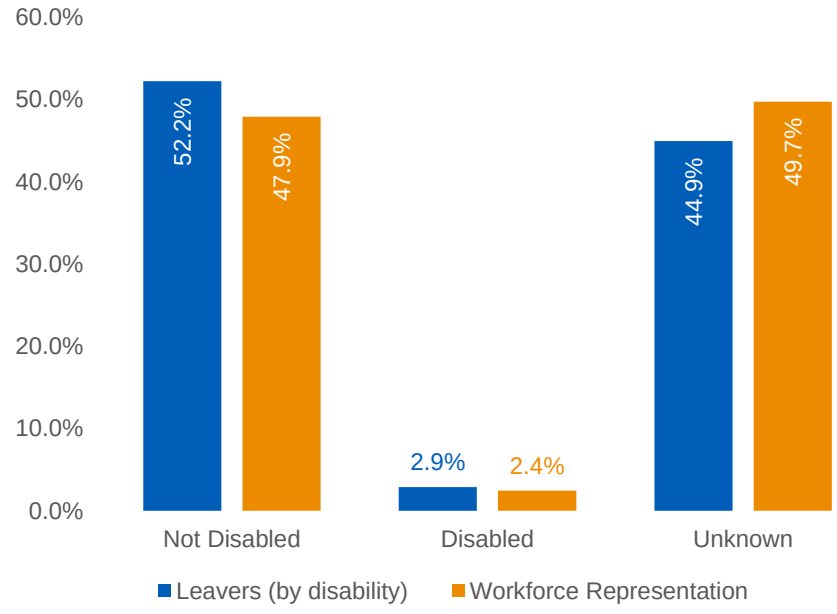


Chart 60 (left) shows the representation of staff that have left the Trust by disability status; the overall workforce representation has been included to aid with comparison.

Compared to the overall workforce, a slightly higher proportion of disabled and non-disabled have left the organisation and a slightly lower one for staff whose disability is unknown.

5.4.3 Marriage civil partnership

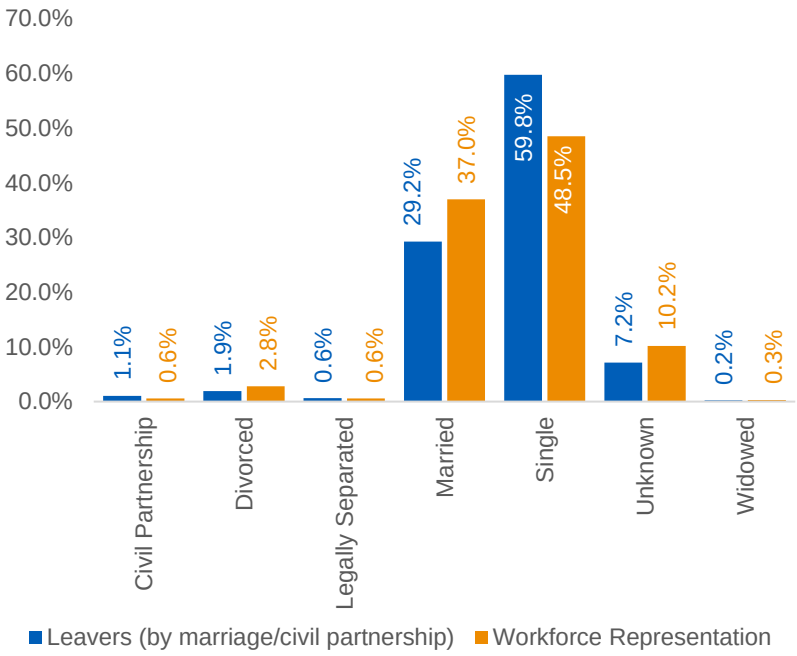


Chart 61 (left) shows the breakdown of staff that have left the organisation by marriage and civil partnership; workforce representation data have been included to aid comparison.

Compared to the overall workforce, more staff in a civil partnership have left the organisation and a lower-than-expected representation of married staff.

A greater proportion of single or divorced staff has also left the organisation compared to the overall workforce representation.

5.4.4 Race (this includes ethnic or national origins, colour, or nationality)

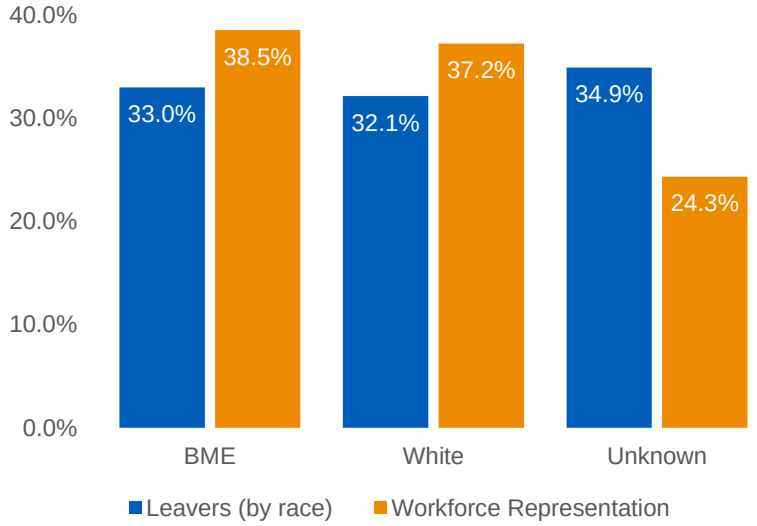


Chart 62 (left) shows the representation of ethnicity of staff that have left the Trust; overall workforce representation has been included to aid comparison.

