NHS
Whittington Health
NHS Trust

Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board held in public on **Tuesday, 26 March 2024** from **12.30pm to 2.10pm** held in Rooms A1 and A2 in the Whittington Education Centre, Highgate Hill, London N19 5NF.

Item	Time	Title	Presenter	Action
		Standing agenda items		
1.	*1230*	Welcome, apologies, declarations of interest	Trust Chair	Note
2.	*1231*	Patient story	Chief Nurse & Director of Allied Health Professionals	Note
3.	*1246*	26 January 2024 public Board meeting minutes, action log, matters arising	Trust Chair	Approve
4.	*1250*	Chair's report	Trust Chair	Note
5.	*1255*	Interim Accountable Officer's report	Interim Accountable Officer	Note
		Quality and safety		
6.	*1305*	Impact of Industrial action	Acting Deputy Chief Executive	Note
7.	*1310*	Quality Assurance Committee report	Committee Chair	Note
		Performance		
8.	*1320*	Finance and capital report	Chief Finance Officer	Discuss
9.	*1330*	Integrated performance scorecard	Chief Strategy, Digital & Improvement Officer	Discuss
		Strategy and governance		
10.	*1340*	University College London Hospitals NHFST and Whittington Health Case for collaboration	Interim Accountable Officer	Approve
11.	*1350*	Audit and Risk Committee report	Committee Chair	Note
12.	*1400*	Charitable Fund Committee report	Committee Chair	Note
13.	*1405*	Questions to the Board on agenda items	Trust Chair	Note
14.	*1410*	Any other urgent business	Trust Chair	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 26 January 2024

Present:	
Baroness Julia Neuberger	Non-Executive Director and Trust Chair
Matthew Shaw	Interim Accountable Officer
Dr Clare Dollery	Acting Deputy Chief Executive Officer & Medical Director
Naomi Fulop	Non-Executive Director (via Microsoft Teams)
Amanda Gibbon	Non-Executive Director
Chinyama Okunuga	Chief Operating Officer
Nailesh Rambhai	Non-Executive Director
Baroness Glenys Thornton	Non-Executive Director
Rob Vincent CBE	Non-Executive Director
Terry Whittle	Chief Finance Officer
Sarah Wilding	Chief Nurse & Director of Allied Health Professionals
In attendance:	
Norma French	Director of Workforce (via Microsoft Teams)
Jonathan Gardner	Chief Strategy, Digital & Improvement Officer
Tina Jegede MBE	Joint Director of Inclusion & Nurse Lead, Islington Care Homes
Alex Negut	Patient Experience Manager (item 1)
Andrew Sharratt	Associate Director of Communications and Engagement
Swarnjit Singh	Joint Director of Inclusion and Trust Company Secretary
Alicia St. Louis	Interim Head of Midwifery (item 8)
Helen Taylor	Clinical Director, Acute Patient Access, Support Services and Women's Health (item 8)
The minutes of the meeting should be read in conjunction with the agenda and papers	

No.	Item
1.	**Welcome, apologies and declarations of interest**
1.1	The Chair welcomed everyone to the meeting. Apologies for absence were received from Junaid Bajwa, Non-Executive Director. There were no new declarations of interest.
2.	**Patient story**
2.1	Sarah Wilding introduced Mr X who had attended to highlight areas where the patient experience could be improved. Mr X explained that he had been a patient at Whittington Health since 2009 under the care of various departments. He had a severe visual impairment and hearing difficulties and outlined the following:

	• Mr X was concerned about the administration and communication of appointments to patients. For example, in early 2023, when he went for a blood test on the 5th floor, he found out that the system had changed. Previously, patients took a number and waited for that number to be called. The receptionist explained to him that the new system involved patients' names and appointment details being displayed on the monitor. • Mr X was told his appointment had passed and had been shown on the monitor. Mr X was concerned at the data protection impact of his and other patients' names being displayed openly in this way. He also raised concerns that accessibility requirements in equality legislation for public services were not being met. • In September 2023, he made a formal complaint to the Trust. He was concerned that, every few months, he received an email apologising for the delay in responding substantively to his complaint which was still being investigated. • A key issue for Mr X had been the lack of access to a working escalator in the main hospital reception. The steep staircase next to the escalator was not accessible for visually impaired people. He reported this in March 2023 and was told that it was being looked into. Mr X felt that quick actions could be taken to make the stairs more accessible by using colour strips and different floor tiling to help patients be aware of each stair. • Mr X pointed out that accessibility was also a concern with the current lifts: they were often not all working and needed an audio facility installed to tell patients which floor had been reached. • Mr X drew attention to the appointment letters he received. They were in a low font and unhighlighted and were not at all helpful. • In addition, Mr X recounted his experience on 8 January 2024 at a podiatry appointment which he had been looking forward to because of an ingrowing toenail. Upon his arrival at the reception desk at the Holloway Health Centre on Hornsey Street, he was told that his appointment had been cancelled. However, Mr X recalls receiving a text message on the previous weekend reminding him of his forthcoming podiatry appointment. He was told that the earliest he could re-book the appointment for was 22 February and was concerned at the additional pain he would face during the additional wait. He therefore rang the main hospital appointments booking team and managed to get an appointment on 10 January instead. Mr X was concerned that not all patients were able to call the main hospital appointments team and that the appointments team staff should be more sensitive to the needs and health and wellbeing of patients.
2.2	In discussion, Board members raised the following points: • The Chair thanked Mr X for his well-made points and commented that, many Board members were nodding, as they, too, had been highlighting similar issues, for some time now. She gave Mr X an undertaking that the Trust would take action and make changes, particularly through the use of yellow strips on the staircase. • Glenys Thornton proposed that an external organisation, such as the Royal National Institute for the Blind (RNIB), be asked to carry out a health

	check audit of the Trust's estate and its correspondence with visually impaired patients. • Matthew Shaw also thanked Mr X for his feedback and commented that the suggestions highlighted should be the norm and not an aspiration. He suggested that patient experience feedback should help to inform a wayfinding strategy for disabled visitors and patients to Trust services. Matthew Shaw gave assurances that there would be a focus on resolving the issue with the escalator in the current quarter and that the yellow strips suggested for the staircase would be implemented quickly and an update on progress reported at the February Board meeting, along with the timeline for any outstanding actions. • The Chair confirmed that blood testing at University College London Hospitals NHS Foundation Trust used a ticket numbering system and the Trust should be looking at different options other than patient names on a monitor. Amanda Gibbon asked for advice on the use of patient names on monitors and whether this breached the provisions of the general data protection regulation (GDPR). • Rob Vincent reminded Board members that an update was due to come to the Board on the patient letter issues which arose in September 2023. Chinyama Okunuga confirmed that a report on this matter would be discussed by the executive team prior to coming to the next Board meeting. • Swarnjit Singh supported the proposals to work in partnership with external disabled organisations to develop a wayfinding strategy. He also suggested that a review of compliance with the Accessible Information Standard (AIS), introduced in the NHS in 2017, be undertaken. The AIS required organisations, at the first point of contact with patients, to ask them whether they needed communication to be in an alternative format. **The Chair thanked Mr X for sharing his experiences with Board members who agreed the following actions:** • **A focus on escalator repair/solution in quarter four** • **The implementation of yellow strips and other alternative flooring on the staircase within the next two weeks and a timeline for other actions required** • **A review of the Trust's estate and communication with an external body such as the RNIB to help inform a wayfinding strategy** • **An update on the patient letter issues in September 2023 be reported at the next meeting in February, following discussion by the executive team** • **Confirm whether having patients' names on monitors breached GDPR requirements** • **A review of compliance with the AIS requirements for patient communication**
3.	**Minutes of the previous meeting**
3.1	The minutes of the meeting held on 29 November 2023 were agreed as a correct record and the updated action log was noted. There were no matters arising.

4.	**Chair's report**
4.1	The Chair thanked staff who continued to work extremely hard in the face of significant demand for services and the additional pressures caused by industrial action. She reported that, on Wednesday, 17 January, she was delighted to attend a special event to acknowledge 40 members of staff who had completed 30 years or more of long service at Whittington Health. Amongst the attendees was Evadney Stewart, who celebrated an incredible 47 years of service with the Trust, and Mandy and Jason Whittaker, who met at the Whittington and married in 2004.
4.2.	The Chair welcomed the fact that Whittington Health was one of the first NHS trusts to roll out a groundbreaking genetic test for patients with inherited blood disorders, like sickle cell disorder and thalassaemia. This world-first test aimed to reduce the risk of side effects from blood transfusions.
4.3	The Chair also reminded Board members that on 27 January many of our patients and staff would be marking Holocaust Memorial Day – an important opportunity for everyone to remember the millions of people murdered under Nazi persecution, and to acknowledge the genocides which followed in Cambodia, Rwanda, Bosnia and Darfur. **The Trust Board received and noted the Chair's report.**
5.	**Interim Accountable Officer's report**
5.1	Matthew Shaw acknowledged the hard work and efforts of staff. He recognised that the Trust was beginning to see the start of improved performance against the four hour emergency department standard in December 2023 and January 2024. Although there remained significant challenges with high demand, performance needed to continue on an upward trajectory. Matthew Shaw reported that the Chief Operating Officer and he would also be reviewing the urgent treatment centre contract. He reported that he had meetings scheduled with colleagues at the London Borough of Haringey to discuss patient flow and the respective roles of the North Central London Integrated Care System, the NHS and local authorities. On 20 February, he was due to see Beverley Tarka, Director of Adults, Health and Communities and Councillor Lucia das Neves, Cabinet Member for Health, Social Care and Wellbeing Nevis, prior to meeting Andy Donald, Chief Executive, on 27 February.
5.2	Board members were informed of the outcome of the British Medical Association's ballot of consultants, with 51% voting to reject the pay offer. There had been no further communication of dates of further industrial action by consultants and junior doctors also remained in dispute over their pay offer.
5.3	Matthew Shaw outlined the clear financial challenges faced across the NHS. He provided assurance that the Trust was working on a financial recovery plan which included robust arrangements for the delivery of more cost improvement programme savings to help address the underlying deficit. He had also spoken with Phill Wells, Interim Accountable Officer at the North Central London Integrated Care System, about the Trust's intention to have a two to three year recovery plan in place.

5.4	Matthew Shaw congratulated Huda Mohamed on receiving her Member of the British Empire award in the King's New Year's Honours for her services to midwifery. Glenys Thornton reported that she had mentioned Huda Mohamed and the Trust's female genital mutilation unit during a debate on maternity services in the House of Lords on 25 January. **The Trust Board noted the Interim Accountable Officer's report.**
6.	**Quality Assurance Committee Chair's report**
6.1	Naomi Fulop explained that the Committee's previous meeting was curtailed due to the significant operational pressures on 8 November and its 10 January meeting met for a longer time. She took the report as read and drew attention to the following points: • There were a number of reports from which the Committee took good assurance, including: o The maternity incentive scheme which demonstrated good compliance in meeting all ten safety actions. o The draft patient safety incident response framework policy (PSIRF). o The quarter four Board Assurance Framework, for which suggested changes to the descriptor for the Quality 2 entry were discussed with members of the Audit and Risk Committee, before an updated BAF was brought to the February Board meeting. o A fantastic presentation from Tim Blackburn, consultant anaesthetist, on a new approach for fasting for patients before surgery where they were encouraged to sip small amounts of water prior to going to theatre, or before the induction of a general anaesthetic. The evidence for the change had shown a reduction in post-operative vomiting, less metabolic issues and less delirium in some elderly patients. • The four key risks which Committee members wished to communicate to the Board were: o Cleaning services and particularly the timeframe for the recruitment of domestic staff and their training o The need to look strategically at services for mental health patients across the Trust o Safety concerns around unfunded flex beds o The impact of industrial action
6.2	Sarah Wilding reported that Theresa Renwick had been appointed as the Head of Vulnerable Adults. She also updated Board members on Simmons House: the unit was closed on 22 December 2023; staff were being redeployed either across the Trust or to the North Central East London collaborative; two external investigations were taking place into the suicide of a young person at the unit; and complaints had been received from the families of the two patients transferred on 22 December.
6.3	In discussion, the following issues were raised: • In reply to a question from Nailesh Rambhai, Sarah Wilding clarified that the two complaints were concerned with the change of healthcare setting and the appropriateness of the speed of the transfer.

	• The Chair welcomed the Committee's continued attention to cleaning standards. • Sarah Wilding confirmed to Jonathan Gardner that the concerns regarding flex beds centred on the nursing leadership which had been stretched. • Amanda Gibbon asked how the Board would continue to receive reports on the level of harm caused by incidents under the new PSIRF policy, especially lower levels of harm which were not surfaced as much. In reply, Clare Dollery confirmed that the Trust was to confirm how it would quantify aspects of the PSIRF and to also provide assurance to Board members and the local community on the quality and safety of care provided. • Glenys Thornton welcomed the training packages being provided and hoped it would cover low levels of harm from incidents. Clare Dollery explained that a good external human factors trainer was being brought in to provide PSIRF training. Matthew Shaw reported that Great Ormond Street Hospital for Children had had a 1.5 hour Board development training session on PSIRF. The Chair agreed that similar training be put in place for Board members. • Rob Vincent raised the importance of non-executive directors having oversight of information on the numbers of cases and how the Trust benchmarked against other providers. The Chair asked that the Quality Assurance Committee enabled non-executive directors to receive adequate assurance on the new PSIRF arrangements for managing cases, their themes and the scale of investigations and cases compared with other providers. **The Trust Board noted the Chair's assurance report for the Quality Assurance Committee meeting held on 10 January 2024 and agreed the draft patient safety incident response framework policy which would now go out to consultation.** **The Trust Board also agreed that:** • **Non-executive directors should be provided with assurance on the arrangements for managing cases, their themes and the scale of investigations and cases compared with other providers.** • **PSIRF training would be provided to all Board members**
7.	**Impact of Industrial Action**
7.1	Clare Dollery took the report as read. She drew attention to the following issues: • The report covered eight periods of industrial action during the period March – October 2023 • An enormous amount of time had been spent by management and frontline staff to ensure that safe staffing was in place during industrial action. There had a been much reliance on the goodwill of consultants who had acted down to cover the absence of junior doctors. In addition, there were many other healthcare professionals who had done an exemplary job in stepping in to help to maintain safety and morale. • In terms of adverse impact, at this point, it was difficult to measure the level of potential harm which may have been caused and the report had

	concentrated on highlighting the number of consultant days and junior doctors' shifts that had been lost. By comparing strike days with non-strike days, it had been calculated that there was a loss of c. 6,000 outpatient appointments and 770 procedural slots. • Many of the patients affected had been waiting for a protracted time already. The impact of the strikes had also been demoralising for our staff. • The Trust had received very few complaints regarding cancelled appointments and procedures, and no deaths had been identified. However, there had been some near miss events where a patient deteriorated and work took place to reinstitute the safety standard needed. • During the January 2024 strikes, the Trust did consider submitting a derogation request through the North Central London Integrated Care System, but this was not needed, as staff such as dermatologists stepped in to fill senior house officer slots. There were two gaps for foundation year one staff, which were filled by advanced clinical practitioners. • The outcome of the British Medical Association's ballot of consultants on their pay offer was disappointing and they retained a mandate to call further industrial action until the end of June; junior doctors had a similar mandate till the end of February.
7.2	In discussion, Board members raised the following points: • The Chair thanked Clare Dollery for her efforts in persuading colleagues to come to work to provide cover. • Rob Vincent felt the way in which the industrial action had been managed was incredibly impressive, especially in the face of a number of challenges presented by the strikes so far. • Nailesh Rambhai said it was important to highlight the significant activity which did go ahead, despite the industrial action, particularly in outpatients. He asked what percentages of consultants and junior doctors did go on strike. In response, Clare Dollery explained that this information was not at hand and conveyed anecdotal evidence that there was a high percentage of junior doctors striking and c. 20% of junior doctors worked through the industrial action. **The Trust Board noted the report on the impact of industrial action and agreed that information on the percentages of consultants and junior doctors who went on strike be provided at the next meeting.**
8.	**Maternity Incentive Scheme**
8.1	Sarah Wilding introduced Alicia St. Louis and Helen Taylor who reported on the compliance achieved for all ten safety actions. Helen Taylor highlighted safety action four where NHS providers were asked to provide evidence that compensatory rest breaks had been implemented for consultants and doctors as non-resident on-call out of hours. She confirmed that a plan had been developed to ensure compliance over the next six months through a formal process. Alicia St. Louis explained that the Trust was declaring compliance with safety action five and reported that a consultation of the maternity workforce structure was planned for 2024, with the aim to increase the number of labour ward and flow coordinators to ensure appropriate cover for the unit.

8.2	This would allow for the presence of two senior midwives at all times and strengthen the supernumerary status of the coordinator. Clare Dollery reported that appendix three of the report showed the updated obstetric workforce action plan, which provided greater assurance. She thanked all maternity service colleagues for their hard work to meet the safety standards. Glenys Thornton also thanked maternity colleagues and welcomed the focus on improving and on reducing risks in the service. The Chair thanked colleagues for achieving compliance for year five of the scheme. **The Trust Board approved the submission for year five of the maternity service incentive scheme and agreed the action plan for compensatory rest breaks. It was also agreed that the maternity services team be thanked on behalf of the Board.**
9.	**Finance report**
9.1	Terry Whittle took the month nine finance report as read. He reported the following: • A deficit of £16.1m which was £3.5m off plan. The principal drivers for the deficit remained underperformance in the delivery of cost improvement savings, (the trajectory for the year forecast £6.3m of savings against a target of £18.1m), unfunded additional bed capacity, the impact of industrial action, underperformance on the level of elective recovery fund monies achieved, and expenditure overspends. • Work to review costs was discussed by the Finance and Business Development Committee and would include a review of rostering arrangements. • Confirmation was awaited on reimbursement for the strike action in December 2023 and January 2024. The reduced elective activity as a result of the strikes had resulted in a shortfall in income received. • Capital expenditure spent during the period April to December 2023 was £17.6m and the total expenditure programme for the financial year was £39m. A review of capital schemes had identified slippage in some of them and led to the re-allocation of capital funds to other areas. • The cash position was £64m and this would reduce further in quarter four as a result of increased capital expenditure and the underlying deficit
9.2	During discussion, the following points were made: • In reply to a query from the Chair on the re-allocation of capital funds, Terry Whittle said that the paper discussed at the 25 January meeting of the Finance and Business Development Committee would be circulated to Board members. • Matthew Shaw emphasised the need to start the new financial year with a clear cost improvement plan in place which started delivering quickly in quarter one and was realistic. • Clare Dollery commented that, a proportion of activity during the strikes, especially in outpatients, was undertaken by allied health professionals. She also thanked Jonathan Gardner and his team for organising and running the 25 January clinical sustainability and improvement workshop.