Compared to the overall workforce, a lower-than-expected proportion of BME and White staff have left the organisation. Still, a greater-than-expected proportion of staff where ethnicity is unknown has left.

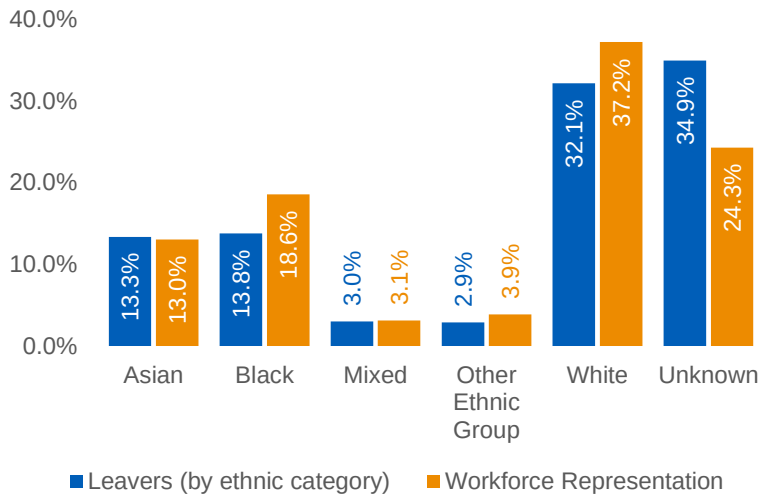


Chart 63 (left) breaks down the BME Category above into main ethnicity categories. Broadly a proportional number of Asian and Mixed staff has left the organisation compared to the workforce representation.

A lower proportion of Black, Other and White staff have left the Trust compared to the overall workforce representation.

5.4.5 Religion or Belief

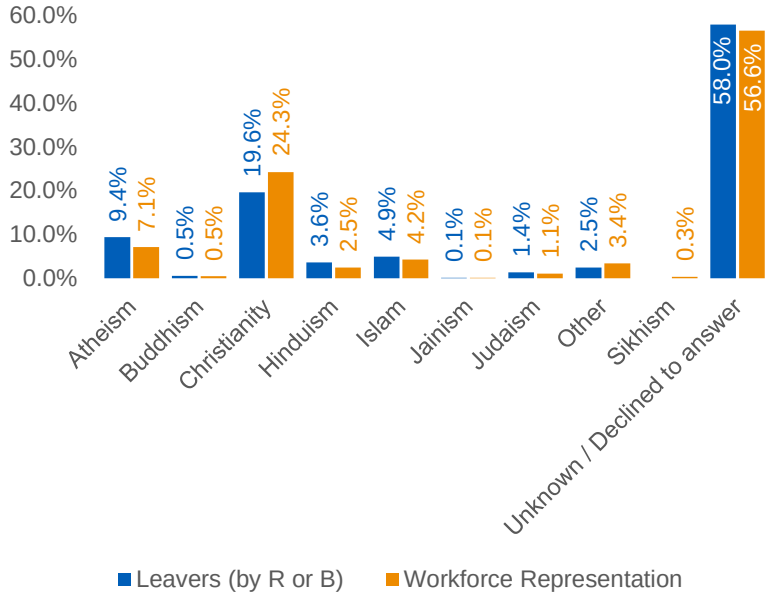


Chart 64 (left) shows the breakdown of leavers by religion or belief; overall workforce representation has been included to aid comparison.

Compared to the overall workforce, there is a greater than expected representation of Atheists, Hindu, Muslim and Jewish staff members whose religion or belief is unknown or they have elected not to share. There is a lower-than-expected representation of Christians, Sikhs and staff with other religions or beliefs and broadly equal representation for Buddhists and Jains.

5.4.6 Sex

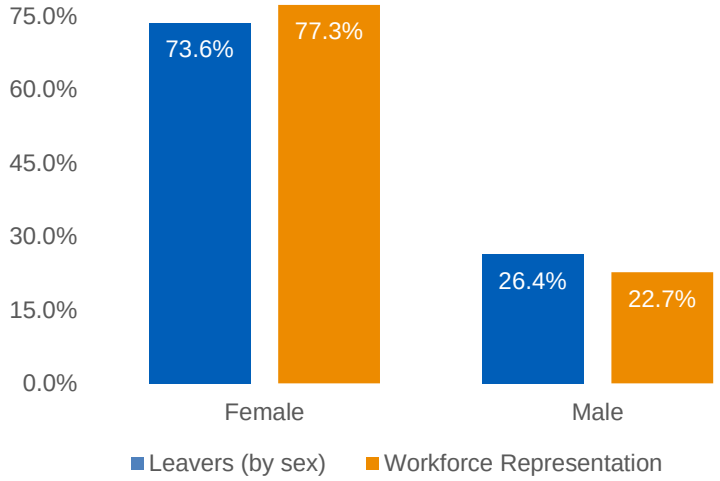


Chart 65 (left) shows the breakdown of leavers by sex; the overall workforce representation has been included to aid in comparison.

Compared to the workforce representation, there are slightly fewer women represented in staff that have left and slightly more men.

5.4.7 Sexual Orientation

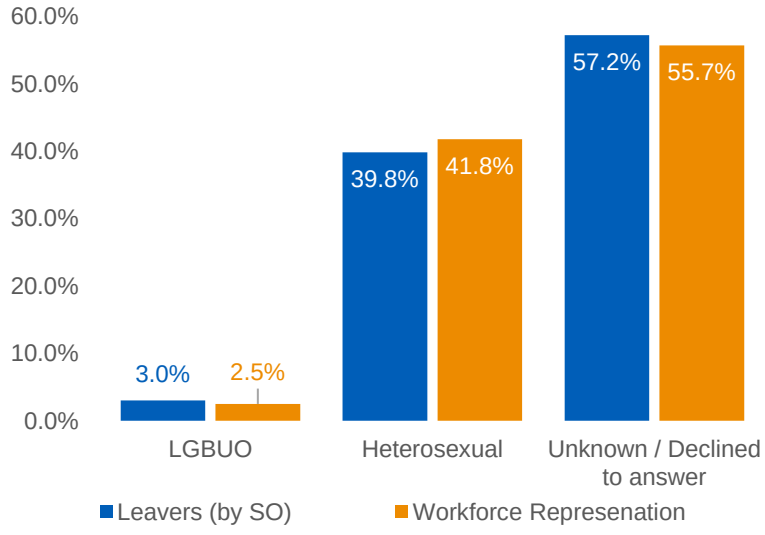


Chart 66 (left) shows a breakdown of leavers by sexual orientation; the overall workforce representation has been included to aid comparison.

Broadly, all groups are represented in line with the workforce representation. However, LGBUO staff appear to be slightly overrepresented in staff that have left the Trust.

5.5 NHS Staff Survey

The annual NHS Staff Survey provides insight into staff satisfaction with the organisation and their work. The survey looks at a range of issues related to inclusion which can be broken down by most of the protected characteristics; this section will explore those issues.

The data explores the average scores for the national acute average for Trusts, Whittington Health's average score for the question and a breakdown of the protected characteristic.

Where the Whittington Health score is in red, it indicates worse performance compared to the national acute average. Where it is green, it indicates better performance.

In the columns breaking down the scores for individual groups within the protected characteristics, a red score would indicate worse performance than the Whittington average; a green score would indicate better.

5.5.1 Age

	21-30	31-40	41-50	51-65	66+	Whittington Health Average	Acute Average
q.4b - The organisation values my work	41.0%	44.6%	46.6%	43.9%	35.7%	**42.8%**	40.7%
q.9e - Feels their manager values their work	76.2%	74.4%	74.6%	70.6%	69.8%	**72.0%**	69.4%
q.7h - Feels valued by my team	67.6%	70.1%	73.8%	66.9%	69.8%	**42.8%**	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	51.4%	47.0%	51.1%	42.4%	38.1%	**46.2%**	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	34.1%	34.3%	24.8%	24.0%	14.3%	**28.5%**	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	13.4%	12.9%	16.8%	16.9%	20.0%	**16.2%**	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	19.1%	22.4%	21.9%	21.2%	17.1%	**22.8%**	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	54.2%	51.8%	46.2%	43.6%	25.0%	**47.7%**	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	16.2%	15.1%	11.1%	9.1%	7.0%	**12.5%**	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	10.2%	10.0%	10.9%	14.9%	7.1%	**12.3%**	8.8%
q.16c(6) - Age was the cause of the discrimination	32.9%	15.0%	10.2%	31.3%		**21.5%**	18.9%

5.5.2 Disability

	Staff with Disabilities	Staff without Disabilities	Whittington Health Average	Acute Average
q.4b - The organisation values my work	33.8%	46.5%	**42.8%**	40.7%
q.9e - Feels their manager values their work	67.0%	74.9%	**72.0%**	69.4%
q.7h - Feels valued by my team	63.8%	71.1%	**42.8%**	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	38.5%	49.2%	**46.2%**	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	33.4%	27.4%	**28.5%**	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	22.7%	13.8%	**16.2%**	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	27.7%	19.9%	**22.8%**	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	44.7%	48.6%	**47.7%**	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	13.6%	11.9%	**12.5%**	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	18.7%	10.2%	**12.3%**	8.8%
q.16c(5) - Disability was the cause of the discrimination	18.9%	1.3%	**21.5%**	18.9%