	• Naomi Fulop asked when the 2024/25 cost improvement plan would be discussed by the Board. Matthew Shaw confirmed that it would be presented to the Board in March. He explained that he had seen the first iteration of business plans from integrated clinical service units which would be rationalised **The Trust Board noted:** **i. the finance and capital expenditure report;** **ii. that the paper discussed at the Finance and Business Development Committee on capital re-allocations would be circulated to Board members; and** **iii. the 2024/25 cost improvement plan would be presented at the March Board meeting.**
10.	**Integrated Performance Report**
10.1	Jonathan Gardner highlighted the following key points: • During December 2023, performance against the four-hour access standard was 57.8%, however, as shown in the Interim Accountable Officer's report, performance in January had been much better. There were 322 12-hour trolley breaches. • In terms of performance against cancer targets, the 28 day faster diagnosis was at 66.3% in November 2023 showing an improvement. An early review of December's performance showed further improvement and the likely achievement of the 75% target. • At the end of December 2023, 36 patients had waited more than 78 weeks for treatment. • On a positive note, staff appraisal rates in December were 79.4% • There was continued improvement shown in diagnostic performance and the magnetic resonance imaging scanner in the community diagnostic centre would help further. • While there was an improvement in the percentage of e-referrals by GPs, the position on appointment slot issues continued to worsen. The robotic automation solution identified was yet to be implemented. • The addendum to the integrated performance report included updates on quality and safety, including an increase in C difficile cases to 13 for the year-to-date and there was a case of MRSA bacterium in the intensive treatment unit. • He had taken on responsibility for leading improvement at Whittington Health and the new Improvement Unit had three areas of focus: patient access, flow and elective recovery.
10.2	In discussion, Board members raised the following points: • Matthew Shaw commented that there was a need to review case mix and also the financial impact and to discuss the principles laid down by the integrated care system for collaboration, including not suffering a financial detriment from collaboration, with integrated clinical service units. • Amanda Gibbon asked for the reasons behind the fall in performance in musculoskeletal (MSK) services. In reply, Chinyama Okunuga explained that the additional weekends worked in 2023 to reduce the MSK backlog

	would be repeated. She added that better recording and reporting was in place for MSK services along with a recovery plan for it and audiology services. • Clare Dollery confirmed that there had been one never event, rather than the two highlighted in the report. • In reply to a request for an update from the Chair on pressure ulcers, Sarah Wilding explained that community services remained challenged with grade three and four pressure ulcers. The themes identified from cases included delays in patients receiving equipment and support needed by carers. **Board members noted the integrated performance report**
11. 11.1	**Q3 delivery of corporate objectives** Jonathan Gardner thanked colleagues for their contributions to the report. He highlighted the increased risks in the quality objectives and the improved performance on statutory and mandatory training and on performance appraisals for the people objectives. In addition, he highlighted the green rating for the integration objectives and the red rating for the sustainable objectives, due to the lack of further savings being delivered and the run rate. **Trust Board members received and noted the outcomes against performance indicators for delivery of Whittington Health's corporate objectives in quarter three.**
12.	**Questions from the public**
12.1	No questions had been received.
13.	**Any other business**
13.1	There were none.

Trust Board, 26 January 2024 public meeting action log

Agenda item	Action	Lead(s)	Progress
Patient story	Focus in quarter four on the escalator repair/solution	Terry Whittle/ Estates & Facilities team	Completed
	In the next fortnight, implement yellow strips and other alternative flooring on the staircase and provide a timeline for any outstanding actions at the next meeting in February	Terry Whittle/ Estates & Facilities team	Completed – further details are provided in the paper in the part II meeting
	Carry out a review of the Trust's estate with an external body, such as the RNIB, to help inform a wayfinding strategy and also review with an external body, the Trust's communication with disabled patients, including compliance with the requirements of the Accessible Information Standard	Chief Nurse, Estates & Facilities, Patient Experience Team	We have been in contact with RNIB, Visibly Better, Blind Aid, Sight Action, Vision Foundation, Sight Loss Council and will continue with this action.
	Provide an update at the February meeting on the	Chinyama Okunuga	Completed – a paper setting out the details of actions being taken was included as an addendum to the action log for the February meeting

Agenda item	Action	Lead(s)	Progress
	patient letter issues from September 2023		
	Confirm whether having a patient's name on monitors breaches GDPR requirements	Jonathan Gardner	The use of SwiftQueue to book phlebotomy appointments is part of an initiative taken across the North Central London (NCL) sector. The system is running at NMUH, UCLH, Royal Free Hospital and most of the GP practices that have phlebotomy services run by these trusts. When a patient attends their appointment, the name shown on the screen is derived from when the patient creates an account with SwiftQueue. Whatever name they use to create the account is used to book an appointment, and when they check in on arrival, the name is then displayed on the screen. Patients do have an option to not have their name displayed on the screen, and should they exercise this option, the phlebotomist will come and call them once it is their turn. When the patient arrives for their appointment, they can ask the receptionist for their name not to be displayed on the screen when they are being checked in. The patient's details will then be available to the phlebotomist on their device, but not visible on the main calling screen.
Quality Assurance Committee Chair's report	Arrange a 1½ hour training session for Board members on the patient safety incident framework in the 2024/25 seminar programme	Clare Dollery	This training will be included in the 2024/25 Board seminar programme

Agenda item	Action	Lead(s)	Progress
	Enable all Board members to received adequate assurance on the numbers of incidents, the issues identified and how the Trust benchmarked against other providers	Quality Assurance Committee members	We will report on performance for duty of candour, the number of patient safety incident investigations and projects being undertaken under the Patient Safety Incident Response Framework (PSIRF) and the PSIRF plan on a quarterly basis in the Quality report
Impact of industrial action	Report back at the March meeting on the impact of the December 2023 and January 2024 strikes	Clare Dollery	Completed – on agenda
Maternity Incentive Scheme	Thank the maternity services team on behalf of the Board	Sarah Wilding	Completed
Finance report	Circulate to all Board members the paper considered at January's Finance & Business Development Committee on the review and re-allocation of capital expenditure	Terry Whittle	Completed
	Bring the 2024/25 Cost Improvement Programme to the March part II meeting	Terry Whittle	Completed

Meeting title	**Trust Board – public meeting**	**Date: 26 March 2024**
Report title	**Chair's report**	**Agenda item: 4**
Non-Executive Director lead	Julia Neuberger, Trust Chair	
Report authors	Swarnjit Singh, Joint Director of Inclusion and Trust Secretary, and Julia Neuberger	
Executive summary	This report provides an update and a summary of activity since the last Board meeting held in public on 26 January 2024.	
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 activities since the last Board meeting held in public.

I want to begin by thanking all of our staff and volunteers for their hard work in ensuring there are safe services in place, and for helping to ensure a good experience for patients. I know that staff have been working under significant pressure with high demand for services and during periods of industrial action and I and all of the board are immensely grateful to them.

Leadership and competency framework for board members
On 28 February, NHS England published its framework for chairs, chief executive and all board members in NHS systems and providers[1], as well as serving as a guide for aspiring leaders of the future. It is designed to:

- support the appointment of diverse, skilled and proficient leaders;
- support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce;
- help organisations to develop and appraise all board members; and
- support individual board members to self-assess against the six competency domains and identify development needs

February private Board meeting
The Board of Whittington Health held a private meeting on 28 February. The agenda items discussed included a report from the Interim Accountable Officer, an update on the draft 2024/25 plan submission to the North Central London (NCL) system, the monthly reports on performance and finances, along with Chair's assurance reports from the Improvement, Performance and Digital Committee, the Workforce Assurance Committee, the Finance and Business Development Committee and the Audit and Risk Committee.

Senior staff changes
There are a number of changes to the senior team which I would like to report formally, a follows:

- Helen Brown has resigned as Chief Executive. She has been working on a review of provider collaboratives for NHS England (London) and was critical in bringing in excellent candidates to key executive positions at the Trust and created a stable and credible senior team. The Trust wishes Helen well in her future career.
- I, and the whole board, would like to thank Matthew Shaw, Chief Executive of Great Ormond Street Hospital (GOSH), who has been our Interim Accountable Officer, for leading and supporting the Trust so well during the past few months. I know he and his counterparts across North Central London will continue to provide any support we may need. We really are very grateful.
- I am now pleased to let you know that, from the end of this month, Dr Clare Dollery will be taking over as acting Chief Executive and Accountable Officer. She will be supported by Terry Whittle, our Chief Finance Officer who will

[1] NHS England » NHS leadership competency framework for board members

become acting Deputy Chief Executive. This arrangement is expected to last for about a year and will be reviewed in six months' time, to ensure that it is working well for everyone concerned.

- Dr Clarissa Murdoch will become acting Medical Director from 1 April whilst a longer-term appointment is made for the period that Clare is acting Chief Executive.
- Norma French announced in October last year that she had taken the decision to retire as Director of Workforce on 27 March following 9 years at Whittington Health and 40 years of service to the NHS as a whole. Since then, the board, have been carefully considering what arrangements should be put in place for the future.
- These discussions have taken place alongside our work with colleagues at University College London Hospitals NHS Foundation Trust (UCLH) and looked at how we can collaborate more closely. By working together more closely, we believe we can improve the quality, safety and experience of people and patients across a common local population, whilst remaining two separate organisations. One area where it makes operational sense to work together more closely is the appointment of a shared workforce director. Both organisations' human resources teams have very good working relationships at a senior level and both are part of the NCL recruitment shared service collaborative.
- I am delighted therefore to report that Liz O'Hara, who is the current UCLH workforce director, will become Chief People Officer for both Whittington Health and UCLH from 27 March 2024. This appointment will initially be for a 12-month period, and it will be reviewed after around six months to ensure that it is working effectively for both trusts. Both organisations will retain separate dedicated workforce teams, as they do currently. We would like to wish Norma a very happy retirement and we look forward to welcoming Liz to Whittington Health very shortly.

Consultant recruitment panels

There were two recruitment and selection panel for consultant posts during this period, as shown below:

Post title	Non-Executive Director	Panel date
Consultant Community Paediatrician	Glenys Thornton	7 February 2024
Consultant in Obstetrics and Gynaecologist	Julia Neuberger	8 February 2024

Corporate induction

On 12 February and 11 March, I took part in corporate induction training and welcomed new starters to Whittington Health.

I have also participated in the following meetings:

- University College London Health Alliance
- Whittington Health Charitable Funds Committee
- Lord Adebowale, Chair of the NHS Confederation
- David Lammy, Member of Parliament for Tottenham
- Whittington Health Board, Remuneration Committee and Medical Committee

- Formal opening of the Wood Green Community Diagnostic Centre
- UCLH/Whittington Health Partnership Board Committee
- NCL Strategy and Development Committee
- NCL ICB shortlisting for a new system Chair

Meeting title	**Trust Board – public meeting**	**Date: 26 March 2024**
Report title	**Interim Accountable Officer report**	**Agenda item: 5**
Executive lead	Matthew Shaw, Interim Accountable Officer	
Report authors	Swarnjit Singh, Trust Company Secretary, Clare Dollery, Acting Chief Executive and Medical Director and Matthew Shaw	
Executive summary	This report provides Board members with a report covering important developments since the last Board meeting held in public on 26 January 2024.	
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	
Appendices	None	

Interim Accountable Officer report

This is my final report to a Board meeting in public at Whittington Health NHS Trust. I am grateful to have had the opportunity lead and support the senior team over the past few months and I want to thank staff for their tremendous work in challenging circumstances.

2023 NHS Staff Survey results

The results of the 2023 NHS Staff Survey[1], which took place between 27 September and 24 November 2023 (along with historical results back to 2019), are now available. A full report and action plan will be presented to Trust Board in April 2024. Results are presented in the context of best, average and worst results for similar organisations where appropriate. Data in this report ais weighted to allow for fair comparisons between organisations.

The results of the NHS Staff Survey are measured against the seven People Promise[2] elements and against two of the themes reported in previous years (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes.

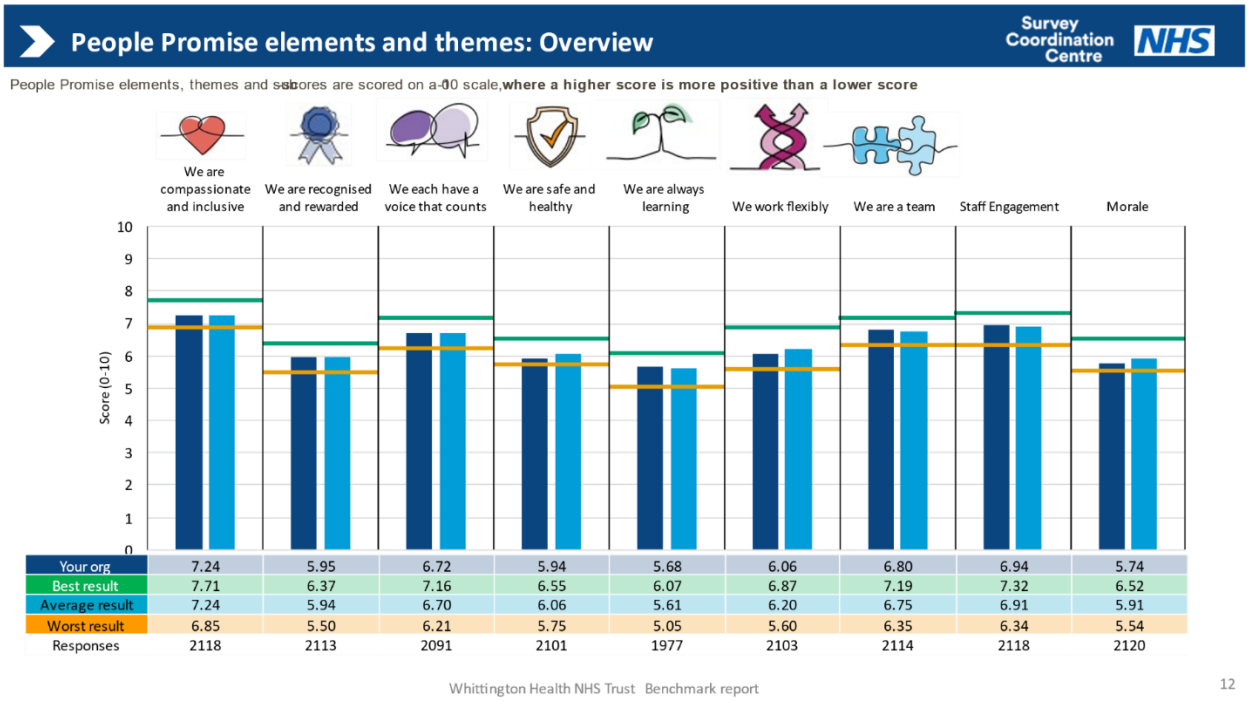
As an organisation, we have done **better than the average** in the following People Promise themes: we are recognised and rewarded; we each have a voice that counts; we are always learning; we are a team and staff engagement. We are the **same** as the national average for we are compassionate and inclusive. We are **worse than the average** in we are safe and healthy; we work flexibly; and morale.

The table below shows Whittington Health's scores against the national average for acute and community trusts:

People promise element	Whittington Health	Average result
We are compassionate and inclusive	7.24	7.24
We are recognised and rewarded	5.95	5.94
We each have a voice	6.72	6.70
We are safe and healthy	5.94	6.06
We are always learning	5.68	5.61
We work flexibly	6.06	6.20
We are a team	6.80	6.75
Staff Engagement	6.94	6.91
Morale	5.74	5.91

The slide overleaf an overview of the people promise elements in a graph format from the survey benchmark report.

[1] Results | Working to improve NHS staff experiences | NHS Staff Survey (nhsstaffsurveys.com)
[2] NHS England » Our NHS People Promise



National workforce disability and race equality standard reports

On 18 March, NHS England published its workforce disability[3] (WDES) and race[4] (WRES) reports for 2023 outcomes. Both reports are a snapshot of where NHS trusts are in addressing workforce inequalities. The disability report shows that disability declaration rates by NHS staff has significantly improved in 2023, up by 19.9% due to improved engagement by NHS trusts. While board members declaring a disability has risen from 2.1 % in 2019 to 5.7%. The race report data highlighted the fact that 26.4% of the 1.6m NHS workforce is from an ethnic minority. This proportion increases to nearly half (47.5%) for doctors, dentists and consultants and more than one-third (33.6%) of our nurses, midwives and health visitors. It was positive to see that ethnic minority representation at Board level has increased to 11%. The Secretary of State for Health and Social Care said "I want to see the NHS recruit and retain brilliant people from all backgrounds. It is important that the NHS at all levels represents the people it cares for, and I welcome progress in appointing more black and minority ethnic staff to senior positions and better representation of disabled people in the NHS workforce. Through our introduction of the first ever NHS long-term workforce plan, we are creating more opportunities for doctors and nurses here at home, which will boost the NHS workforce and the diversity within it."

Start Well review

The consultation on the North Central London Integrated Care System's proposals for maternity, neo-natal and paediatric care closed on 17 March. I am grateful to Clare Dollery as our executive lead for Start Well for her efforts in engaging with staff and local people during the engagement and consultation events which took place and to all those who contributed to engagement and the consultation itself. In terms of next steps, the consultation responses will be analysed by an independent company, Opinion Research Services, who will produce a report for the NCL

[3] NHS England » Workforce Disability Equality Standard: 2023 data analysis report for NHS trusts
[4] NHS England » NHS Workforce Race Equality Standard (WRES)

Integrated Care Board and NHS England and further details will be provided by the NCL Integrated Care Board in due course.

Collaboration with University College London Hospitals NHSFT
The next steps for increased collaboration between Whittington Health and University College London Hospitals NHS Foundation Trust are outlined in a separate item on today's meeting agenda. There are considerable benefits for local people in having a more integrated approach to pathways and eight specific areas have been identified for further collaboration. Approval is sought from Board members for the case for collaboration and the recommended next steps.

Community Diagnostic Centre
On 23 February, I am delighted to report that the official opening of the Wood Green Community Diagnostic Centre's lower ground floor was opened by Professor Sir Mike Richards. Catherine West, MP for Hornsey and Wood Green attended and Baroness Neuberger DBE gave a presentation thanking staff for the wide range of diagnostic activity taking place at the centre – blood tests, x-rays, ultrasounds, eye (ophthalmology) clinic, and now MRI and CT scanning too. Patients can now receive diagnostic imaging without having to attend a main hospital site of wait for a hospital referral. This centre will really make a difference to help the NHS to achieve its aims of reducing waiting times for diagnostic imaging and address health inequalities for local people.

2024/25 Plan
Colleagues have been focussed on developing activity, workforce and financial plans for 2024/25 and have been discussing draft iterations with the NCL system. While at the time of writing this report, national planning guidance is yet to be published, NHS England has already published financial allocations for 2024/25 and outlined that the

overall financial framework will remain consistent, including the payment approach used to support elective recovery. System plans will need to achieve and prioritise financial balance. In addition, the priorities and objectives set out in the 2023/24 planning guidance and the published recovery plans for the urgent and emergency care and elective and cancer care will not fundamentally change. In terms of workforce, the expectation is that there will be net growth in staffing numbers next financial year. Board members will discuss a draft plan submission in the part II meeting later today.