5.5.3 Race

	BME Staff	White Staff	Whittington Health Average	Acute Average
q.4b – The organisation values my work	44.0%	44.9%	**42.8%**	40.7%
q.9e - Feels their manager values their work	71.2%	75.9%	**72.0%**	69.4%
q.7h - Feels valued by my team	66.7%	73.1%	**42.8%**	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	39.9%	54.4%	**46.2%**	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	28.6%	27.9%	**28.5%**	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	16.2%	14.2%	**16.2%**	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	22.0%	19.8%	**22.8%**	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	50.3%	45.8%	**47.7%**	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	18.7%	6.7%	**12.5%**	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	15.2%	8.3%	**12.3%**	8.8%
q.16c(1) - Race was the cause of the discrimination	79.9%	35.0%	**21.5%**	18.9%

5.5.4 Religion or Belief

	Atheist	Christian	Buddhist	Hindu	Judaism	Muslim	Other religion	Prefer not to say	Whittington Health Average	Acute Average
q.4b – The organisation values my work	46.0%	46.3%	50.0%	51.1%	28.9%	46.6%	47.9%	29.1%	42.8%	40.7%
q.9e - Feels their manager values their work	76.5%	74.6%	75.0%	77.3%	68.9%	76.0%	70.8%	59.0%	72.0%	69.4%
q.7h - Feels valued by my team	73.7%	71.5%	50.0%	73.9%	71.1%	69.0%	72.9%	52.2%	42.8%	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	49.0%	48.8%	65.0%	52.9%	46.7%	44.1%	48.9%	36.1%	46.2%	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	26.1%	28.1%	36.8%	29.5%	25.0%	26.2%	27.9%	36.5%	28.5%	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	13.2%	15.3%	0.0%	11.5%	13.6%	15.1%	9.3%	25.5%	16.2%	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	17.7%	22.7%	26.3%	10.5%	13.6%	25.2%	20.9%	28.1%	22.8%	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	46.8%	51.0%		48.4%	53.3%	39.2%	50.0%	39.1%	47.7%	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	6.3%	14.9%	0.0%	6.8%	15.6%	16.4%	16.7%	14.1%	12.5%	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	7.5%	12.6%	5.0%	9.1%	13.3%	13.2%	8.3%	19.7%	12.3%	8.8%
q.16c(3) - Religion was the cause of the discrimination		0.9%		7.7%		57.6%		13.7%	21.5%	18.9%

5.5.5 Sex

	Female	Male	Prefer not to say	Whittington Health Average	Acute Average
q.4b – The organisation values my work	44.8%	45.7%	29.8%	**42.8%**	40.7%
q.9e - Feels their manager values their work	73.3%	77.8%	54.2%	**72.0%**	69.4%
q.7h - Feels valued by my team	70.0%	72.8%	48.2%	**42.8%**	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	47.9%	48.9%	32.5%	**46.2%**	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	29.4%	24.4%	33.3%	**28.5%**	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	14.8%	16.0%	26.0%	**16.2%**	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	21.7%	19.4%	26.9%	**22.8%**	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	50.2%	40.3%	39.4%	**47.7%**	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	12.4%	11.0%	14.3%	**12.5%**	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	11.7%	10.0%	20.5%	**12.3%**	8.8%
q.16c(2) - Sex was the cause of the discrimination	20.3%	29.1%	28.6%	**21.5%**	18.9%

5.5.6 Sexual Orientation

	Heterosexual	Gay or Lesbian	Prefer not to say	Bisexual	Other	Whittington Health Average	Acute Average
q.4b – The organisation values my work	45.4%	49.4%	29.2%	50.0%	46.2%	**42.8%**	40.7%
q.9e - Feels their manager values their work	74.5%	83.5%	60.8%	82.4%	61.5%	**72.0%**	69.4%
q.7h - Feels valued by my team	70.3%	82.1%	60.2%	88.2%	46.2%	**42.8%**	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	48.3%	60.7%	33.3%	44.1%	41.7%	**46.2%**	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	27.1%	35.8%	35.2%	29.4%	36.4%	**28.5%**	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	14.7%	12.3%	25.5%	5.9%	9.1%	**16.2%**	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	20.7%	24.4%	27.5%	12.1%	9.1%	**22.8%**	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	48.9%	46.3%	39.7%			**47.7%**	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	11.8%	14.3%	12.4%	14.7%	30.8%	**12.5%**	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	11.1%	10.6%	16.4%	8.8%	15.4%	**12.3%**	8.8%
q.16c(4) - Sexual orientation was the cause of the discrimination	0.9%	52.6%				**21.5%**	18.9%

5.6 Summary of observations from workforce data

5.6.1 Age

Most of the workforce is aged between 26-55; there is a lower-than-expected representation of staff aged <20-25 and 66+ compared to the local population.

In the pay bands, younger workers are concentrated in more junior roles; older workers are concentrated in either junior or senior roles; while workers aged 26-55 generally have a good representation across all pay bands/grades. For medical roles, the greatest representation of staff aged 26-65; in senior manager roles, representation of staff 36-60 and VSM 51-60.

In the Trust recruitment and selection process, at the appointment stage, there is a greater workforce representation of applicants under 40, whilst those over 40 have a proportional lower representation.

Data relating to employee relations and training were not available at the time of writing.

Most age groups have a lower representation in leavers data than overall workforce representation. Only staff aged <20-35 and 61-70 are leaving at a proportionally higher rate.

Staff aged 21-30 and 66+ are less likely to feel the organisation values their work compared to the Whittington Health average. Staff aged 51+ are less likely to feel their manager values their work; all groups state they feel valued by their team to a high degree compared to the Whittington Health Average.

Staff aged 51+ are less likely to feel that the Trust acts fair regarding equal opportunities for promotion or progression compared to the Whittington Health average; all other groups score higher.

Younger workers are more likely to experience poor behaviour from patients, service users, etc. They are also more likely to state that they have experienced discrimination based on age. Those under 40 are more likely to report bullying, harassment and abuse incidents than the Whittington Health average.

Staff aged 41+ are more likely to experience poor behaviour from their manager, and those aged 51-65 are more likely to state the discrimination they experience was related to their age – compared to the Whittington Health average.

5.6.2 Disability

The representation of disabled staff is lower than the local population; however, there is also a disparity of 15% of staff that have stated they have a disability in the 2021 Staff Survey compared to data held on Electronic Staff Records. Nearly half of the organisation has either not declared or chose not to declare their disability status, impacting the quality of the Trust's data.

Disabled staff have a good representation within bands 5-8a and 8c. However, there is low to no representation in bands 2-4, 8b, 8d-9, VSM and all medical roles. However, given that nearly 50% of the organisation has not declared, a true picture of the representation will not be seen until this improves.

Within the Trust's recruitment processes, there is an increase in the representation of disabled applicants throughout the three main stages. This could indicate that initiatives such as the

guaranteed interview scheme are performing well and positively impacting the recruitment data. There is also a higher proportional representation of disabled applicants in the recruitment processes than workforce representation.

From the data available, there were no disabled staff involved in disciplinary cases; however, there is an overrepresentation of staff where disability status is unknown. This overrepresentation could be masking the true picture. There is more information about disability equity in the Workforce Disability Equality Standard report, which is available on the Trust website.

At the time of writing this report, no data relating to non-mandatory and continued professional development training broken down by disability available.

There is a slightly higher representation of disabled staff leaving the organisation than the overall workforce representation. However, with a higher representation of disabled applicants being appointed, workforce representation should still increase.

Overall, disabled staff experiences detailed in the Staff Survey are lower than the Whittington Health average. Comparing non-disabled staff to disabled staff demonstrates a worse experience in all factors relating to poor behaviour, feeling valued and perception of equal opportunities.

There is more information about disability equality in the Workforce Disability Equality Standard Report on the Trust's website.

5.6.3 Gender Identity

Data for this protected characteristic is either not recorded.

5.6.4 Marriage and Civil Partnership

Regarding workforce representation, staff in a civil partnership are broadly in line with the local population, while married staff have a greater representation than the local population.

When comparing to overall workforce representation, staff in a civil partnership there is a higher than expected representation in bands 7, 9 and medical consultants. Lower than expected representation in bands 2-6, and no representation in 8b-d, VSM and medical other and training grades. Married staff have a higher-than-expected representation in senior management and VSM roles but a low representation in bands 3-7 and all other grades; it is broadly in line with workforce representation.

In the Trust's recruitment and selection processes, applicants in a civil partnership representation in appointments are proportionally lower than the overall workforce, whilst married applicants have a higher representation.

When this report was written, data relating to employee relations or accessing non-mandatory or continued professional development broken down by this protected characteristic was not available.

Overall, staff in a civil partnership are leaving at a proportionally higher rate than the overall workforce representation, but married staff are leaving at a lower rate.

Data from the staff survey for this protected characteristic is not available.

5.6.5 Maternity and pregnancy

Data for this protected characteristic is not routinely collected.

5.6.6 Race (this includes ethnic or national origins, colour or nationality)

Compared to the local population, there is a slightly higher proportion of BME staff in the workforce. However, nearly a quarter of the workforce not declaring their ethnicity will impact the quality of Trust data. When disaggregating the BME category, compared to the local population, there is a greater than expected representation of Asian and Black staff and a lower than expected representation of Mixed and White.

BME staff representation follows the national pattern of higher representation in lower bands and lowers in more progressively senior roles. BME staff have a lower-than-expected representation in bands 7-9 and VSM; this staff group is also well-represented in all medical roles.

There is a good representation of BME applicants in the Trust's recruitment processes (compared to the workforce); however, there is a progressive step down for this group when looking at the three reported stages. It should be noted that BME applicants have a greater representation at the appointment stage than the overall workforce representation.

BME staff are overrepresented in disciplinary procedures. When disaggregating this category, Black staff have the highest representation level.

BME staff was accessing non-mandatory and continued professional development training in broad proportion to the representation within the workforce.

BME staff are not overrepresented in leavers data; all ethnicity categories representation is broadly in line or lower than the workforce representation.