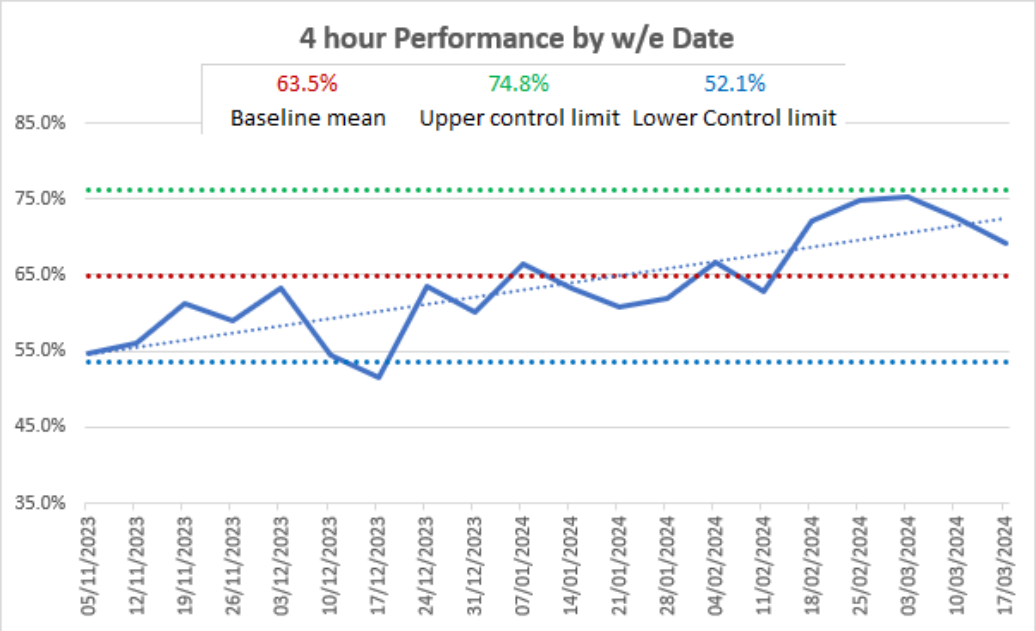
Operational performance

The integrated performance report is a separate item on the agenda. Headlines show these outcomes:

- Emergency care: performance against the four-hour access standard in February was 70.8% representing a 13% improvement since December 2023 (57.8%). There were 221 12-hour trolley breaches in February 2024, a drop of 219 compared to January's performance of 440.
- Cancer care performance against the 28 day faster diagnosis standard: after seeing excellent performance in December (79.5%), a deterioration of 9.5% to 70% in January 2024, however, this is an upward trend compared to previous months.
- Referral to treatment: performance against 18-week standard in February was 66.5% and remains consistent compared to previous months. The Trust's position on 52-week waits continues to improve from 607 patients in January to 500 in February 2024. The Trust had 17 patients over 78 weeks at the end of February 2024 against a target of 0.

Performance against the 4 hour emergency department standard

The graph below shows how the ED department has fared with meeting the four hour emergency access standard between 5 November 2023 and 17 March 2024. Since the week ending 18 February, there have been five weeks where performance was consistently over 70%, with the week of 17 March at 70.4%.



Maternity services
On 5 March, I visited our maternity services team and met with Isabelle Cornet, Director of Midwifery and the team. I was struck by their dedication to delivering a safe environment and good patient experience for local expectant mothers.

Basi Vertebral Nerve Ablation: Leading the way in pain management

I am also pleased to announce that Whittington hospital has the first pain clinic in the UK that offers Basi Vertebral Nerve (BVN) ablation procedure which targets the basilar vertebral nerve and is a minimally invasive solution for chronic back pain associated with degenerative disc disease. Ablating the nerve helps to effectively disrupt pain signals, offering patients long-term relief. Historically, the only procedure offered to those patients was spinal fusion surgery; however, this is not a routinely offered procedure nowadays because of associated risks. Patients would usually be left with no other option other than relying on painkillers to manage their pain so the introduction of the BVN procedure will make a huge difference to the lives of patients.

All staff briefings
Since the January Board meeting, I am grateful to Clare Dollery for delivering four all staff Chief Executive briefings which take place fortnightly. The last one took place on 21 March and covered these key areas: leadership changes; the introduction of the Patient Safety Incident Response Framework which will launch on 1 April 2024; the introduction of an Act Now acronym and framework which advises staff how to respond to patients in crisis with sickle cell disease; and the outcome of the 2023 Care Quality Commission Maternity survey which will be used to inform our improvement plan.

27 March Brigante exercise
On Wednesday 27 March, our emergency planning team will be running 'Brigante's Lamp' exercise alongside the London Fire Brigade, Metropolitan Police and London Ambulance Service. Brigante's Lamp is a major incident exercise that will test our response to a fake mass casualty incident. These types of exercises help us to strengthen our confidence in major incident escalation, communication, and coordination, so should any kind of incident occur in the future, we are better prepared.

Physical environment changes
Work on our hospital site's escalator is continuing, and our estates and facilities team will endeavour to ensure there are no trip hazards and that dust is kept to a minimum.

New Clinical Directors and thanks to Deepak and Chetan
Following a competitive recruitment process, I am happy to announce that the appointments of Dr Duncan Carmichael and Dr Chetan Parmar as Clinical Directors in our Emergency and Integrated Medicine and Surgery and Cancer clinical divisions respectively. I would also like to take this opportunity to thank Dr Deepak Suri and Dr Chetan Bhan for their tireless service as clinical directors as they have been critical to maximising opportunities and meeting challenges in the clinical divisions. Chetan has demonstrated great leadership in developing our collaboration with UCLH and the wider sector and Deepak has seen us through several difficult winters and kept us safe through the industrial action.

Extra Mile Awards
I am pleased to announce last month's winners of the Trust's Extra Mile awards – Toby Kent and Mariatu Sesay. Toby is a Multi-Agency Care and Coordination team service manager and was nominated by one of his team members for being exemplary in showing his care, respect and interest to every member of his team and going the extra mile to understand their cultural and religious backgrounds and being successful in making each one of us feel appreciated. Mariatu is a Staff Nurse and her nomination cited her excellent rapport with patients who trusted her and felt safe She is compassionate and 100% focused on the patient. Her holistic approach also meant she identified emerging needs, such as a bed rail assessment, an analgesia review and a dietician referral.

In addition, we also gave an extra mile award to a previous monthly winner, Beth Bamberger, a speech and language therapist in our Barnet children's therapy services.

'Five a Day' fruit and vegetable stall

On 13 March, the Trust officially launched a “Five a Day” healthy living fruit and vegetable stall at the main hospital site to encourage healthy eating and wellbeing. The Five a Day team are also putting together seasonal fruit boxes for smaller teams and will be sent to our community sites.

Lord Mayors’ annual walk

On Sunday, 17 March, the annual five mile sponsored walk took place for London’s Lord Mayors. They followed the route that Richard ‘Dick’ Whittington, one of London’s most famous mayors, took some 600 years ago from the spot of the cat statue near the Whittington Hospital to Mansion House in the City of London. I am grateful to Jonathan Gardner for meeting the Lord Mayors on behalf of the Trust.

Meeting title	**Trust Board – public meeting**	**Date: 26 March 2024**
Report title	**Impact of 2023/2024 Junior Doctor and Consultant Industrial Action**	**Agenda item: 6**
Executive lead	Dr Clare Dollery, Executive Medical Director	
Report authors	Dr Clare Dollery, Executive Medical Director, Kemi Ogunseitan, Medical staffing HR business partner, Paul Attwal, Head of Performance, and Vicki Pantelli, Business Manager to the Medical Director	
Executive summary	This paper considers the quality impact of the 10 periods of industrial action (IA) between March 2023 and January 2024. This does not consider the IA in February 2024 as this data was still being collated at the time this report was due for submission. The approach to providing services during the IA has been focused throughout on the prioritisation of patient safety with a secondary but important objective to maintain long term team relationships between all professional groups taking or ensuring safety during IA in order to have teams can come back together after IA ends to deliver safe high quality patient focused health services. Over the 10 strikes the following impact was seen: • 2862 junior doctor shifts lost, 100 Consultant workdays lost. • 6177 outpatient appointments not available for use between March and October 2023. • 1411 outpatient appointments not available for use in December 2023 and January 2024. • 768 inpatient procedures not available for use between March and October 2023. • 156 inpatient procedures not available for use in December 2023 and January 2024. • No serious incidents were declared, a number of lower impact events had to be urgently mitigated when detected – overall incident reporting increased during the strike periods. • No deaths attributable to IA were reported with variable numbers of deaths. • There were 8 patient advice and liaison concerns related to IA and no complaints were received. Nursing, allied health professionals, and operational management teams have worked very hard to ensure safety through the strikes. The professionalism of the multidisciplinary team throughout this period is to be commended.	

	The flexibility of consultant medical teams to act down or out of their usual area of speciality has been key to safe cover. The BMA IA has had significant adverse impact on patients waiting times for outpatient and inpatient care – the full impact is as yet unknown. Staff have stepped up to ensure immediate patient safety in difficult circumstances with ongoing fatigue and some impact on morale.
Purpose:	Discussion
Recommendation	Trust Board is asked to consider the quality impacts of the industrial action by Consultants and Junior Doctors
Board Assurance Framework	BAF Quality Risk 1
Appendices	None

1. Introduction

1.1. This paper undertakes an analysis of the safety impact of the 2023 and January 2024 junior doctors' and Consultants IA (IA) drawing on activity, workforce, and patient and staff feedback data, as well as after-action reviews conducted at intervals. It considers the strikes to January 2024 but not the most recent IA in February 2024.

2. Background

1.1. The IA undertaken via the British Medical Association (BMA) is outlined in the table below.

Table 1 Industrial Action dates

Date	Staff group	Nature of Action
13 – 16 March 2023	Junior Doctors	Full walkout
11 – 15 April 2023	Junior Doctors	Full walkout
14 – 17 June 2023	Junior Doctors	Full walkout
13 – 18 July 2023	Junior Doctors	Full walkout
20 – 22 July 2023	Consultants	Christmas day service
11 - 15 August 2023	Junior Doctors	Full walkout
19 September 2023	Consultants	Christmas day service
20 September 2023	Joint Junior Doctors/Consultants	Christmas day service
21 September 2023	Junior Doctors	Full walkout
22 - 23 September 2023	Junior Doctors	Full walkout
2 – 5 October 2023	Joint Junior Doctor/Consultants	Christmas day service
20 – 23 December 2023	Junior Doctors	Full walkout
3 – 9 January 2024	Junior Doctors	Full walkout

1.2. The BMA had a positive mandate following a national ballot for junior doctors to take IA during specific dates from March 2023 – January 2024. There was also a positive ballot for consultants to take IA in conjunction with the juniors during July, September and October 2023.

1.3. For dates in March - August pertaining to the junior doctor IA the BMA had a national mandate and there was no derogation of services, except for arrangements to recall staff in the event of a mass casualty incident. All services in all NHS organisations employing junior doctors were affected. This also applied to September, December, January and February junior doctor strikes.

1.4. The Consultant strikes had a national derogation that a Christmas day service was maintained which meant urgent and emergency care pathways and usual out of hours on call services were staffed. The underlying principle for the Trust services impacted by the IA was that all elective activity was cancelled. Some consultants elected to tell the Trust that they were not intending to take IA and asked that their clinical work was modified or retained – whichever was appropriate to the team skill mix needed to deliver the type of care.

1.5. Joint junior doctor and consultant action also followed a Christmas day service national derogation.

1.6. The Trust response was led by the Medical Director and the Chief Operating Officer who is responsible for emergency planning, with the Director of Workforce and their teams as well as the ICSU triumvirates and vital support services such as pharmacy, radiology, IM&T and pathology. Planning commenced as soon as each action was announced, with a focus on keeping patients safe, delivering high standards of care in urgent and acute services that could not be stood down, and supporting those colleagues providing essential cover.

1.7. Long term team relationships between all professional groups taking action or ensuring safety during IA have been prioritised throughout to ensure that teams can come back together after IA ends to deliver safe high quality patient focused health services.

2. Junior Doctor and Consultant Absences

2.1. Methods to exactly measure those choosing to take strike action are imperfect. National returns were subject to change as strike action evolved and were frequently required on short deadlines which may have led to both under and overestimates of staff taking IA. The changing nature of derogations across the different periods of IA also make comparison of the periods unhelpful.

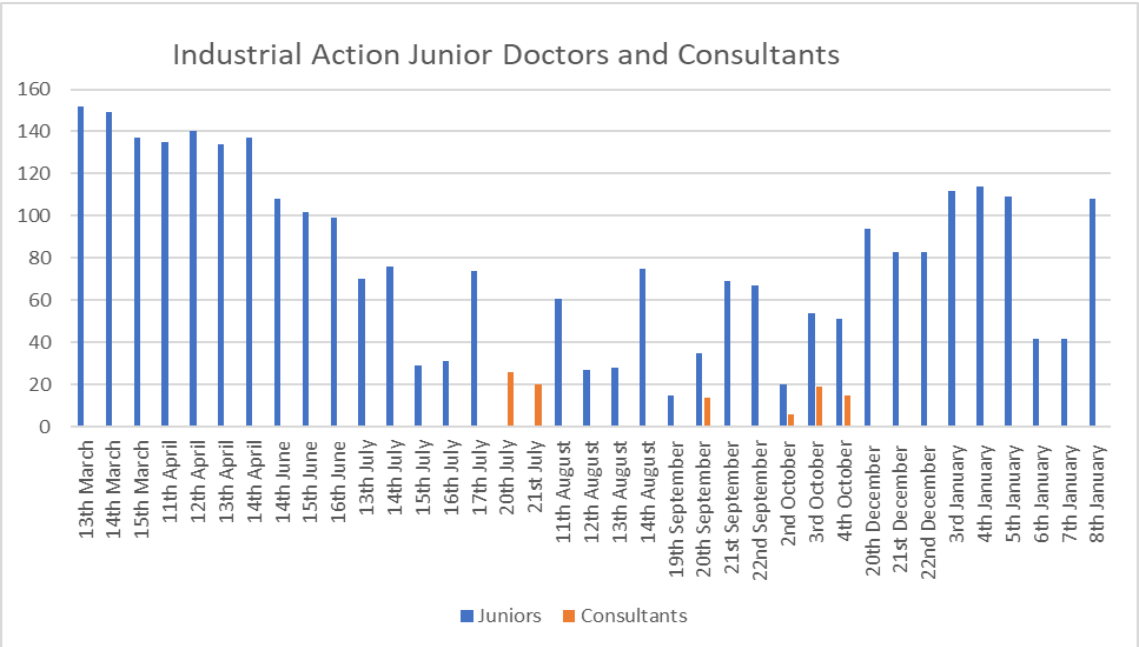
2.2. Data from the human resources teams used to inform payroll actions is presented in Graph One. This data derives from returns made by the doctors or management teams.

2.3. Higher number of individuals took action during the early part of the year, July and August trends reduced but may have been attributed to annual leave and August would have seen a junior doctor rotation within the Trust.

2.4. The highest level of junior's absences in early March, represents 53% of juniors taking IA. Consultants in July represents 10% of consultants taking action understanding that some were ineligible to take IA due to the Christmas day derogation.

2.5. In total 2862 workdays for junior doctors and 100 workdays were lost due to IA.

Graph One - Breakdown of junior doctors' and Consultant absences during IA



2.6. Table One below details both junior doctor and consultant absences and participation during all IA periods.

Graph One –Industrial Action Uptake

Date From	Date To	Rank	Absent During Industrial Action (number)	Doctors on Rota (number)	* Percentage absent (%)	** Doctors attending to work
13/03/2023	14/03/2023	Junior	96	104	92%	8
14/03/2023	15/03/2023	Junior	83	107	78%	24
15/03/2023	16/03/2023	Junior	91	108	84%	17
Overall total for IA period			**270**	**319**	**85%**	**49**
11/04/2023	12/04/2023	Junior	89	89	100%	0
12/04/2023	13/04/2023	Junior	89	89	100%	0
13/04/2023	14/04/2023	Junior	92	93	99%	1
14/04/2023	15/04/2023	Junior	92	93	99%	1
Overall total for IA period			**362**	**364**	**99%**	**2**
14/06/2023	15/06/2023	Junior	90	108	83%	18
15/06/2023	16/06/2023	Junior	83	93	89%	10
16/06/2023	17/06/2023	Junior	85	93	91%	8
Overall total for IA period			**258**	**294**	**88%**	**36**
13/07/2023	14/07/2023	Junior	63	82	77%	19
14/07/2023	15/07/2023	Junior	49	62	79%	13
15/07/2023	16/07/2023	Junior	32	33	97%	1
16/07/2023	17/07/2023	Junior	30	36	83%	6
17/07/2023	18/07/2023	Junior	82	89	92%	7
Overall total for IA period			**256**	**302**	**85%**	**46**
20/07/2023	21/07/2023	Consultant	No data	No data	No data	No data
21/07/2023	22/07/2023	Consultant	No data	No data	No data	No data
Overall total for IA period						
11/08/2023	12/08/2023	Junior	64	70	91%	6
12/08/2023	13/08/2023	Junior	26	28	93%	2
13/08/2023	14/08/2023	Junior	26	28	93%	2
14/08/2023	15/08/2023	Junior	80	84	95%	4
Overall total for IA period			**196**	**210**	**93%**	**14**
19/09/2023	19/09/2023	Consultant	17	27	63%	10
20/09/2023	20/09/2023	Junior (Joint)	43	46	94%	3
20/09/2023	20/09/2023	Consultant (Joint)	24	24	100%	0
21/09/2023	21/09/2023	Junior	59	61	97%	2
22/09/2023	22/09/2023	Junior	59	60	98%	1
Overall total for IA period			**202**	**218**	**93%**	**16**
02/10/2023	03/10/2023	Junior (Joint)	70	159	44%	89
03/10/2023	04/10/2023	Junior (Joint)	62	136	46%	74
04/10/2023	05/10/2023	Junior (Joint)	64	131	49%	67
Overall total for IA period			**196**	**426**	**46%**	**230**
02/10/2023	03/10/2023	Consultant (Joint)	29	106	27%	77
03/10/2023	04/10/2023	Consultant (Joint)	53	129	41%	76
04/10/2023	05/10/2023	Consultant (Joint)	29	112	26%	83
Overall total for IA period			**111**	**347**	**32%**	**236**
20/12/2023	21/12/2023	Junior	97	111	87%	14
21/12/2023	22/12/2023	Junior	89	96	93%	7
22/12/2023	23/12/2023	Junior	80	85	94%	5
23/12/2023	24/12/2023	Junior	0	9	0%	9
Overall total for IA period			**266**	**292**	**91%**	**26**
03/01/2024	04/01/2024	Junior	143	163	88%	20
04/01/2024	05/01/2024	Junior	141	161	88%	20
05/01/2024	06/01/2024	Junior	134	158	84%	24
06/01/2024	07/01/2024	Junior	54	66	82%	12
07/01/2024	08/01/2024	Junior	44	53	83%	9
08/01/2024	09/01/2024	Junior	129	153	84%	24
09/01/2024	10/01/2024	Junior	3	89	3%	86
Overall total for IA period			**645**	**754**	**86%**	**109**

The table illustrates a variable level of participation in IA. The method of gathering returns has had minor variations over this period and teams have become more experienced at

collecting the data at a time when they are also actively managing risks to safety and morale due to lower staffing levels. In general the junior doctors have had high level uptake of the IA with 99% out of work in the second strike and 86% in the January strike. Consultant uptake has been lower and varied between teams with more recent strikes at 32% - this will also reflect consultants who were working in the Christmas day service who were not part of the strike due to the derogation.