Staff Survey data suggest that BME staff are less likely to feel valued; also less likely to feel that the organisation acts fairly concerning equal opportunities compared to the Whittington Health average. BME staff are also slightly more likely to experience bullying, harassment and abuse than the Whittington Health average and white colleagues; but are more likely to report such incidents. However, BME staff are twice more likely to experience discrimination than their white colleagues, and the reported discrimination is likely related to race (BME staff rate this factor four times higher than the Whittington Health average).

More details on race equity can be found in the Workforce Race Equality Standard on the Trust's website.

5.6.7 Religion or belief

Nearly 60% of the workforce have not declared their religion or belief on Electronic Staff Records, which impacts data quality. From the data available, compared to the local population, there is a higher than an expected representation of Hindu, Jains and Sikhs staff.

There is a good representation of most religions or belief groups (except Christianity and Other) for most medical roles. In bands 2-6, declaration rates are generally very low; only Christian and Other have consistently good representation across all pay bands.

In the Trust's recruitment and selection processes, there is a good representation of most religions or belief groups throughout, which is greater than the workforce representation.

There was no employee relations or non-mandatory/continued professional development training data at the time of writing this report that was broken down by this protected characteristic.

Nearly 60% of leavers' religion or belief was unknown; from the available data, there appears to be a greater proportion of Atheist, Hindu, Muslim and Jewish staff leaving than workforce representation. All other groups are leaving in proportion or at a lower rate.

Data from the staff survey suggests that Jewish staff are less likely (nearly half compared to the Whittington Health Average) to feel that the organisation values their work. Jewish and other religions are less likely to feel that their manager values their work. However, all groups state that they feel supported by their team more than the Whittington Health average.

Buddhist and Hindu staff are more likely to experience bullying, harassment, and abuse from patients, service users, colleagues, etc. Compared to the Whittington Health average, all declared groups are less likely to report bullying, harassment and abuse from their manager. Atheists and Muslim staff are less likely to report bullying, harassment and abuse incidents.

Christians, Jewish, Muslims and Other religions are more likely to state that they have experienced discrimination. However, disproportionately high numbers of Muslims state the discrimination they have experienced based on their religion.

Many staff have decided not to share their religion or belief in the Staff Survey.

5.6.8 Sex

Female staff make up more than three-quarters of the workforce; this does not correlate with the local population but does with national NHS workforce statistics.

Compared to overall representation, female staff have good representation in bands 3-8b but low representation in 2, 8c-9 and VSM roles. Male staff have good representation across most pay bands and grades; however, there is a slightly lower representation in bands 4-7. Male staff are overrepresented in senior manager, VSM and medical roles.

In the Trust recruitment processes, female and male applicants are appointed proportionately to workforce representation.

In employee relations, female staff have a lower-than-expected representation, and male staff have an equivocal representation in disciplinaries. However, in nearly a third of cases, the sex was unknown, impacting the data quality.

At this report's writing, non-mandatory/continued professional training data disaggregated by sex was unavailable.

Both female and male staff leave the organisation in broad proportional representation to the overall workforce representation.

Both male and female staff are more likely (compared to the Whittington Health average) to report that they feel valued and that the Trust acts fairly regarding equal opportunities.

For the majority of factors looking at bullying, harassment and abuse – both male and female staff are less likely (compared to Whittington Health ave) to report experiencing this type of behaviour. Except female staff receiving bullying, harassment and abuse from patients, service users, etc. Male staff are less likely to report bullying, harassment and abuse incidents than the Whittington Health average.

Both male and female staff state they have experienced discrimination at a lower rate than the Whittington Health average; however, male staff are more likely to state the discrimination they faced was due to their sex.

5.6.9 Sexual Orientation

Declaration of sexual orientation is very low; as a result, Lesbian, Gay, Bisexual, Undecided and Other (LGBUO) groups were combined to help analyse the data. There is a disparity of staff that have declared their sexual orientation on ESR (2.5%) and Staff Survey (6.1%).

Staff in the LGBUO group have a proportional higher representation in bands 7-8d and medical–consultant and training roles. There is no representation in band 9 and VSM and a low representation in all other bands/grades.

In recruitment, LGBUO applicants are appointed proportionally higher than workforce representation.

No LGBUO staff were involved in disciplinaries; heterosexual staff have a broadly similar representation to the workforce. However, 60% of the disciplinaries sexual orientation was unknown, which impacted the data quality.

LGBUO staff are accessing non-mandatory and continued professional development training at a slightly higher rate than the overall workforce representation.

LGBUO staff leave the organisation at a slightly higher proportional rate than the overall workforce representation.

From the Staff Survey, many staff elected not to share their sexual orientation; however, this group's experience was poorer on nearly all factors relating to feel valued, equal opportunities, discrimination and bullying/harassment/abuse. Most groups stated that they felt valued to a greater extent than the Whittington Health average, except for 'prefer not to say (organisation and manager) and 'Other' (manager).

Gay and Lesbian staff are more likely than heterosexual staff to say they feel the organisation acts fairly concerning equal opportunities; bisexual staff, however, are less likely compared to the Whittington Health average.

Unlike the Whittington Health average, all minoritised groups are more likely to report experiencing bullying, harassment or abuse from patients, service users, etc. All minoritised groups are less likely to report bullying, harassment or abuse from their manager; only gay and lesbian groups are likely to report this behaviour from other colleagues. Gay and Lesbian staff are also less likely to report incidents of bullying, harassment and abuse compared to the Whittington Health average.

All minoritised groups are more likely to report they have experienced discrimination from patients, service users, etc., and only 'Other' is also like to report discrimination from staff. Gay and Lesbian staff are disproportionately (compared to the Whittington Health average) likely to state the discrimination they experienced was due to their sexual orientation.

D. Equality Delivery System

6.0 Equality Delivery System (EDS2) Activities

6.1 The EDS2 is the second 'slimmer and more flexible version' of this tool to help NHS organisations, in discussion with local partners, including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. It aims to support four goals:

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership

6.2 The goals have specific elements to consider when grading performance:

6.2.1 **Goal 1: Better health outcomes** considers whether:

- Services are commissioned, procured, designed and delivered to meet the health needs of local communities
- Individual people's health needs are assessed and met in appropriate and effective ways
- Transitions from one service to another for people on care pathways are made smoothly with everyone well-informed
- When people use NHS services, their safety is prioritised, and they are free from mistakes, mistreatment and abuse
- Screening, vaccination and other health promotion services reach and benefit all local communities

6.2.2 **Goal 2: Improved patient access and experience** considers whether:

- People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
- People are informed and supported to be as involved as they wish to be in decisions about their care
- People report positive experiences with the NHS
- People's complaints about services are handled respectfully and efficiently

6.2.3 **Goal 3: A representative and supported workforce** considers whether:

- Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
- The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
- Training/development opportunities are taken up and positively evaluated
- When at work, staff are free from abuse, harassment, bullying and violence from any source
- Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
- Staff report positive experiences of their membership in the workforce

6.2.4 **Goal 4: Inclusive leadership** considers whether:

- Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
- Papers that come before the Board and other major Committees identify equality-related impacts, including risks, and say how these risks are to be managed

- Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

6.3 The EDS2 tool requires organisations to grade performance on each goal and outcome collaboratively with staff, patients and partners. The grading system provides four levels of performance as follows:

- **Undeveloped** if there is no evidence one way or another for any protected group of how people fare or if evidence shows that the majority of people in only two or less protected groups fare well
- **Developing** if evidence shows that the majority of people in three to five protected groups fare well
- **Achieving** if evidence shows that the majority of people in six to eight protected groups fare well
- **Excelling** if evidence shows that the majority of people in all nine protected groups fare well

6.4 The NCL joint grading events were paused as a result of COVID. The Trust, therefore, undertook a self-assessment, which was presented to the Patient Experience Group. Alternative methods to engage with stakeholders will be sought.

6.5 Concerning staff and leadership-related goals 3 and 4, several focus groups have been scheduled; however, in comparison to the previous year, they were not well attended, possibly as a result of the already high level of engagement with other equality and inclusion initiatives, and possibly as a result of the focus to manage the pandemic.

6.6 Tables 6 and 7 below show the grading for goals one and two

Table 6

Outcomes for Goal One – Better Health Outcomes	Grading
1. Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing
2. Individual people's health needs are assessed and met in appropriate and effective ways	Developing
3. Transitions from one service to another for people on care pathways are made smoothly with everyone well-informed	Developing
4. When people use NHS services, their safety is prioritised, and they are free from mistakes, mistreatment and abuse	Achieving
5. Screening, vaccination and other health promotion services reach and benefit all local communities	Developing

Table 7

Outcomes for Goal Two – Improved patient access and experience	Grading
1. People, carers & communities can readily access hospital, community health or primary care services & should not be denied access on unreasonable grounds	Developing
2. People are informed and supported to be as involved as they wish to be in decisions about their care	Developing
3. People report positive experiences with the NHS	Achieving
4. People's complaints about services are handled respectfully and efficiently	Developing

6.7 Tables 8 and 9 below show the grading for goals three and four

Table 8

Outcomes for Goal Three – A representative and supported workforce	Grading
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Developing
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving
3.3 Training and development opportunities are taken up and positively evaluated by all staff	Developing
3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Developing
3.6 Staff report positive experiences of their membership in the workforce	Developing

Table 9

Outcomes for Goal Four – Inclusive Leadership	Grading
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing
4.2 Papers that come before the Board & other major Committees identify equality-related impacts, including risks, and say how these risks are to be managed	Developing
4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Developing

6.7 The focus groups' discussions indicate that more tangible evidence is required in the form of data, particularly reportable data from ESR. This needs to be one of the equality objectives. Results indicate that the policies and procedures underpin good practice in supporting equality and inclusion in the workplace. More consistency is required in compliance with agreed processes, particularly new procedures relating to recruitment specifically designed to reduce bias and monitor outcomes.