3. IA Planning

3.1. Prior to each round of IA in the lead up to the strike days, Operational, Clinical and Corporate teams came together at daily meetings, chaired by either the Medical Director in the planning phase or the Chief Operating Officer during the emergency (IA) period.

3.2. The purpose of these meetings was to ensure the safety of patient services via receipt of RAG ratings on the pre planning and in particular the fill rates of the medical rotas that were being put in place within each ICSU. This planning group included Clinical Directors, Directors of Operations or their deputies and representatives from HR, nursing, pharmacy, radiology, IM&T, and pathology etc. This team approach has been critical to ensuring safety through the IA. The Whittington Health Clinical Advisory Group has also received regular updates on the strike planning.

3.3. During the actual days of IA, this group met daily for operational check in calls and all clinical leads were invited to attend to understand the dynamic level of risk on the sites.

3.4. The COO and Executive Medical Director also attended system update calls across NCL.

3.5. The Medical Director or deputy walked the inpatient wards each day of the strikes to update and thank the multidisciplinary team for their work.

3.6. Elective activity was cancelled or curtailed and multi-disciplinary teams came together to provide additional support. Support for IT was delivered with “floor walkers” to aid consultant support on systems when juniors took action.

3.7. Pharmacy staff worked additional shifts to ensure additional support was present on wards and to fast track TTAs.

3.8. Senior nurses provided visible leadership across the clinical areas and other nursing colleagues took on additional work as needed.

3.9. Vacant medical shifts were covered wherever possible by Bank and agency, however the law changed in August 2023 and no agency staff were allowed to be booked to cover strike action. Staff continued to be booked to cover pre-existing vacancies and sick absence.

3.10. No Trust specific derogations were requested during the periods of IA. The process to submit derogations was held nationally by the BMA and in general were not agreed.

3.11. Prior to each round of IA a strike committee met with staff side representatives from the BMA and local reps to discuss operational practicalities of the action and to ensure that those who chose to take action were supported.

4. Reduction of Activity

4.1. Staffing of acute inpatient and emergency services required a significant step down of elective activity, including outpatient appointments, inpatient procedures and day case surgery.

4.2. The minimum legal 2 weeks' notice was given for most strikes with some giving longer periods of notice. The pattern of patients being cancelled therefore changed as the strikes continued with pre-emptive action taken not to book patients for strike dates which give an appearance that cancellations have reduced. In order to reflect the activity that usually is carried out average activity for a 4-week index period outside IA was taken as a comparator.

4.3. Table 2 contains details of stand down of bookings ahead of the strikes as well as direct patient cancellations of already booked activity. Table 2 shows that 88.3% of all outpatient activity was undertaken on the strike days including non-medical led clinic activity. This is 7588 fewer appointments than expected for the relevant index periods.

4.4. Where possible 2 week wait clinics have not been cancelled and target endoscopy has been maintained.

Table Two. Outpatient Activity Comparison

Type of activity	**Total Outpatients**		
Activity Undertaken	**Strike**	**Average**	**%**
Mon 13/03/2023	1680	1895	88.7%
Tue 14/03/2023	1719	1984	86.6%
Wed 15/03/2023	1618	2040	79.3%
Tue 11/04/2023	1647	1932	85.2%
Wed 12/04/2023	1656	2017	82.1%
Thu 13/04/2023	1534	1828	83.9%
Fri 14/04/2023	1533	1558	98.4%
Sat 15/04/2023	398	342	116.4%
Wed 14/06/2023	1714	1886	90.9%
Thu 15/06/2023	1662	1706	97.4%
Fri 16/06/2023	1376	1487	92.5%
Thu 13/07/2023	1469	1700	86.4%
Fri 14/07/2023	1144	1455	78.6%
Sat 15/07/2023	383	405	94.6%
Sun 16/07/2023	198	176	112.5%
Mon 17/07/2023	1628	1808	90.0%
Tue 18/07/2023	1701	1804	94.3%
Thu 20/07/2023	1395	1700	82.1%
Fri 21/07/2023	1234	1455	84.8%
Fri 11/08/2023	1183	1466	80.7%
Sat 12/08/2023	283	353	80.2%
Sun 13/08/2023	108	148	73.0%
Mon 14/08/2023	1606	1778	90.3%
Tue 15/08/2023	1902	1839	103.4%
Thu 24/08/2023	1536	1654	92.9%
Fri 25/08/2023	1279	1466	87.2%
Tue 19/09/2023	1535	1743	88.1%
Wed 20/09/2023	1550	1632	95.0%
Thu 21/09/2023	1355	1607	84.3%
Fri 22/09/2023	1285	1213	105.9%
Mon 02/10/2023	1491	1766	84.4%
Tue 03/10/2023	1300	1722	75.5%
Wed 04/10/2023	1354	1742	77.7%
Thu 05/10/2023	1386	1712	81.0%
Wed 20/12/2023	1449	1696	85.4%

Thu 21/12/2023	1368	1526	89.6%
Fri 22/12/2023	1104	1461	75.6%
Sat 23/12/2023	307	295	104.1%
Wed 03/01/2024	1565	1698	92.2%
Thu 04/01/2024	1367	1704	80.2%
Fri 05/01/2024	1477	1414	104.5%
Sat 06/01/2024	251	315	79.7%
Sun 07/01/2024	118	164	72.0%
Mon 08/01/2024	1693	1825	92.8%
Tue 09/01/2024	1721	1733	99.3%
Total	**57262**	**64850**	**88.3%**

4.5. Table 3 below demonstrates the comparison of elective inpatient procedural activity, contrasting number of procedures undertaken on strike days with average procedure numbers. This shows that 94.2% of average activity took place, a reduction from 2685 to 2529 procedures - that is 156 procedures were lost over this period for all the strike periods up to and including January 2024.

Table Three Elective Inpatient Activity Comparison

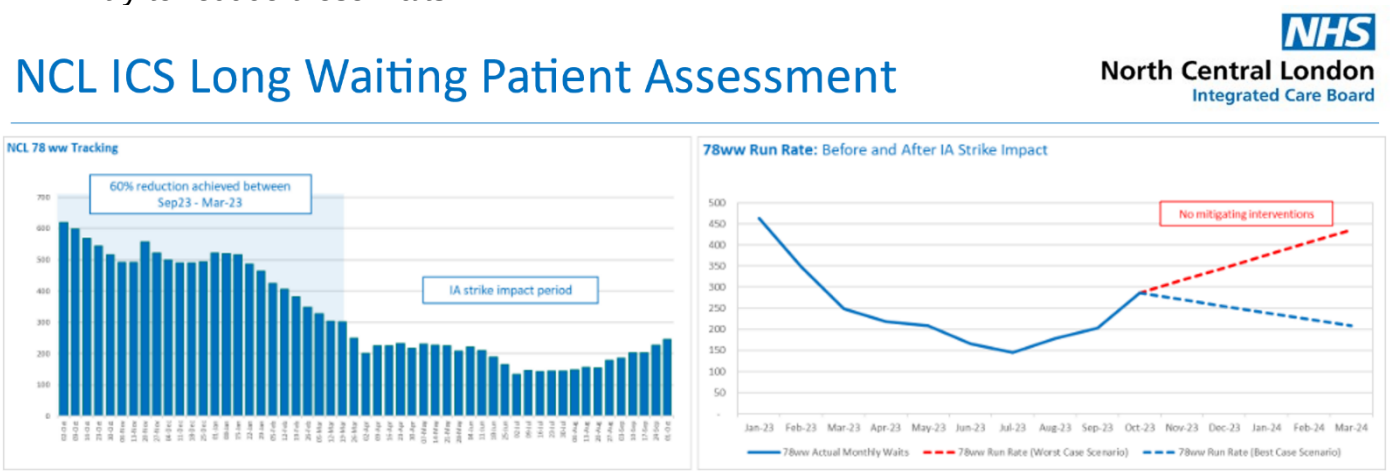
Type of activity	**Total Elective**		
Activity Undertaken	**Strike**	**Average**	**%**
Mon 13/03/2023	43	80	53.8%
Tue 14/03/2023	42	83	50.6%
Wed 15/03/2023	66	91	72.5%
Tue 11/04/2023	52	106	49.1%
Wed 12/04/2023	78	97	80.4%
Thu 13/04/2023	66	102	64.7%
Fri 14/04/2023	66	101	65.3%
Sat 15/04/2023	7	4	175.0%
Wed 14/06/2023	81	98	82.7%
Thu 15/06/2023	90	107	84.1%
Fri 16/06/2023	84	100	84.0%
Thu 13/07/2023	79	82	96.3%
Fri 14/07/2023	47	63	74.6%
Sat 15/07/2023	7	4	175.0%
Sun 16/07/2023	1	3	33.3%
Mon 17/07/2023	46	85	54.1%
Tue 18/07/2023	88	101	87.1%
Thu 20/07/2023	74	82	90.2%
Fri 21/07/2023	46	63	73.0%
Fri 11/08/2023	68	66	103.0%
Sat 12/08/2023	0	6	0.0%
Sun 13/08/2023	3	2	150.0%
Mon 14/08/2023	55	95	57.9%
Tue 15/08/2023	91	88	103.4%
Thu 24/08/2023	65	98	66.3%
Fri 25/08/2023	42	66	63.6%
Tue 19/09/2023	66	105	62.9%
Wed 20/09/2023	68	93	73.1%
Thu 21/09/2023	59	99	59.6%
Fri 22/09/2023	51	97	52.6%
Mon 02/10/2023	64	108	59.3%
Tue 03/10/2023	62	90	68.9%

Wed 04/10/2023	72	110	65.5%
Thu 05/10/2023	88	110	80.0%
Wed 20/12/2023	67	89	75.3%
Thu 21/12/2023	69	95	72.6%
Fri 22/12/2023	55	84	65.5%
Sat 23/12/2023	1	1	100.0%
Wed 03/01/2024	68	90	75.6%
Thu 04/01/2024	82	102	80.4%
Fri 05/01/2024	78	90.2	86.5%
Sat 06/01/2024	5	3	166.7%
Sun 07/01/2024	5	3	166.7%
Mon 08/01/2024	76	83	91.6%
Tue 09/01/2024	106	108	98.1%
Total	**2529**	**2685**	**94.2%**

4.6. In addition to the on-the-day impact, the cancellations of activity on the strike days will have a negative impact on the size of waiting lists, resulting in longer waits for patients. This will be reflected in future performance reports.

5. NCL impact on waiting lists

5.1. The following graphic gives a North Central London view on the impact of IA on waiting lists. The number of patients waiting 78 weeks or more had been steadily falling but had then plateaued as IA commenced and has since risen somewhat. All Trusts are taking action to try to reduce these waits.



6. Incidents, Mortality Data and Patient Experience

6.1. In order to have an overall assessment of impact on reported incidents or deaths a sample period spanning the strike dates with a 1-week margin before and after the actual IA has been measured. A comparator period from February shows the number of reports prior to IA. To provide a comparison, the same data are also given for the period between 8-20th February. Both are 15-day periods.

6.2. **Incidents**

6.2.1. Overall, in the first IA period similar numbers of incidents were reported to the comparator period but during and around the subsequent IA higher numbers were reported. The severity profile of incidents was similar.

6.2.2. One incident was noted in which a patient was monitored less closely than intended but was judged not to have affected their outcome. During the post easter strike several patients deteriorated on a ward caring for medically optimised patients and staff or patients needed to be moved to reinstate safety.

6.2.3. Through the hard work of staff from all the professions who were working, safety was otherwise maintained with no serious incidents occurring.

Table 4 Incidents

Date	Whose action	Sample period	No of patient safety incidents
Comparator period	NA	8-20 February 2023	297
13 – 15 March 2023	Junior Doctors	8 – 20 March 2023	292
11 – 15 April 2023	Junior Doctors	6 – 20 April 2023	315
14 – 16 June 2023	Junior Doctors	9 – 21 June 2023	403
13 – 21 July 2023	Joint Junior Doctors/ Consultants	8 – 26 July 2023	474
11 - 15 August 2023	Junior Doctors	6 – 20 August 2023	389
19 - 22 September 2023	Joint Junior Doctors/Consultants	14 – 27 September 2023	375
2 – 5 October 2023	Joint Junior Doctor/Consultants	28 September – 10 October 2023	393
20 – 23 December 2023	Junior Doctors	15 – 28 December 2023	224
3 – 9 January 2024	Junior Doctors	29 December to 14 January 2024	320

6.3. **Mortality data**

6.3.1. The number of deaths in the 2 weeks surrounding IA was considered with the same methodology as that used for incidents. The numbers are quite variable making interpretation difficult.

6.3.2. No concerns have been raised via the Trust's Medical Examiners about deaths impacted by IA.

Table 5 Deaths

Date	Whose action	No. of deaths plus 5 days either side of IA
8 – 20 February 2023	NA	From 8 to 20 February 2023 **15 inpatient deaths** (inc. ED)
13 – 15 March 2023	Junior Doctors	From 8 to 20 March 2023 **25 inpatient deaths** (inc. ED)

Date	Whose action	No. of deaths plus 5 days either side of IA
11 – 15 April 2023	Junior Doctors	From 6 to 20 April 2023 **18 inpatient deaths** (inc. ED)
14 – 16 June 2023	Junior Doctors	From 9 to 21 June 2023 **20 inpatient deaths** (inc. ED)
13 – 21 July 2023 (NB: 19 July 2023 was not a strike day but included to simplify dates however there were 0 deaths on 19 July 2023)	Joint Junior Doctors/ Consultants	From 8 to 26 July 2023 **12 inpatient deaths** (inc. ED)
11-15 August 2023	Junior Doctors	From 6 to 20 August 2023 **28 inpatient deaths** (inc. ED)
19 -22 September 2023	Consultants	From 14 to 27 September 2023 **16 inpatient deaths** (inc. ED)
2 October – 5 October 2023	Joint Junior Doctor/ Consultants	From 28 September to 10 October 2023 **9 inpatient deaths** (inc. ED)
20 – 23 December 2023	Junior Doctors	From 15 to 28 December 2023 **23 inpatient deaths** (including ED)
3 – 9 January 2024	Junior Doctors	From 29 December to 14 January 2024 **27 inpatient deaths** (including ED)

6.4. **Patient feedback**

6.4.1. Eight PALS concerns specifically related to IA have been logged. Seven were in surgery and cancer ICSU and one in ACW. 5 have been closed after information was given to the patient or relative – three are under further investigation. Concerns related to cancelled procedures and appointments and included patients worried they had incurred costs or taken time off work for appointments that were cancelled close to the expected date. One related to a 2 week wait pathway. No formal complaints were received.

6.4.2. Overall, there were surprisingly few complaints or concerns received about the impact of IA.

Table 6 Patient complaints

Date	Whose action	Information required for this whole period please	No of complaints received	No of PALS concerns received
13 – 15 March 2023	Junior Doctors	8 – 20 March 2023	16 – None about strikes/IA	119 - **1** about strikes/IA
11 – 15 April 2023	Junior Doctors	6 – 20 April 2023	16 – None about strikes/IA	125 - **1** about strikes/IA
14 – 16 June 2023	Junior Doctors	9 – 21 June 2023	8 – None about strikes/IA	148 - **1** about strikes/IA

Date	Whose action	Information required for this whole period please	No of complaints received	No of PALS concerns received
13 – 21 July 2023	Joint Junior Doctors/ Consultants	8 – 26 July 2023	16 – None about strikes/IA	162 - **4** about strikes/IA
11 - 15 August 2023	Junior Doctors	6 – 20 August 2023	23 – None about strikes/IA	117 - None about strikes/IA
19 - 22 September 2023	Joint Junior Doctors/ Consultants	14 – 27 September 2023	12 – None about strikes/IA	152 - **1** about strikes/IA
2 – 5 October 2023	Joint Junior Doctor/ Consultants	28 September – 10 October 2023	8 – None about strikes/IA	99 - None about strikes/IA
20 – 23 December 2023	Junior Doctors	15 – 28 December 2023	19 – None about strikes/IA	43 - None about strikes/IA
3 – 9 January 2024	Junior Doctors	29 December to 14 January 2024	10 – None about strikes/IA	41 - None about strikes/IA

7. Staff wellbeing

7.1. There is a recognition that the IA is impacting on all colleagues involved, including both those taking action and those working differently to support services and patient care whilst action is ongoing.

7.2. Nursing, allied health professionals, and operational management teams have worked very hard to ensure safety through the strikes. In addition to nursing colleagues the pharmacy, radiography and IM and T teams have been key. The professionalism of the multidisciplinary team throughout this period is to be commended.

7.3. The flexibility of consultant medical teams to act down or out of their usual area of speciality has been key to safe cover. This has included consultant staff resident first on call overnight for ICU, NICU, obstetrics, the general medical take and wards, and ED. Medical ward cover has been particularly stretched with some wards operating with one doctor and senior nurse but in general two doctors per ward area. In some strikes one of the consultants has been a general medical consultant on their home ward but the second doctor has stepped up to work outside their usual remit which might be outpatient rheumatology, haematology or dermatology.

7.4. It is important to acknowledge ongoing fatigue resultant from the IA and a gradual erosion of good will.

8. Impact on Patient Care

8.1. Colleagues are concerned about the impact on elective care as well as those patients who were treated during the strike. There is an acute awareness that the patients who are not booked or cancelled related to IA remain on waiting lists and may suffer harm or express dissatisfaction with future episodes of care due to erosion of their goodwill and faith in the NHS.

8.2. In most strike periods senior decision making throughout pathways has reduced ED waits and admissions while increasing some discharges – this likely reflects that higher level of risk that can safely be taken with the benefit of a consultant's experience. This is also reflected in fewer out of hours requests for tests.

9. Other impacts

9.1. This paper has specifically not included the financial impact of IA which has already been reported elsewhere.

9.2. Negotiation of rates of pay for consultants acting down and bank rates for other staff groups have been the subject of intense debate locally, regionally and nationally. The position the Trust has taken is to try to set principles across the Trust or region. The negotiations with medical staff were led by the Medical Director and HR Director or Associate Director. The HR teams have carried a very significant additional workload to ensure appropriate remuneration with new systems required in the setting of an emergency response.

10. Conclusion

10.1. The BMA IA has had significant adverse impact on patients waiting times for outpatient and inpatient care – the full impact is as yet unknown.

10.2. Staff have stepped up to ensure immediate patient safety in difficult circumstances with ongoing fatigue and some impact on morale.

11. Recommendation

11.1. Trust Board is asked to note the contents of this report.

Meeting title	**Trust Board – public meeting**	**Date: 26 March 2024**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 7**
Committee Chair	Amanda Gibbon, Non-Executive Director	
Executive leads	Clare Dollery, Acting Deputy Chief Executive and Medical Director, Chinyama Okunuga, Chief Operating Officer, and Sarah Wilding, Chief Nurse & Director of Allied Health Professionals,	
Report author	Swarnjit Singh, Trust Company Secretary	
Executive summary	The Quality Assurance Committee met on 13 March 2024 and was able to take good assurance from the following items considered: • Dialectical Behaviour Therapy presentation • Q3 Maternity report • Bi-annual adult and children safeguarding report • Q4 Board Assurance Framework • Summary Hospital-level Mortality Indicator • Serious Incident report Committee members took partial assurance from the following agenda items: • Chair's assurance report, Quality Governance Committee Trust Risk Register • Q3 Quality report • Q3 Patient experience report • Anti-ligature assessment review • Pressure ulcer report The Committee also noted a verbal update on the urgent and emergency care pathway and approved the plan for production of the 2023/24 Quality Account. Following discussion, the following key concerns were agreed to be reported to the Trust Board: 1. IRMER incidents reported to CQC 2. The adverse impact of industrial action 3. Pressure ulcers in the community 4. Anti-ligature assessments	
Purpose	Noting	
Recommendation	Board members are asked to note the Chair's assurance report for the meeting held on 13 March 2024	
BAF	Quality 1 and 2 entries and Integration 2 entry	
Appendices	1. Q3 Maternity report (without appendices) 2. Q3 Quality report 3. Q3 Patient experience report 4. Bi-annual Safeguarding adults and children report	

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	13 March 2024

Summary of assurance:

The Committee confirms to the Trust Board that it took good assurance from the following agenda items:

Dialectical Behaviour Therapy presentation

Committee members welcomed a presentation from Daryl Parker, North Central London's (NCL) Clinical Lead for dialectical behaviour therapy (DBT) in child and adolescent mental health services (CAMHS). He explained that DBT was a community based, intensive psychological therapy for young people aged between 13 and 18 across NCL who presented with chronic emotional dysregulation. The young people, due to their emotional dysregulation, may also present with chronic self-injury, suicidal acts/ideation and be frequent attenders at accident & emergency and/or CAMHS inpatient units. This service offered up to 12 months of intensive therapeutic work.

The Committee learnt of the benefits provided by the service, particularly improvement in quality of life for many of the young people seen and also a significant reduction in visits to accident & emergency departments and need for paediatric inpatient days. The service had been put on a permanent footing this year, through the use of recurrent funding, and was also establishing partnership arrangements with CAMHS in North East and East London too. Daryl Parker explained that the model of care implemented had been successful. It had a strong focus on working with young people on validating the emotional impact of situations and helping them to reduce their emotional disregulation, working as a partner, and not using a top-down model approach.

The Committee discussed the risks around a lack of equity of access across boroughs and around under-represented need as there were disproportionately less referrals for young ethnic minority patients. The Committee Chair thanked Daryl Parker for his presentation and agreed on the positive impact this service had delivered. It was agreed that Daryl Parker would also deliver a presentation at the Safeguarding Committee and to the local youth justice forum.

Q3 Maternity report

The Committee took good assurance from the comprehensive quarter three maternity report which detailed the following achievements:

- The creation of an Audit and Guidelines Midwife role had helped to ensure that relevant maternity policies and guidelines were being brought up to date.
- Work by the estates and facilities department had helped the Trust to implement the Birmingham Symptom Specific Obstetric Triage System from 18 March. This triage system required the availability of a dedicated triage room for expectant mothers within fifteen minutes of their arrival, before transfer to a labour ward, if needed. Multidisciplinary team training on the new triage system was being arranged.

- The Trust was successful in achieving full compliance with all ten of the safety actions outlined in year five of the maternity incentive scheme and rebated funding was being used to support delivery of the Care Quality Commission action plan and to increase representation from under-represented ethnic minority groups in the Maternity Voices partnership forum with local mothers.
- The Birthrate Plus report received in December 2023 showed a positive variance of 3.78wte from the current funded staffing establishment. A deficit of 3.42wte in specialist midwifery roles is looking to being addressed through a service restructure which was being developed for quarter one 2024/25.

The Committee noted that mandatory level three safeguarding training for obstetric junior doctors on rotation was an issue and recommended that steps be taken to deliver this through an extra half day of their induction programme. An update would be provided at the next meeting on this.

Bi-annual adult and children safeguarding report

Committee members were assured by the six-monthly safeguarding report which covered the period, April to October 2023. In terms of child safeguarding, they were apprised of the improvements in training compliance; the continuing increase in the complexity of cases with reflected higher incidences of mental illness, substance misuse and domestic abuse; mandatory Oliver McGowan training was being rolled out for completion by 30 June for all staff in the Trust; a national consultation was taking place on the mandatory reporting of child sexual abuse for anyone working in a regulated activity with children.

For adult safeguarding, the key areas highlighted to the Committee included the creation of some excellent learning disability films co-produced with patients and family members. The films focussed on visits to the emergency department, outpatients and theatres. A bespoke film had also been produced to support level two adult safeguarding training. Care Bags for use across the hospital site had been launched to help people with a learning disability to help reduce anxiety. There had been an increase in the complexity and numbers of adult safeguarding referrals. This was also being experienced by partner agencies in the London Boroughs of Haringey and Islington and reflected a national pattern.

Sarah Wilding thanked Theresa Renwick, Stella Balsamo and Sara Earle for their hard work, particularly in covering a gap in the Head of Safeguarding Children role for the last few months. She also flagged a potential risk to the Committee as there was no nominated individual domestic violence lead within the Organisation. This role had recently been part of the duties of the Head of Children's Safeguarding role and conversations were taking place on that. The Committee also learnt that work was taking place with the estates and facilities leadership to help increase compliance with level one safeguarding training in that department.

Q4 Board Assurance Framework

The Committee considered and approved the quarter four Board Assurance framework for entries to the delivery of the Trust's quality and integration strategic objectives. The Committee advised that the reference to the pandemic in the integration two entry be removed.

	Summary Hospital-level Mortality Indicator (SHMI) Committee members were informed of an increase in the SHMI, a marker of quality of care. The Whittington SHMI for the data period October 2022 to September 2023 was 0.9907. Although this SHMI level remained within the expected range, it is rising. Historically, Whittington Health had one of the lowest SHMIs. The rise was being looked into: there has been an increase in crude mortality rates in the 12-month period to August 2023, and secondly, some changes to coding e.g. with respect to palliative care patients, which is now reviewed on a monthly basis. Coding depth has also reduced for elective patients which may represent the low complexity high volume cohort but needs review. Overall, the depth of coding in the whole patient group has not changed over the period the SHMI has risen. The Committee received assurance that structured judgement reviews (SJR) of cases had not seen any avoidable deaths or areas of concern. There were no avoidable deaths from non-SJR mortality reviews for the period under review that have been flagged. The Committee also received assurance that there was no discernible increase in the deaths of people with a learning disability and was informed that the Mortality Review Group would continue to carry out deep dives into areas such as community-acquired pneumonia. The Committee agreed that a further update be brought back once there were further conclusions for the increase in the SHMI rate. **Serious Incident report** Committee members considered the serious incident (SI) report covering the months of December 2023 and January 2024. They noted that there were no SIs declared during this time which reflected the shift to the culture and approach for the patient safety incident response framework reporting arrangements. The paper included learning from three SIs, for which the reports had been sent to the NCL Integrated Care Board, and covered the following issues: • Delays in the delivery of equipment by NRS Health Care and the need for appropriate escalation from staff and communication with the provider. • Missing controlled drugs from the critical care unit and the subsequent Trustwide review of access to medicines, increased controls through management processes within the pharmacy team and the use of software to highlight any significant increases in the supply of controlled drugs to a clinical area. • A case where a patient being restrained by the police had a cardiac arrest, requiring active resuscitation by the emergency department team where the highlighted learning included adherence to s136 requirements for assessment and documentation of mental health patients, effective working relationships and communication in addition to reviewing the seclusion room's environment with input from the mental health team.
2.	**Committee members took moderate assurance from the following agenda items:** **Chair's assurance report, Quality Governance Committee** The Committee reviewed the report of the items covered at the meeting held on 14 February 2024 where significant or reasonable assurance was taken from most of the items discussed, including three presentations from different clinical

divisions. There were three items for which the Committee was able to take only limited assurance:

- The health and safety report was not considered due to the unavailability of a senior estates and facilities team leader to present it; the Chief Finance Officer, who is the executive lead for this function has been informed.
- The Committee saw an early draft of the emergency planning report and fed back comments which have been incorporated into subsequent iterations.
- Performance during winter pressures: on the whole, performance in the emergency department has significantly improved and the Deputy Chief Operating Officer was preparing a report for future meetings of the Trust Management Group, Quality Assurance Committee and Trust Board

There were four areas of risk escalated by the Committee, as follows: Imaging – IRMER investigation; the impact of industrial action; pressure ulcers in community services; and assurance around closed actions from the 2019/20 Care Quality Commission (CQC) action plan. Committee members were alerted to the circumstances around the IRMER investigation, namely that the trust had reported to the regulator that c.60 patients were exposed to very low levels of additional radiation when they were due to have single plain film but required two radiation exposures to acquire an image. The radiation for each individual is equivalent to the background level of living in Cornwall for 3 days. This incident had been communicated to the CQC and was being investigated using patient safety incident response framework methodology and would be brought back to this Committee, in due course.

Trust Risk Register

The Committee reviewed the risk register report. It noted the addition of a newly approved risk in relation to the tracking of gynaecological referrals and potential delays in treatment and an increased risk which related to the non-achievement of the cost improvement programme savings target in the Surgery and Cancer Integrated Clinical Service Unit. The Committee also agreed that future reports should include a table showing the length of time that risk entries scored at 15 and above had been on the register.

Q3 Quality report

The Committee reviewed the quarter three Quality report. It noted that there were currently 41 outstanding cases which occurred in quarters one and two, which had a duty of candour requirement. Committee members were made aware that, following changes in reporting requirements, the level of harm will be categorised as both psychological and physical and that this was likely to see an increase in cases. The data would be included in the quarter four Quality report.

The Committee was made aware of challenges to complete clinical harm reviews completed for urology services due to staff sickness and limited staffing capacity. The Cancer team was addressing this. The presence of a locum was providing some mitigation. In addition, the Committee was informed that a system solution was being sought with the NCL ICB for the rheumatology service through a review of the model in place but is not yet resolved.

The Chief Nurse and Director of Allied Health Professionals reported that the total number of C difficile infections was above the target of 13 for the year with 21 cases so far. Assurance was provided that the Infection Prevention and

Control team was carrying out a deep dive into all cases and had identified only one case where there was cross contamination. Nationally, there had been an increase in infections post-pandemic. Other actions being taken forward included completing the documentation required for anti-microbial stewardship and running a campaign to remind people of the importance of hand hygiene and being bare below the elbows. It was noted that environmental factors could also impact on infection rates due to the risk of contamination from sharing equipment.

The Committee was also told that there had been one case of MRSA in a very unwell patient. This was assessed as an unavoidable case. The Mortality Review Group was reviewing a case which involved an incidence of community-acquired pneumonia.

Q3 Patient experience report

The Committee discussed the patient experience report presented by the Deputy Chief Nurse who outlined the following points:

- Complaint response timescales remained below the 80% target at 47% during quarter three. While performance had increased to 66% in February 2024, some clinical teams were struggling to ensure good quality responses were produced on time.
- On the family and friends test (FFT) outcomes, the Trust maintained a score above the 85% NHS benchmark at 88.39% for positive responses. However, the Trust continued to be an outlier for negative responses above the 5% NHS benchmark, at 7.39%.
- An additional 13 new volunteers were recruited, taking the total number of volunteers to 53.
- Access to interpreting services was an area of challenge due to the high demand. Work was taking place with clinicians to demonstrate the benefit of online translation services.

Committee members reviewed the FFT results for the emergency department which saw a significant increase in “poor and very poor” responses at 21.68% (Q2 13.86%), remaining an outlier at 16.68% over the NHS benchmark of 5%. While the Committee acknowledged that the results were significantly impacted by winter and operational pressures and industrial action by junior medical staff, they emphasised the need for these outcomes to improve in ED in future reporting.

Anti-ligature assessment review

The Committee reviewed the ligature risk assessment report which required high and medium risk areas to be assessed annually. It noted that this was an initial report and that further work was taking place to ensure that a consistent and standardised approach is in place along with reporting arrangements and the mitigation of identified risks. Recently issued CQC guidance would also be used to assess high, medium and low risk areas. The Committee was made aware that some estate works were needed following assessments.

The Committee noted the report and that an updated paper would be brought back to the Committee which included an assessment of areas as tier 1, 2 or 3 and with confirmation from the estates and facilities team of necessary work taking place.

	Pressure ulcer report The Committee discussed the contents of the pressure ulcer report and noted the following: • Incidences of category three and four pressure ulcers continued to increase. • A pressure ulcer improvement plan was being implemented to help support progress and remove barriers for attaining improvement. • A number of positive changes had taken place in regard to improving hospital equipment contracts, formal and bespoke education provision and increasing staff focus on pressure ulcer prevention. These changes have been particularly beneficial in the hospital setting • However, several challenges have limited progress in community patients, many of which are outside the control of Whittington Health. Challenges in relation to failure in performance of external factors such as community equipment providers, the quality of carer input/community as well as instances of non-engagement of patients and family have contributed to a rise in community pressure ulcer incidence. • Following publication of the national Wound Care strategy in November 2023 there would be a re-categorisation of pressure ulcers, with the likelihood that there would be a significant increase in cases. • Other actions being taken forward as part of the plan included having skin assessment take place within the emergency department, additional training being provided to our teams and also to Islington social services' re-ablement carers. The Committee noted the report and the work taking place as part of the pressure ulcer improvement plan.
3.	**Present:** Amanda Gibbon, Non-Executive Director (Chair) Junaid Bajwa (JB) Non-Executive Director Dr Clare Dollery, Acting Deputy Chief Executive and Medical Director Chinyama Okunuga, Chief Operating Officer Sarah Wilding, Chief Nurse & Director of Allied Health Professionals **In attendance:** Stella Balsamo, Named Nuse, Safeguarding Children, Islington Kamilla Bessessar, Clinical Site Manager & Anti Ligature & MH Section Lead Isabelle Cornet, Director of Midwifery Kat Nolan-Cullen, Compliance and Quality Improvement Manager Anne O'Connor, Associate Director of Quality Governance Daryl Parker, CAMHS DBT and South Hub Manager Theresa Renwick, Head of Vulnerable Adults Nicola Sands, Deputy Chief Nurse Swarnjit Singh, Joint Director of Inclusion & Trust Secretary Carolyn Stewart, Executive Assistant to the Chief Nurse Pauline Vyse, Pressure Ulcer Lead Nurse **Apologies:** Naomi Fulop, Non-Executive Director Phillip Lee, Associate Medical Director for Patient Safety Clarissa Murdoch, Deputy Medical Director Baroness Glenys Thornton, Non-Executive Director

Meeting title	**Quality Assurance Committee**	**Date: 13th March 2024**
Report title	Whittington Health Maternity Services Quarterly Board Report	**Agenda item: 4.2**
Executive director lead	Sarah Wilding, Chief Nurse and Director of Allied Health Professional	
Report author	Isabelle Cornet- Director of Midwifery Helen Taylor – Clinical Director ACW	
	This report provides a quarterly summary of the work being undertaken in the Whittington Health Maternity Unit. This report covers Q3 of the financial year 2023/2024 (October, November, December 2023). <u>Care Quality Commission (CQC) Standards</u> The medical workforce level 3 child protection compliance has reduced as the new trainees need training. Thie is being addressed, 2 Guidelines midwives have been successfully recruited. The estates work to support achieving Birmingham Symptom Specific Obstetric Triage System (BSOTS)has commenced. <u>Maternity Incentive Scheme (MIS) – Year 5</u> The Trust is fully complaint for all 10 safety standards. <u>Complaints and Compliments</u> In Q3 we received 9 complaints, from those 2 were approved. The key themes from the complaints were: Birth experience, Lack of communication, Consent, Medicine Management *Awards nominations* Huda Mohamed our FGM Specialist Midwife, has been awarded an MBE (Member of the British Empire) award for her services to midwifery. The Maternity Dashboard - POWER BI went live in November 2023 *Maternity Dashboard.*	

	Addendum: Addressing a point from QAC from July 2023 where a request was made to investigate the APGAR scores of babies in the community. In 2023, there were 32 births in the community. Out of these, 8, were planned homebirths,1 woman free birthed and 23 were Born-Before-Arrival births (BBA). Out of the planned homebirths and the freebirth, all babies were born with good APGAR Scores. The APGAR Score is considered as good if it is equal to 7 or above (up to 10). Out of the other 23 births in the community, 3 had low APGAR scores (below 7) and were preterm births. 2 of them were Twins born at 33 weeks and admitted to the special care unit at Whittington Health, and 1 was a neonatal death at 22+6.
Purpose:	Provide an overview of maternity services to the committee
Recommendation(s)	Note the contents of the report.
Risk Register or Board Assurance Framework	BAF Quality 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	None
Appendices	Appendix 1 – MIS board declaration Appendix 2 – Position and Progress against MIS Appendix 3 – Whittington LMNS feedback Appendix 4 - Perinatal Quality Surveillance Model Q3 Appendix 5 – OPEL parameters Appendix 6 – Consultant Attendance Audit Appendix 7 – MVP workplan

Whittington Health Maternity Services Board Report
13th March 2024

This report provides a quarterly summary of the work being undertaken in the Whittington Health Maternity Unit. This report covers Q3 of the financial year 2023/2024 (October, November, December 2023).

1.0 Care Quality Commission (CQC) Standards

Whittington Health Maternity services received the unannounced inspection by the Care Quality Commission (CQC) in January 2023, as part of the national maternity programme. 2 out of 5 domains were inspected and the maternity services overall were rated as "Requiring Improvement". The domains inspected were "Is the Service Safe?" and "Is the Service Well-Led?". Regulation 12 "Safe Care and Treatment", Regulation 17 "Good Governance" and Regulation 18 "Staffing" were identified as not met for 8 reasons.