7.0 Equality objectives

1.1 The Trust's equality objectives are driven by the results of the grading outcomes following discussion with all the stakeholders attending the focus groups using the EDS2. Staff networks supported by senior leaders and non-executive directors have been vocal in suggesting changes to procedures and indicating priorities. These are listed below:

1.1.1 Continuing work on our data systems to maximise the available data, accuracy, and usefulness. For example, the data descriptions need to be aligned, systems must be amended to ensure it is possible to hold data not currently held, and it is important to continue digitalising paper-based records.

1.1.2 Reviewing recruitment processes from the content of job descriptions and person specifications, advertising roles, preparing interview panels and monitoring their demographic composition, to monitoring the demographics of applicants, interviewees and the outcome of interviews.

1.1.3 Details of equality objectives can be found in Appendix A

Appendix A – Developing Public Sector Duty Objectives from EDS2 Grading Results

GOAL ONE: BETTER HEALTH OUTCOMES

Outcome	Grading	Draft Objective	Approach
Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing	To successfully implement the national Maternity Transformation programme	Performance is monitored via the maternity dashboard
Individual people's health needs are assessed and met in appropriate and effective ways	Developing	To improve the Trust PLACE scores for access, privacy and dementia	Scrutiny by CQRG and the Estates and Facilities Team
Transitions from one service to another for people on care pathways are made smoothly with everyone well-informed	Developing	To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (achieve CQUIN)	Annual scrutiny via QNIC
When people use NHS services, their safety is prioritised, and they are free from mistakes, mistreatment and abuse	Achieving	To maintain the number of falls at less than 5 per 100 bed days To increase compliance with the falls bundle	Continue with the actions of the Falls Group
Screening, vaccination and other health promotion services reach and benefit all local communities	Developing	To increase the rate of screening for tobacco use and support patients to quit using brief advice and onward referral	Continue with actions as part of the NCL STP Prevention Workstream, including setting up a smoking cessation working group with a clinical lead in the Trust

GOAL TWO: IMPROVED PATIENT ACCESS AND EXPERIENCE

Outcome	Grading	Draft Objective	Approach
People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing	To improve the quality of information – increase accessibility	Monitoring performance against the accessible information standard
People are informed and supported to be as involved as they wish to be in decisions about their care	Developing	To maintain or increase the score for the percentage involved in decisions in the CQC Maternity Survey	Continue to action and monitor via ICSU
People report positive experiences with the NHS	Achieving	To increase the FFT rate of patients recommending treatment in ED	Patient experience leads in ED to continue to meet with the corporate patient experience team
People's complaints about services are handled respectfully and efficiently	Developing	To improve the response rates to complaints	Performance monitored via the Quality Committee

GOAL THREE: A REPRESENTATIVE AND SUPPORTIVE WORKFORCE

Outcome	Grading	Draft Objective	Approach
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Developing	Achieve recruitment ten-year goals outlined in the London WRES Strategy	Expand the requirement for all interview panels to include a BAME representative and continue to report 'close' BAME candidates to the Director of Workforce for further scrutiny. Maintain positive action statements in recruitment advertisements. Add compulsory set "inclusion questions" into each interview.
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving	Eliminate the gender pay gap over the next ten years by reducing year on year	Continue to report on the gender pay gap; work on reducing the gap through current initiatives, including the Women's network and use the gender pay gap report to help identify specific focus areas.
3.3 Training and development opportunities are taken up and positively evaluated by all staff	Developing	Equal access to non-mandatory training	The WRES data shows 50/50 access; therefore, further scrutiny of the data shows which specific groups in the workforce do not have equal access to training.
3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing	Year-on-year reduction in reporting of bullying	Continue to develop and deliver the various elements of the #CaringForThoseWhoCare programme. Continuous overall and local monitoring of staff survey results.
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Developing	Create a process for requesting flexible working arrangements to enable the creation of a reliable database with outcomes	We currently have a policy that benefits everyone, but we do not have data to show how it is being implemented locally and how much it is being taken up. Creating a request system might be an added process layer, but it will provide data we currently lack. Then we will be able to assess whether our policy is being consistently applied and is effective.
3.6 Staff report positive experiences of their	Developing	The year-on-year increase in existing measures, including engagement score, and other	The #CaringForThoseWhoCare programme is designed to improve culture and engagement, the working environment and the staff experience working at Whittington Health.

membership in the workforce		measures from the Staff Survey, Staff FFT/Pulsepoint Survey etc	These objectives must be supported wherever possible by existing programmes of work where they align.

GOAL FOUR: INCLUSIVE LEADERSHIP

Outcome	Grading	Draft Objective	Approach
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing	Visibility of ETM and NED during projects	ETM and NED support major projects, networks and scrutiny of results and outcomes for staff and patients
4.2 Papers that come before the Board and other major Committees identify equality-related impacts, including risks, and say how these risks are to be managed	Developing	A template is created and used to accompany Board, WAC, ETM and TMG reports, in the way cover sheets are expected	Any template must be short, simple and realistic, avoiding jargon and clearly stating the impact and risk to ensure it is used appropriately.
4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Developing	A reduction in the experience of discrimination and other related measures is reported in the annual staff survey, Pulse survey etc	This can be achieved through the various workstreams as part of the #CaringForThoseWhoCare programme and leadership programmes.