The action plan addressing these points and shared with the CQC is attached as Appendix 1. Areas of concern and focus are the mandatory training rates of medical staff, children safeguarding level 3 training of medical staff, maternity theatre and support worker staff; policies, guidelines and procedures being reviewed and up to date as well as dedicated staffing cover for the maternity triage telephone line.

Table 1: Mandatory Training update

Whittington Health Maternity Mandatory Training Compliance (%)				
	December 2023			
Staff Group	Neonatal Basic Life Support	Obstetric Emergency Training	Fetal Monitoring	FM Test combined for all 85.3%
Midwives	92%	92%	92%	85%
Consultant Obstetricians	N/A	95%	90%	74%
Obstetric staff (all other grades)	N/A	94%	94%	90%
Anaesthetic Consultants	N/A	80%	N/A	N/A
Anaesthetic Trainee's	N/A	88%	N/A	N/A
MSW	N/A	93%	N/A	N/A
ANNP	100%	N/A	N/A	N/A
Neonatal Nurses	82%	N/A	N/A	N/A
Consultant Neonatologists	>90%	N/A	N/A	N/A
Trainee Neonatologists	100%	N/A	N/A	N/A

Table 2: Children Safeguarding Level 3 Training update.

Child Safeguarding level 3	December 2023
Midwives	87%
Obstetricians & Gynaecology	68%
Staff Nurse	80%
MSW/NN	83%

The two other areas of concerns are policies and guidelines being out of date and dedicated staffing cover for the maternity triage telephone line. Regarding the clinical guidelines - new Audit and Guideline Midwives commenced their role on 4th and 15th January respectively - 0.5WTE each. Since commencing the post, 22 guidelines that have been have now been updated and uploaded on the intranet.

Maternity has a total of 125 guidelines (3 guidelines are currently being amalgamated into 1 guideline). 32 guidelines are currently under review. This is 25.6% of the maternity guidelines. From those:

- 2 of these are being formatted post ratification for uploading on the intranet.
- 2 are owned by the anaesthetic department.
- 4 are owned by Gynaecology department.
- 3 are owned by the neonatology department.
- 15 are owned by the Obstetric team.
- 5 are owned by the midwifery team.
- 1 is owned jointly by the different teams.

Relevant ICSUs have been asked to support in addressing the 3 guidelines owned outside of maternity.

The Guidelines database is reviewed monthly at the Maternity Clinical Guidelines meetings. 5 high risk documents to be prioritised and reviewed monthly, until overdue documents completed. Progress in completing the overdue documents is monitored at the monthly Maternity Clinical and Safety Champion meeting and escalated to the monthly ACW ICSU Board meeting.

The maternity triage telephone line is now covered by triage staff and the call is redirected to the labour ward midwifery office if not answered by triage staff. This

allows for a 24/7 answer of the calls. The role for a dedicated midwife covering maternity triage line has advertised. Unfortunately, no applications were received. The advert closed on the 31st of January 2024 and is being readvertised.

Birmingham Symptom Specific Obstetric Triage System (BSOTS) is nationally recommended as it is a unique safety tool for maternity care. It provides an intuitive system to clinically prioritise care for pregnant women attending the triage department. BSOTS enables midwives to see women promptly and confidently manage their care with clinical safety at its centre. The aim is to fully implement BSOTS by the 18th of March 2024. For the triage unit to meet this standard some changes are required to environment. This refurbishment is currently underway. Once the refurbishment has been completed, MDT training will be cascaded to all staff.

2.0 Maternity Incentive Scheme (MIS) – Year 4

The maternity unit was compliant with the Maternity Incentive Scheme (MSI) Year 4 ten safety actions requirements for the last financial year.

The Trust received the return of its contribution into the incentive funds, together with a share of unallocated funds, in total £807,598. Out of this sum, £319,860 represent the MIS Bonus.

Trust Management Group (TMG) on the 6th of December 2023 reinvestment of the MIS Bonus into the maternity services was agreed as outlined below. In this way the money was used to support the delivery of the CQC action plan and compliance going forward to meet the MIS Year 5 requirements.

Table 3: Investment of MIS rebate as agreed at TMG.

Order	Requirements	Estimated Costs (PYE)	Progress
1	BP Machines x 71 with large cuffs - Requirements for Delivery of MIS Year 5 + SBLC V3	£6,749.86	Purchased – dispatch to the different wards and midwives in progress
2	Guidance and Audit Midwife - 1.00 WTE - Band 7 - until end March 2024	£28,180	Recruited – started in January 2024
3	Digital midwives - 1.40 WTE - Band 7 - until end March 2024	£31,561	0.40 WTE recruited to – 1.00 WTE Expression of Interest out
4	Labour Ward Coordinators - 3.00 WTE - Band 7 - Delivery of SA 5 - MIS Year 5 - until end March 2024	£66,964	Expression of Interest out
5	MNVP - to support the Neonatal aspect of the MNVP - Requirement for Deliver SA7 of MIS Year 5	£7,000	MNVP establishing the plan for use and deliver their workplan

6	Dedicated Triage Phone Midwife - 1.80 WTE - Band 6 - Until end March 2024 - Delivery of CQC (Requires Improvement) Action Plan	£37,980	Expression of Interest Out
7	BSOTS Works - Delivery of CQC (Requires Improvement) Action Plan	£22,494.4 + VAT	Works starting on the 5th of February 2024 for 1 month.
8	Communications and Patient Information Midwife - 0.5 WTE - Band 7 - until end March 2024	£14,090	Recruited – Started in January 2024
9	HSJ Table	£3,864	Attended in September 2023
10	Fixed Term External Support Manager to Deliver Restructure - Eddie Herter - until end March 2024	£30,000	Ongoing
11	Band 4 for clinical governance team - until end March 2024	£17,163	To Be recruited to
	Total	**£266,046.26**	

3.0 Maternity Incentive Scheme (MIS) – Year 5

Obstetric incidents can be catastrophic and life-changing, with related claims representing the Clinical Negligence Scheme for Trusts' (CNST) biggest area of spend. Of the clinical negligence claims notified to NHS Resolution in 2021/22, obstetrics claims represented 12 per cent of clinical claims by number but accounted for 62 per cent of the total value of new claims; almost £6 billion.
The Maternity Incentive Scheme supports and rewards Trusts who have taken action to improve maternity safety. It sets out 10 Safety Actions for which Trusts must evidence compliance to receive the financial rebate.
The Declaration Form for the submission was published by NHS Resolution in November 2023, and the submission date was 12 noon on the 1st of February 2024.
Whittington Health NHS Trust has declared full compliance with MIS Year 5, and the details are in the Declaration Form attached as **Appendix 1**:

- Safety Action **1** (PMRT): **Fully Compliant**
- Safety Action **2** (MSDS): **Fully Compliant**
- Safety Action **3** (Neonatal Unit): **Fully Compliant**
- Safety Action **4** (Clinical Workforce): **Fully Compliant**
    - As a plan forward, audit criteria 1 & 2 will be part of the quarterly maternity report to Board.
    - Action plan established for the implementation of the compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.
- Safety Action **5** (Midwifery Workforce): **Fully Compliant**

    - As a plan forward, a consultation of the maternity workforce structure is planned for 2024 with the aim to increase the number of labour ward and flow coordinators to ensure appropriate cover for the unit. This will allow the presence of 2 senior midwives at all times and strengthen the supernumerary status of the coordinator.
- Safety Action **6** (SBLCB v3): **Fully Compliant**
- Safety Action **7** (MNVP): **Fully Compliant**
- Safety Action **8** (Multi-Professional Training): **Fully Compliant**
    - Action Plan established and approved at the Quality Assurance Committee to ensure 90% of Obstetric Anaesthetic Consultants and 90% of Obstetric Anaesthetic doctors (staff grades and anaesthetic trainees) are compliant with the Maternity Emergencies and multiprofessional training by the 23rd of February 2024.
    - Action Plan established and approved at the Quality Assurance Committee to ensure 90% of Neonatal Nurses (who attend any births) are compliant with the Neonatal Basic Life Support training by the 23rd of February 2024.
- Safety Action **9** (Board Governance): **Fully Compliant**
- Safety Action **10** (HSIB & EN): **Fully Compliant**

The Joint Presentation Set, attached as **Appendix 2** is compliant with requirement within the Guidance tab of the Declaration Form.

4.0 Saving Babies Lives Care Bundle Version 3

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The care bundle is a significant driver to deliver the commitment to reduce stillbirth, maternal mortality, neonatal mortality, and serious brain injury by 50% and preterm births from 8% to 6% by 2025.

Version 3 of the Care Bundle (SBLCBv3) was published on the 1st of June 2023, followed by an implementation tool. The tool allows Trusts to track their progress with implementation of the interventions within the SBLCBv3, which will then serve as evidence in support of the maternity incentive scheme year 5 submission. It will also allow for informed quarterly discussions with ICBs.

To evidence adequate progress against this deliverable by the MIS submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. These percentages are calculated within the tool.

The 6 elements are:

- Element 1: Reducing Smoking in Pregnancy
- Element 2: Fetal Growth: Risk Assessment, surveillance, and management
- Element 3: Raising awareness of reduced fetal movements
- Element 4: Effective fetal monitoring during labour

- Element 5: Reducing Preterm births and optimising perinatal care.
- Element 6: Management of Pre-Existing Diabetes in Pregnancy

Whittington Health Maternity Services and the NCL LMNS have been meeting regularly since the end of August 2023 to discuss progress against these standards.

The Q1 submission for monitoring was done on the 6th of October 2023.The Q2 submission was successfully completed on the 21st of December 2023.

Table 4 CNST submission

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemented	60%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	96%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	50%	CNST Met
All Elements	TOTAL	Partially implemented	90%	Partially implemented	86%	CNST Met

Table 5: Deadlines for the Q3 submission:

ACTION:	**Q3**
Trust will receive email reminder to complete a draft of SBLCBv3 implementation tool and reconfirmation of the face-to-face date	15th January 2024
Trusts to compile evidence (Initial upload to platform) prior to face-to-face meeting with LMNS	**29th January to 9th February**
LMNS and Trusts to review evidence, interventions, actions if required face-to-face	19th February to 23rd February
Trusts to upload any additional evidence	26th February to 1st March
Finalisation of SBLCBv3 implementation template and upload all evidence for **review by LMNS**	**4th March to 15th March**
LMNS Feedback to Trusts for review of comments and discuss	**16th March to 20th March**
Final call with trusts to discuss any changes to SBLCB	**21st March to 22nd March**
Submission of all finalised SBLCBv3 templates	**25th March**

The progress for compliance is monitored weekly and is presented through the different stages of governance within the Trust: Maternity Clinical Governance and

Safety champions meeting, the quarterly meetings within the LMNS, monthly updates to Board regarding MIS compliance.

See appendix 3.

5.0 Perinatal Quality Surveillance Model

The Perinatal Quality Surveillance Model is a MIS Year 5 Safety Action 9 requirement, and is to be fully embedded by Trusts, LMNS/ICS, local and regional teams. The model sets 5 principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families:

- Principle 1: Strengthening trust-level oversight for quality.
- Principle 2: Strengthening LMS and ICS role in quality oversight.
- Principle 3: Regional oversight for perinatal clinical quality
- Principle 4: National oversight for perinatal clinical quality
- Principle 5: Identifying concerns, taking proportionate action and triggering escalation.

These measures are to be monitored at maternity and neonatal safety board meetings, hence the presentation in this report.

Table 6: Actions as a consequence of the surveillance model

Actions	October 2023	November 2023	December 2023
Findings of review of all perinatal deaths using the real time monitoring tool	One neonatal death - Lung or respiratory system malformation – 39+6 Two stillbirths We will support PMRT review	No neonatal deaths. No stillbirths.	One neonatal death: Pulmonary hypoplasia, multicystickidney, renal dysplasia, congenital hydronephrosis (36+3) One Stillbirth - We will support PMRT review.
Findings of review all cases eligible for referral to HSIB	No cases met criteria for HSIB referral.	No cases met criteria for HSIB referral.	No cases met criteria for HSIB referral.
Number of incidents logged graded as moderate	2 Incidents graded as Moderate: - Two stillbirths – To be reviewed at PMRT	None	2 Incidents: - Controlled drugs - Term newborn transferred for therapeutic cooling – not HSIB

or above and what actions are being taken;			
Service user voice feedback	•Quarterly MNVP Session •Ockenden Cafes •Weekly meeting		
Evidence of co-production	•IOL Leaflet •Fetal Monitoring Leaflet •BSOTS •COG •Communication •Homebirth Model	•IOL Leaflet •Fetal Monitoring Leaflet •BSOTS •COG •Communication •Homebirth Model	•IOL Leaflet •Fetal Monitoring Leaflet •BSOTS •COG •Communication •Homebirth Model
Themes / main areas from complaints	10 complaints have been received in Q3. The Keys Themes from the complaints are: •Birth experience •Lack of communication •Consent •Information Governance •Medicine Management		
Listening to staff (activities, surveys and actions taken as a result)	•Staff involvement in QI projects. •Maternity Transformation Work streams •Staff survey •Walk arounds	•Staff involvement in QI projects. •Maternity Transformation Work streams •Staff survey •Walk arounds	•Staff involvement in QI projects. •Maternity Transformation Work streams •Staff survey •Walk arounds

Please see **Appendix 4**

6.0 Start Well Programme and Public Consultation

The communications team are working with the executives, the Maternity Safety Champion Non-Executive Director and NCL in carrying out a series of staff briefings. The briefings outline why the changes are proposed, the opportunities for improvement these provide, the proposed options outlined in the consultation and the timelines of the work.
There are also posters across the Trust acute and community sites and information on the website to share with staff and with our patients on how they can provide feedback to the consultation.

7.0 Incidents and learning points from Serious Incidences (SIs)

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

For this reporting period from October to December 2023, there have been no new serious incident declared.

Table 7: Actions undertaken to address findings from the 2 SIs investigations identified in the previous report:

Datix Ref	Description	Actions	Target date of report completion
A99314 09/03/2023	Sickle Cell and Thalassemia Screening – Omission to counsel mother antenatally and to offer PND – 2 triplets diagnosed with sickle cell disease.	The pathway for the sickle cell and thalassemia screening (SCAT) programme and subsequent failsafe checks needs to be jointly revised by the antenatal and newborn screening (ANNB) coordinator and the sickle cell and thalassemia lead nurse.	Presented to SIEAG on 17/08/2023. Completed – Actions been monitored via antenatal and newborn screening steering group.
A101530 HSIB MI-026257 25/04/2023	Unexpected term admission to NICU and subsequent transfer to level three unit for therapeutic hypothermia.	PDM team undertaking daily ward rounds / spot checks. MEOWS, Fluid Balance, Fresh Eyes to be included on the Maternity Mandatory Training. Rolling monthly MEOWS, Fluid Balance, Fresh Eyes Audit of 40 notes - presented as a standing agenda item at the Maternity Clinical Governance and Safety Champions Meeting and presented quarterly at the ICSU Board meeting.	Awaiting final report from HSIB/MNSI.

		Use of helicopter review stickers MEOWS/fluid balance charts to be checked / reviewed as part of a holistic review and during MDT ward rounds.	

8.0 Healthcare Safety Investigation Branch (HSIB) – Q2 2023/2024 – feedback –

The Healthcare Safety Investigation Branch (HSIB) maternity investigation programme is part of a national action plan to make maternity care safer. HSIB undertakes approximately 1,000 independent maternity safety investigations a year to identify common themes and influence systemic change. All NHS trusts with maternity services in England refer incidents to HSIB.

HSIB investigates incidents that meet the criteria as previously defined within the Each Baby Counts programme or HSIB defined criteria for maternal deaths. During the investigations HSIB investigates all clinical aspects of the incident, as well as aspects of the workplace environment and culture surrounding the incident.

From 1 April to June 2023, Whittington Health referred one case (A101530) to the HSIB for investigation which met the criteria. The reason for referral was potential hypoxic ischaemic encephalopathy (HIE). Please see details on previous section of this report. There were no cases referred to MNSI in Q3 2023/2024.

On the 17th of July 2023 the Trust received updates on the HSIB maternity programme and the Maternity and Newborn Safety Investigation (MNSI) programme's transition to the Care Quality Commission (CQC):

- The MNSI is transitioning into new hosting arrangements with the Care Quality Commission (CQC) on 1 October 2023.
- One area of change leading up to 1 October will be the requirement for us to move our IT systems to a new platform. It will therefore be necessary for us to pause our monthly maternity investigation updates and review meetings with trusts.

The joint QRM is scheduled for the 7th of March 2024.

9.0 Perinatal Mortality Review Tool (PMRT)

Perinatal Mortality Review Tool (PMRT) supports systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each

stillbirth and neonatal death, and babies who die in the post-neonatal period having received neonatal care. PMRT provides a structured process of review, learning, reporting and actions to improve future care.

Between 1st October to 31st December 2023, six cases met the eligibility criteria for PMRT review. The eligible cases were:

- Three stillbirths (35 w 5d; 34w 6d; 27w 1d) – Two of these cases (35 w 5d; 34w 6d) were already subjected to PMRT and no care and or service delivery problems that contribute to the outcome were found. The 27w 1 d stillbirth case will be reviewed on the 1st of March 2024.
- Two neonatal deaths – These 2 babies were known to have fetal abnormalities antenatally, and a poor outcome was inevitable. The antenatal care was led by the Fetal Monitoring Unit (FMU) with input from the neonatal and palliative care teams. Both cases have been subjected to PMRT review and the reports are progressing.
- One late pregnancy loss at 23 weeks and 4 days – The baby was diagnosed antenatally as severe Intrauterine Growth Restriction(IUGR) and has been care for under the FMU team. The PMRT is scheduled for the 1st of March 2024.

We are currently on target for all PMRT reviews. Families have been involved in the PMRT reviews.

The use of the PMRT is a requirement for the Safety Action 1 of the Maternity Incentive Scheme Year 5.

Overall for the year 2023 both our stillbirth and neonatal death rates were higher than for 2021. However, still within England stillbirth and neonatal death rates – As per table below:

Table 8: Still birth rates

Classification	Total Numbers	Possible exclusions	Total Rate 2023	Total Rate 2021	Rate with exclusions 2023	Rate with exclusions 2021	England Rates for 2021
24+0 weeks and over – Stillbirth	10	1 x TOP 2 x known anomalies. 1 x not booked, not delivered but counted in figures.	3.5 per 1000	2.47 per 1000	3.17 per 1000 2.81 per 1000 2.46 per 1000	2.47 per 1000	3.52 per 1000

Neonatal Death any gestation	5	2 x extreme prem 3 x known anomalies antenatally	1.76 per 1000	0.83 per 1000	0.7 per 1000	0.55 per 1000	1.60 per 1000

The plan is for once all PMRT reviews have been completed to schedule an extra review meeting to complete a deep dive to ensure all learning has been captured and actions completed. This will be monitored via Maternity Clinical Governance and Safety Champions meeting.

10.0 Escalation – OPEL

NHS England (NHSE) introduced the OPEL framework in 2016. The aim was to achieve consistency to local and regional systems on escalation levels. The OPEL plan is designed to address operational pressures, including Maternity OPEL. The key benefits from using this the OPEL plan are:

- Improved Patient Safety
- Increased Efficiency
- Improved Communication
- Supported Decision Making

See **appendix 5** for a table outlining the OPEL Maternity Parameters and Scoring

The maternity in utero transfer OPEL guideline has been ratified in January 2024. Maternity Services have been working in conjunction with the Trust Emergency Planning Officer to complete a policy for operational pressures escalation levels.

11.0 Complaints and Compliments

11. 1 Complaints

In Q3 we received 9 complaints, from those 2 were approved. The key themes from the complaints were:

- Birth experience
- Lack of communication
- Consent
- Medicine Management

For Q3 7 complaint responses are still outstanding. The team has been unable to timely complete these responses due to staffing pressures, as staff was redeployed to support clinical activity to ensure patient safety is prioritised. There is a weekly MDT meeting lead by the HOM with PALS to monitor and track timely responses.

Table 9: progress against outstanding responses for Q2:

Datix	Complaint	Update
52868	Medicine Management on the AN Ward	Closed October 2023
53062	Communication, Lack of consent and traumatic experience.	Closed November 2023
53102	Referred 21.8.23. Lack of consent with examination, communication Delay due to high activity and redeployment of staff.	Draft with PALS November 23
53188	Out of date for complaint, traumatic birth Event occurred in 2021 – this was logged as an out of time complaint in August 2023. Notes requested from Iron mountains has delayed the answer.	Out of date complaint – progressing
53199	Analgesia effectiveness-Epidural	Ongoing – Lead had to be reallocated – progressing first draft submitted.
53387	Lack of ICARE values during labour	Draft with PALS January 24

11.2 Compliments

Here are some examples of compliments received:

- **November 2023 via PALS** - I have participated to the antenatal classes program provided and I just want to give my compliments and say that I have learned a lot about what to expect when I will give birth ,being informed on how to react and take decisions when in labour . Also after the baby is born the classes have been very helpful and I thank you for this opportunity.
- **December 2023 via PALS -** Firstly, I would like to say a BIG THANK YOU to the surgical team and nurses who looked after me 12/12/2023. Everything was explained to me very clearly from the beginning to the end, all questions I had were answered in a way that was easy for me to understand. I was well supported and cared for throughout the day . I am very grateful to everyone! I had been dealing with non-stop vaginal bleeding, cramps and menorrhagia for well over a year. After having the hysteroscopy and polypectomy procedure I experienced vaginal bleeding, blood-stained watery discharge, cramps, general weakness and a heavier period- but because the team had clearly explained to me (in advance) that this is normal, I had peace of mind!

- **Patient Choice:** I just wanted to say thank you for organising our birth choices meeting in such a timely manner because it was only just in time but made all the difference! The birth centre staff were all incredible. As well as the midwife who came and did our NIPE for us early on Thursday. But a particular thanks to Gina who went above and beyond to make sure that we were comfortable throughout as well as doing everything she can to help me stay in the birth centre. I was allowed to stay the whole time where I'm sure with someone else I could easily have ended up on the labour ward or being sent home when we weren't comfortable to! So thanks again to your amazing team. It made being a patient (which I always dread)a perfectly pleasant and comfortable experience. Thanks again from the whole family.

11.3 Awards nominations

Huda Mohamed our FGM Specialist Midwife, has been awarded an MBE (Member of the British Empire) award for her services to midwifery.

12.0 Legal Claims

In the quarterly report from NHSR there are 31 open obstetric claims.

No. of claims	Total claim	Total damages reserve	Total claimant costs reserve	Total defence costs reserve	Total outstanding estimate	Total NHS Resolution funded payments	Total payments
31	£225,275,092	£212,418,868	£10,213,800	£2,642,424	£191,521,015	£33,754,076	£33,754,076

13.0 Quality Improvement Projects -

13.1 Dilapan update

Dilapan was implemented as the first line of induction of labour, including both in and outpatients, on Monday 6th February 2023. This launch was accompanied by an updated induction of labour guideline and new information leaflet for service users coproduced with the Maternity and Neonatal Voices Partnership (MNVP).

The Dilapan implementation audit has been completed. The audit focused on auditing the use of Dilapan, patient experience and the effectiveness of the pathway. This audit was presented at the audit meeting in November 2023. The findings demonstrate service users had a positive experience as this method of IOL allows them to stay at home and this made them feel empowered. On a less positive note some service users voiced disappointment with delays in being transferred to labour ward when other methods of IOL were required. From a clinical point of view, the pathway has been

well embedded, training is ongoing. No negative outcomes for mothers and babies were noted. This is now our first line of IOL.

13.2 Baby Tagging

Baby tagging is an electronic system where an electronic tag and disposable strap are put on the baby. This is in response to an SI and will enhance the Trust's safeguarding and abduction policies. Xtag is the company installing the system.

Cabling for the system was taken to Capital Management Group on 18/07/2023 and approved. The Xtag System was due to be installed at the end of October and initially it was anticipated that it would take 3 weeks to complete. However, due to further risk assessments related with the configuration of the build and adjacent wards it was delayed and is expected to be completed by the end of January 24.

Staff training has been scheduled for beginning of February 2024, just following completion of the installation. The go live date is the 7th of February 2024.

13.3 Interpreters On Wheels (IOW)

NCL awarded the interpreting contract to DA Languages. The interpreting team alongside other stakeholders from Maternity, IMT, IG met with DA Languages on 17/07/2023 to discuss the requirement. DA are going to prioritise maternity for the tablet on wheels. The asked that we define our requirements (IMT, Operational, IPC etc.) and then they will purchase the kit. They will then use the blueprint to offer this to other depts who need it. SOPs are also being developed in the meantime. The requirements were shared with DA Languages. As of 10/10/2023 DA Languages have said there are currently discussions between the North London Consortium's procurement lead and their executive team as to how they will progress with the Interpreters on Wheels. They have been unable to advise a timeline yet as to when this service will be available for the Trust. In December 2023, the procurement team advised as an interim, the DA Languages video remote interpreting platform InterpreterView can be accessed by the browser on any device (smartphone, tablet, laptop, PC) and that they can give access to any staff nominated by Whittington Health. As of January 2024, we are awaiting sign off from IMT, and then DA Languages will add the maternity staff users to the system so they can access on demand video remote interpreting from any Trust device.

13.4 Care Outside of Guidance

We continue to have large numbers of referrals to the Birth Choices consultant midwife-led Tuesday clinic for care outside guidelines requests. Between October to December 2023, thirteen service users were seen for birth planning, and fifteen in January alone. The NCL Place of Birth Decision Tool was ratified in early January and has now been circulated to the wider maternity team for use in maternity to guide place of birth planning. The new Care Outside Guidance SOP is due for ratification at the next Maternity Guidelines Meeting and will provide a clear pathway for referral and escalation.

14.0 Maternity Dashboard

The Maternity Dashboard - POWER BI went live in November 2023. The expected benefits are:

- Patient Safety
- Better Visualisation of Data
- Early Detection and Flagging of DQ Issues
- In-House / Customisable Solution
- Information Team Skills Development / Enhancement
- National Compliance

This means that the Dashboard is live and can be easily accessed and interrogated for reports. The team are being trained. There will be a process of validation so reports to the governance and board will be one month behind to report validated results. It also provides information on ethnicity and postcode which we will be able to use to understand the outcomes of our women and measure what impact we are having on improving health inequalities. An in-depth report will be proved in the next report to QGC.

Table 10: The dashboard below has been used to direct the actions outlined in table 6 above.

Maternity Perinatal Quality Surveillance Dashboard			Target	23/24 Q3		
				Oct-23	Nov-23	Dec-23
Clinical Metrics	Total Booking			300	270	245
	Booking by 9+6/40			68.5%	72.3%	71.4%
	Livebirths (Term)			249	240	218
	Women in a Continuity of Carer pathway by 29 weeks					
	Percentage of women on CoC pathway: BAME / areas of deprivation					
	Preterm Birth	≤26+6		0	0	0
		≤36+6		17	16	19
	Massive Obstetric Haemorrhage (≥1500ml)		≤3.3% - ≥4.6%	1.5%	3.2%	1.7%
	Induction Of Labour	Primiparous	≤30.5% - ≥37.6%	26.0%	28.8%	28.7%
		Multiparous	≤25.1% - ≥30.6%	25.0%	25.9%	20.9%
	3rd and 4th Degree Tear	SVD – Primp	≤4.1 - ≥5.8%	16.7%	0.0%	0.0%
		SVD – Multip	≤ 1.5 - ≥2.1	0.0%	1.9%	1.9%
		Instrumental – Primip	≤7.3% - ≥10.2%	11.5%	2.9%	3.4%
		Instrumental - Multip	≤4.8% - ≥7.8%	0.0%	0.0%	0.0%
	Maternal Readmission			5	5	0
	Term Admission to NICU		≤ 6%	7.2%	5.0%	6.0%
	Pregnancy loss- non PMRT eligible (<22 weeks or termination)			0	0	0
	Stillbirth- PMRT eligible (>22 weeks, not termination)			2	0	1
	Neonatal Deaths			1	0	1
	Breastfeeding initiation rate within 48hrs of birth			93%	90%	88%
Incident reporting	Maternity incidents moderate/above harm			2	0	2
	Maternity Serious Incidents			N	N	N
	Maternity Never Events			N	N	N
	Coroner regulation 28 made directly to trust (Y/N)			N	N	N
	HSIB/CQC etc. with a concern or request for action (Y/N)			N	N	N
	Number of cases referred / accepted by HSIB			0	0	0
	HIE Cases (2 or 3)			0	0	0
	Notification to ENS			0	0	0
	Number of HSIB reports completed			0	0	0
	Maternal Mortality Rate	Direct		0	0	0
		Indirect		0	0	0
Staffing	Supernumerary Status of the Labour Ward			100%	100%	100%
	Midwifery vacancies			28	16	15
	MW to birth ratio : BR+ recommendation (local review 01/2023): 1:22			1.21	1.22	1.19
	Number of times unit in amber status for low staffing			6	4	4

15.0 Workforce

15.1 Midwifery

15.1.1BirthRate + report

Birth Rate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

Birth Rate Plus considers complexity of patients seen to determine a suitable ratio of clinical staff to births to provide recommendations to the trust regarding appropriate WTE establishment.

The Whittington's Birth Rate Plus report May 2022 (based on 2021 calendar year) recommended:

- An establishment in maternity of **184.04 WTE**
- Comparing against current **177.81 WTE**, this leaves a deficit of **6.23 WTE.**
- The last workforce assessment was completed in May 2022 using an annual birth rate of 3680 which has subsequently fallen by 697 to 2983, thus requiring a reassessment to establish the baseline staffing:

	Annual total
Delivery suite	2677
Birth Centre	261
Home	45
Total births	**2983**

The main factors currently affecting Maternity Services:

- The Governance agenda (Guidelines, audit, training, key health policies).
- Maternity wards provide care to postnatal women and/or babies who are more complex cases.
- Transitional care is often given on the ward.
- Safeguarding needs.
- Shorter postnatal stays before transfer home
- Community based care is expanding - Reduced antenatal admissions and shorter postnatal stays result in an increase in community care.
- Cross border activity can have an impact on community resources.
- New Born and Infant Physical Examination (NIPE) undertaken by midwives instead of neonatologists.
- The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation.

Taking the above into account a refresher of the Birth Rate Plus was undertaken and completed in November 2023 – Please see table below with a summary of the results:

Current Funded Clinical, Specialist, Management wte	Birthrate Plus wte	Variance wte
174.80	171.02	3.78

Table 11: Total Clinical, Specialist and Management wte

The results indicate a positive variance of 3.78 wte from the current funded establishment with 22% uplift.

- Non- clinical midwifery roles:
  - The total clinical establishment as produced from Birthrate Plus® is 152.70wte and this excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services.
  - In addition to these posts, consideration should also be given to recommendations from national reports such as Ockendon 2022 with regards to new roles.
  - The current funded establishment has a deficit of 3.42wte allocated for the non-clinical roles as usually required in all maternity services. This deficit can be addressed from the over allocation in the clinical budget of 7.20wte.

In addition to the midwifery staffing, there is a need to have support staff working on the delivery suite, birth centre, triage, maternity wards, day unit and in outpatient clinics.

15.1.2 Supernumerary status of the labour ward coordinator

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.

A rolling monthly audit is in place since November 2022 as part of the Maternity Incentive Scheme compliance process for Safety Action 5 regarding Midwifery staffing.

Month	Compliance	Staffing	Acuity	Maternity status	Birth Rate Plus	Escalation	Comments
October 2023	100%						
November 2023	100%						
December 2023	100%						

15.1.3 Recruitment and Retention

The specialist roles are for bereavement midwife and safeguarding specialist midwife have been fully recruited to. They have been both filled in as full-time posts. However, the midwife recruited to the safeguarding role has not yet started, this is due to sickness. Once returned from sick leave, an opportunity for development will be available until March 2024. The safeguarding team is at full compliment.

5 new midwives have started their roles in this quarter.

4 new resignations have been received. Midwives are moving to new jobs, closer to home, or with a developmental opportunity or both.

2 Theatre nurses have resigned to new positions: 1 within the Trust (PDN) and 1 with GOSH.

The 3 Theatre nurses are now in post. The team leader position has now been recruited into.

2 additional international nurses are due to start by March 2024. This will mean that this team will be at full complement, this will be the first time in the last 5 years.

Table 11 : Vacancies at the end of December 2023

Roles	Band	Establishment needs - WTE	End of Sept 2023 – WTE vacancies	End of Dec 2023 – WTE vacancies
Midwife	8	11.00	0.00	0.00
Specialist Midwife	7	15.90	0.00	0.00
Midwife	7	15.76	0.00	0.00
Midwife	6	126.04	28.00	14.90
Labour Ward Nurses	5	8.00	4.00	4.67
Nursery Nurses and Specialist Maternity Support Workers	4	11.80	3.67	4.67
Midwifery Support Workers	3	30.30	1.01	0.30

15.1.4 International Recruitment (IR)

5 new midwives have started their roles in this quarter.

2 additional international nurses are due to start by March 2024. This will mean that this team will be at full complement, this will be the first time in the last 5 years.

15.2 Obstetrics

15.2.1 Recruitment

Obstetric recruitment continues.
We have recruited a locum Fertility and Menopause consultant as we were not successful with the substantive recruitment. We will readvertise in the next 6 months.
We have a locum Endometriosis consultant covering a vacancy. Whittington Health is no longer an accredited endometriosis centre and so are working on the hub a spoke model with UCLH. The AAC panel to recruit a substantive Endometriosis consultant in January 2024 was unsuccessful.
The interviews for a substantive Vulval Disease and Colposcopy consultant role are taking place on the 8th of February.

15.2.2 Consultant Attendance Audit

RCOG guidance outlines clinical criteria in which a consultant must attend (criterai1) and clinical criteria where a consultant must attend unless the most senor doctor present has documented evidence of being signed off as competent (criterai2).
An audit was undertaken reviewing births from 1st August 2023 to 7th December 2023.
There were 3 areas that where the 100% standard was not achieved.

Criteria 1:
PPH>2L ongoing and MOH protocol initiated**.**
There were 2 occasions where a consultant was not present. Both occurred on the night shift. In one case the consultant was informed but the PPH was under control before their arrival. In the second case the presence of the consultant was not recorded on CareFlow. The paper notes were not reviewed and an ST7 was present.
Criteria 2
Trial Instrumental birth: on one occasion a consultant presence was not recorded on CareFlow.
Caesarean birth at full dilation: on one occasion a consultant presence was not recorded on CareFlow.

The 2 Criteria 2 incidents on further review post the audit were identified as occurring during the day. A consultant is always present on the wards 8am-10pm and therefore a consultant would have been present. On that basis the requirement is met.
This audit has highlighted an issue with record keeping. It is not possible to make the field mandatory on CareFlow as the system is no longer being developed and is being replaced by Badger Net. The team are developing a QR code and digital method of recording this information to support this rolling audit.
This is a rolling audit and is reported to the maternity clinical governance and safety champions meeting.

See **Appendix 6** for report.

15.2.3 Compensatory Rest Action Plan

The Maternity Incentive Scheme Safety Action 4 has asked for the Trust to develop an action plan on how it will implement the Royal College of Obstetrics and Gynaecology (RCOG) guidance**.**

This is the action plan submitted for MIS after approval from the Medical Director and the Trust Board.

Recommendation	Key Action(s)	Completion date	Responsible Lead(s)	Progress on action and dates:	Evidence of implementation date
Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	**Weekend on call has been split to a Friday and Sunday or a Saturday only. On that basis Friday and Saturday are compliant.**	**June 2023**	**Clinical Lead and CD**	**completed**	**Oncall rota started in June 2023**
	A review of job plans to understand what clinical duties are planned on Mondays or the day after their weekday oncall.	November 2023	Clinical lead and General manager	Completed	
	Review and explore the possibility to change consultant oncall day so that it precedes their day off and impact. If this is possible this will be implemented over the next 6 months.	June 24	Clinical lead and CD	Consultant meeting 18th January 1st discussion to explore this approach.	**Change in job plans if undertaken**
	Diary card exercise to be undertaken to understand the extent of calls and requirements on site between 10pm and 6am.	April 24	Clinical Lead and CD	Consultant meeting 18th January 1st to launch	**Diary card results**
	Each weekday oncall team is made up of 4 consultants. The plan is to discuss with the teams if it would be possible to manage compensatory rest	If agreed it will be formally in place from April 24 based on the findings of the diary card exercise.	Clinical lead and CD	Discussion to be undertaken 18th January to explore options. This support is currently in place in as an	**Outcome recorded in governance meeting.**

	on an adhoc basis within teams as required. If this is possible this will be implemented by the beginning of April 24.			informal Whats App group.	

15.2.4 Junior Doctor Strike:

The consultants covered the junior doctors' strike. Additional midwives were booked to support labour ward and Triage and elective caesarean section lists were run before and after the strikes to reduce the risk of emergency caesarean sections occurring on strike days due to cancellations. For this latest strike some trainees did come to work but it has been difficult to plan as the numbers vary each day and were not expected. The team were able to ensure women and babies were safe. It was a challenge to cover all the areas and feedback from the consultants was that on some days they felt very stretched. We have revised the template to increase the number of consultants to cover labour ward and triage if there is another strike.

15.3 Culture Work:

NHSE on Perinatal Culture and Leadership Course

The Director of Midwifery, Operational General Manager for Maternity and Clinical Lead for Neonates attended the 3-day event run by NHSE on Perinatal Culture and Leadership in Birmingham. The course continues over the next few months in 'action learning sets' and will include the obstetric clinical lead.

The team agreed to support Maternity and Neonates working more closely together to regular fortnightly 'quad' meetings. The team feel that the 'Quad' could be wider and include the Head of Midwifery, the Matron of Neonates and the Clinical Directors for Children and Young People (CYP) and Acute Patient Services, Clinical Support Services and Women's Health (ACW). These meetings are now in place every Wednesday morning. In addition, the team are proposing, that once a month the meeting could be a monthly walk around as a leadership team.

16.0 Maternity and Neonatal Voices Partnership (MNVP) engagement

The work plan with the MVP has been developed.

The objectives of the plan are:

1. Co-production Improvement work on:
    a. patient information leaflets for the Neonatal Unit
    b. Support for Infant feeding
    c. Communication projects which include the way staff communicate and the information available on the website.
    d. Refresh of the environment in counselling rooms
    e. Further develop the Care Outside of Guidance Pathway
    f. Develop a model of a sustainable homebirth service.
2. Expand Service user feedback opportunities.
3. Increase the awareness of the MVP with the Trust service users.

See **appendix 7.**

18.0 Maternity Digital Programme

System C have acquired CleverMed, publishers of BadgerNet EPR and will be 'sunsetting' their existing Careflow Maternity Package (also known as Medway Maternity), which is currently in place across Whittington maternity services. 'Sunsetting' means that the software will no longer be developed except to meet regulatory requirements.
Both TMG and ITDG supported an active move to BadgerNet, supported by System C, as this would enable the Trust to:

- Meet National Health Service England (NHSE) digital requirement of digitally accessible records at all points of care.
- Meet the provision of end-to-end digital care.
- Share information safely and securely with other divisions, wards, hospitals, and agencies.
- Address the clinical safety risks identified by the current systems and drive safer care.

High-level resourcing and implementation plans outline that this would provide long-term value to the Trust.
As the active move to BadgerNet has been agreed a business case and delivery plan is being presented at Investment Group in February and for a decision at Trust Management Group (TMG). This has been identified by IM&T as a priority project for 24/25.

19.0 Maternity and Neonatal Estates Programme

The design pivot that was required to enable the improvement of the neonatal unit to be at the beginning of the programme has been tested and the wider requirements of the maternity and neonatal unit are still viable in this new programme.
Good progress is being made on the 1:200 designs alongside the clinical teams. Clinical planners have been appointed and are testing the assumptions made in terms of activity and space. Due to the complex nature of the build, which will require multiple decants and moves as sections are built and improved, a task group is being set up with the clinical and operational teams. In this way the project will ensure all the complexities, potential solutions and impacts of the programme are understood and managed.

20.0 Conclusion

The success in reaching full compliance for the MIS year 5 submission has been the result of a lot of hard work from the whole MDT in maternity and should be commended.
There is more work to do as outlined in this paper, but the team are motivated to provide high quality safe care.

21.0 Appendices

Appendix 1 – MIS board declaration

Appendix 2 – Position and Progress against MIS

Appendix 3 – Whittington LMNS feedback

Appendix 4 - Perinatal Quality Surveillance Model Q3

Appendix 5 – OPEL parameters

Appendix 6 – Consultant Attendance Audit

Appendix 7 – MVP workplan

Meeting title	**Quality Assurance Committee**	**Date: 13th March 2024**
Report title	**Quality Report: Q3 2023/24**	**Agenda item: 4.3**
Executive director lead	Dr Clare Dollery, Medical Director Sarah Wilding, Chief Nurse and Director of Allied Health Professionals	
Report author	• Anne O' Connor; Associate Director of Quality Governance • Erum Jamall, Associate Medical Director Clinical Effectiveness • Louise Roper, Head of Patient Safety • Sarah Crook, Head of Clinical Effectiveness • Kat Nolan-Cullen, Compliance and QI Manager • Iona MacDonald, Quality Improvement Lead • Tracey Groarke, Infection Prevention & Control Nurse - Operational lead • Tessa Pascall, Service Manager Plastics, Breast, Oncology & Cancer Services	

Executive summary	This is the regular quarterly paper to provide an overview of quality across the organisation, covering patient safety, clinical effectiveness, quality improvement and assurance. This report will cover Q3 2023/24, key highlights include:
	
	• There has been an increase in the number of recorded pressure ulcers in Qtr3 (219) compared to Qtr2 (166).
	• There has been a reduction in full thickness pressure damage and levels of harm; there have been no hospital acquired category 4 pressure ulcers since February 2023. However, the incidence of full thickness pressure damage remains a concern in the community (7 in Q3). This theme will be the focus of the first Quality Improvement initiative under PSIRF expected to commence in March / April 2024.
	• There has been a reduction of 40 in the number of patient falls from Q3 2022/23
	• During Qtr3 there were 1281 patient safety incidents recorded on Datix which is a 27% (478) reduction compared to Qtr2.
	• Trust attributable blood stream infection (BSI) Qtr3
	  ○ MRSA = 1 (zero tolerance)
	  ○ MSSA = 1 (There is no national threshold)
	  ○ There were 5 C Clostridium difficile cases in Q3. This brings to a total of 13 hospital acquired cases of Clostridium difficile infections (CDI) Q-Q3 in the Trust against an annual trajectory of 13.
	  ○ 2 E. coli Blood Stream Infections (BSI) during Qtr3, this brings to a total of 17 cases year to date.
	• There are 41 incidents between Qtr1 2021/22 to Qtr3 2023/24 across the Trust that have outstanding Duty of Candour requirement.	

	• Policies: Jan 23-24 Total policies for review have reduced from 61% to 40%, with Clinical Policies reducing from 19% to 11% and Non-Clinical Policies from 38% to 25% over the same period. • National Diabetes Inpatient Safety Audit (Harms): Has been completed. • National Early Inflammatory Arthritis Audit Outlier Notification: Action planning is underway, with a business case completed to recruit relevant MDT staff to enable patients referred with suspected persistent synovitis to be seen within three weeks of referral. • National Audit on Dementia - Care in General Hospitals: Round 6 data submitted. • 2 Whittington QI Projects have been invited to present posters at the International Forum on Quality & Safety in Healthcare in April
Purpose:	Discussion and approval for Trust Board.
Recommendation(s)	Members are asked to approve for Trust Board: • Identify key issues of good practice to highlight to the Board. • Escalate any concerns where there is insufficient assurance to the Board.
Risk Register or Board Assurance Framework	Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.
Report history	This report comprises elements that have been report to the Quality Governance committee in extended form

1. Introduction

The Quality Governance quarterly report is designed to demonstrate Whittington Health's commitment to continuous learning and improvement. This report provides a systematic analysis of intelligence from patient safety and clinical effectiveness, including key performance metrics, as well as themes and trends for Q3 2023-2024. This aggregated approach allows the Trust to recognise where improvements have been made from previous reporting whilst also proactively identify any underlying concerns and to allocate resources accordingly to drive improvement.

2 Patient Safety

2.1 Exception reports

2.1.1 Pressure Ulcers

The data presented in this report does not include moisture lesions and category 1 pressure ulcers but does include Cat 2-4, mucosal, deep tissue injury, and unstageable pressure ulcers, which are reportable externally.

- The Trust has a target to reduce overall Trust attributable pressure damage by 20%, and full thickness pressure damage by 50% in 2023/2024. Results against this annual target will be reported in the Q4 report.

- There has been an increase in the number of recorded pressure ulcers in Qtr3 (219) compared to Qtr2 (166), across both acute and community sites.

Fig 1: Trust Pressure Ulcer Data by severity Qtr3 2022 – Qtr3 2023

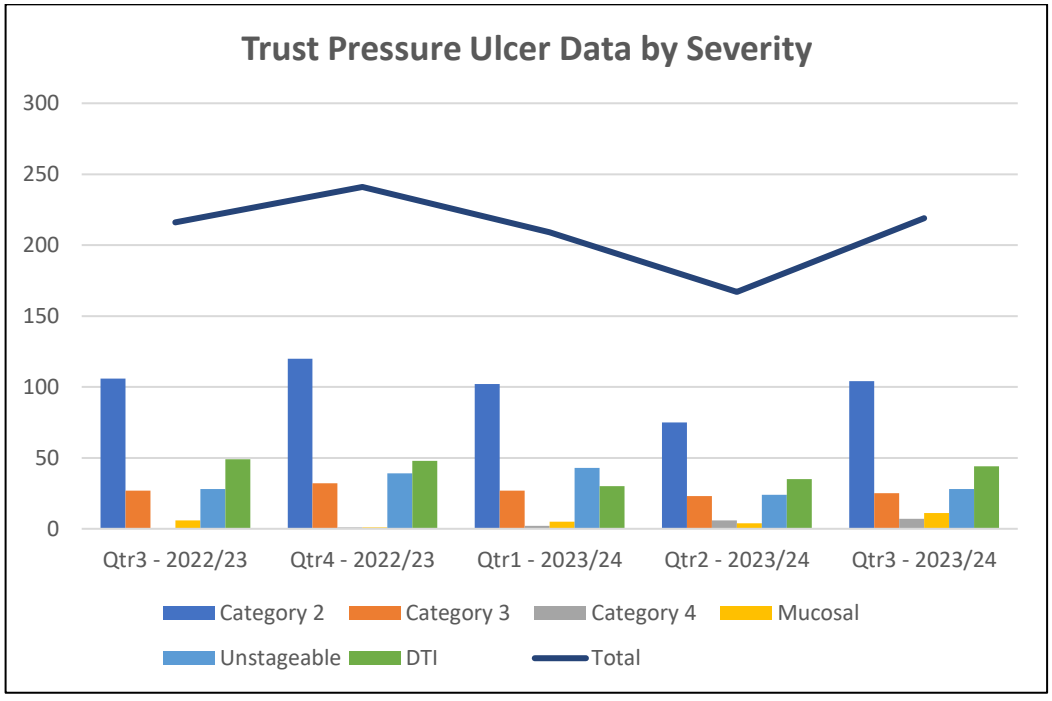
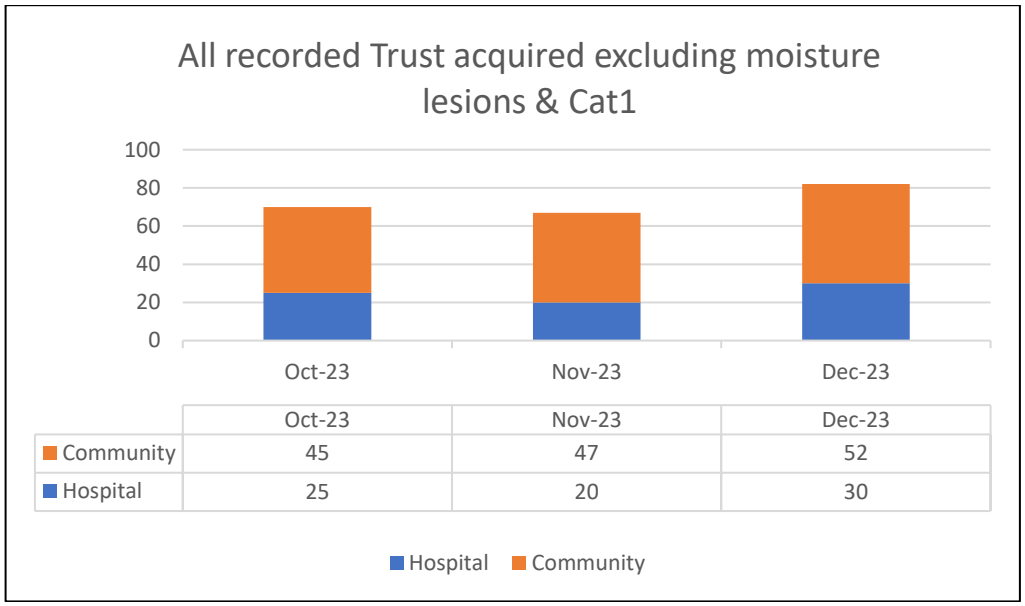
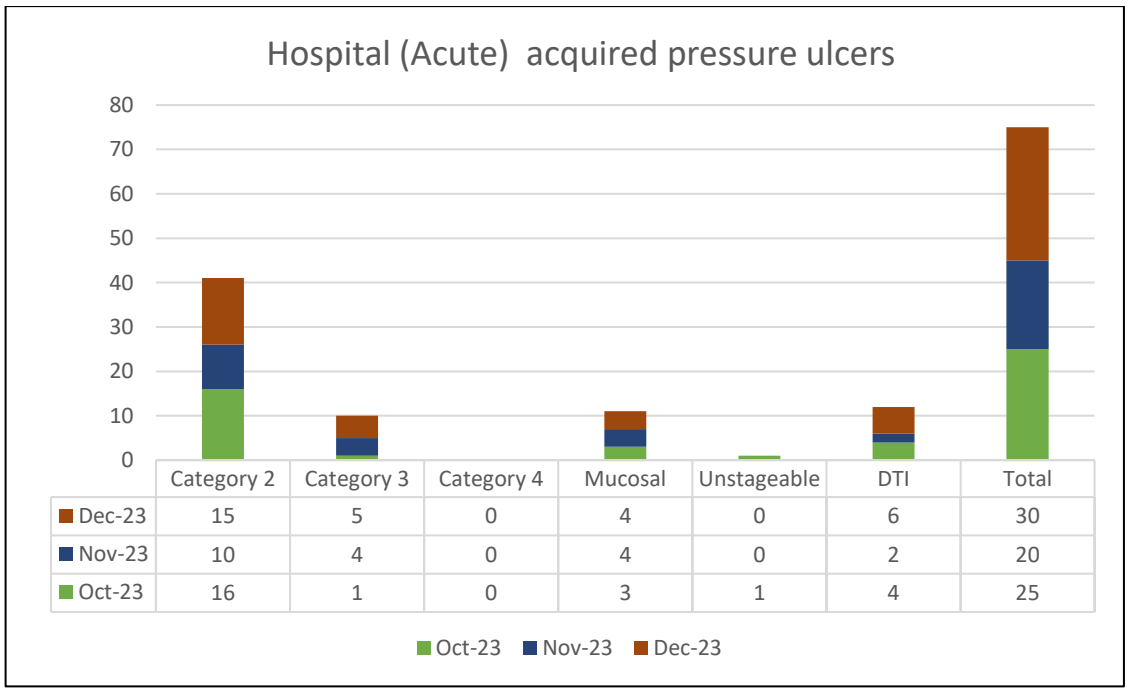


Fig 2: Total number of Trust acquired Pressure Ulcers during Qtr3 23/24



	Oct-23	Nov-23	Dec-23
Community	45	47	52
Hospital	25	20	30

Fig 3: Total number of hospital acquired pressure ulcers recorded for Qtr3



	Category 2	Category 3	Category 4	Mucosal	Unstageable	DTI	Total
Dec-23	15	5	0	4	0	6	30
Nov-23	10	4	0	4	0	2	20
Oct-23	16	1	0	3	1	4	25

- Community acquired pressure damage remains the highest area for reported incidents with critical care and the Emergency Department reporting the highest numbers within the acute setting. To note that ED reports pressure damage on admission, not necessarily as acquired.
- Critical care reported the highest number of hospital acquired pressure ulcers, followed by Coyle ward. Device related mucosal pressure damage accounts for a large proportion of critical care related pressure damage. Work is being caried out in the unit to prevent these types of damage.
- The acute hospital setting has seen a rising trajectory over the last quarter, though it was in line with seasonal and Trust capacity changes but overall lower than the same quarter last year 2022-2023. This should be read in context of an additional 47 additional beds opened during 23/24.

- Following the implementation of a Trust Pressure Ulcer Improvement plan, the Trust has demonstrated a success in reducing the incidence full thickness pressure damage and levels of harm; there has been no hospital acquired category 4 pressure ulcers since February 2023.
-

Fig 4. Hospital attributable pressure damage October 2022 – December 2023

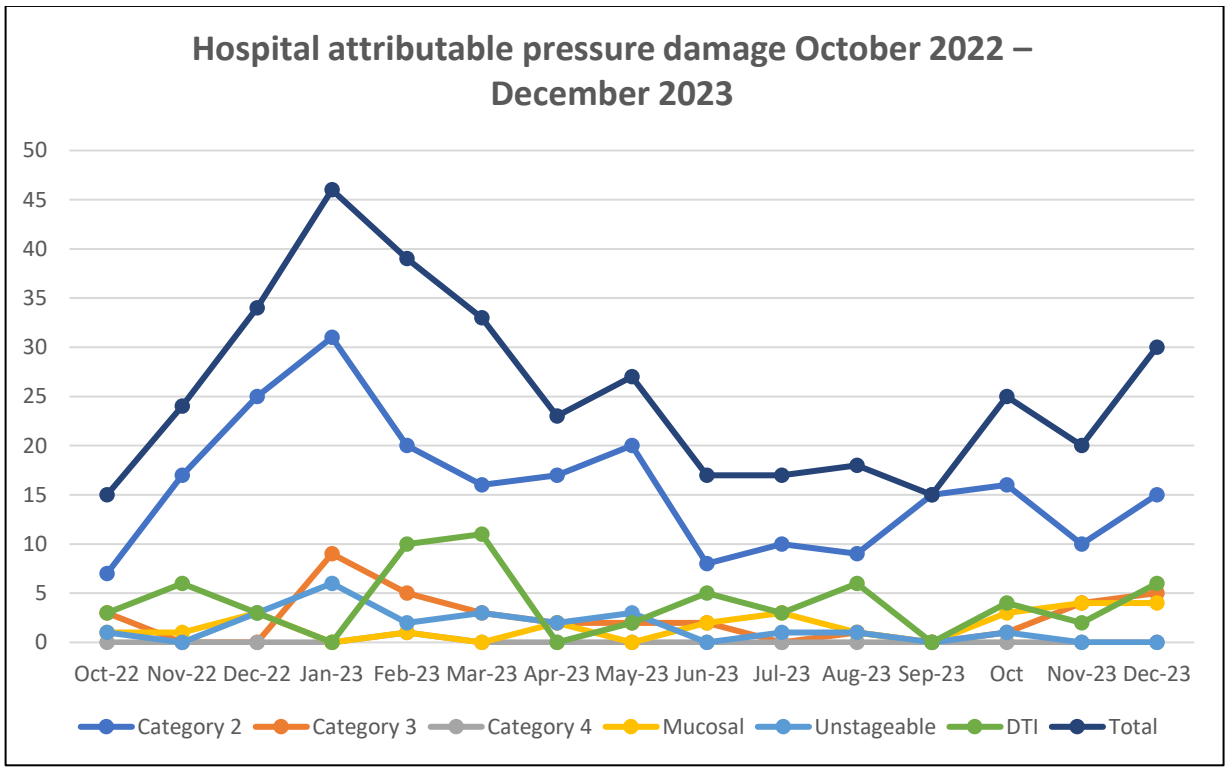
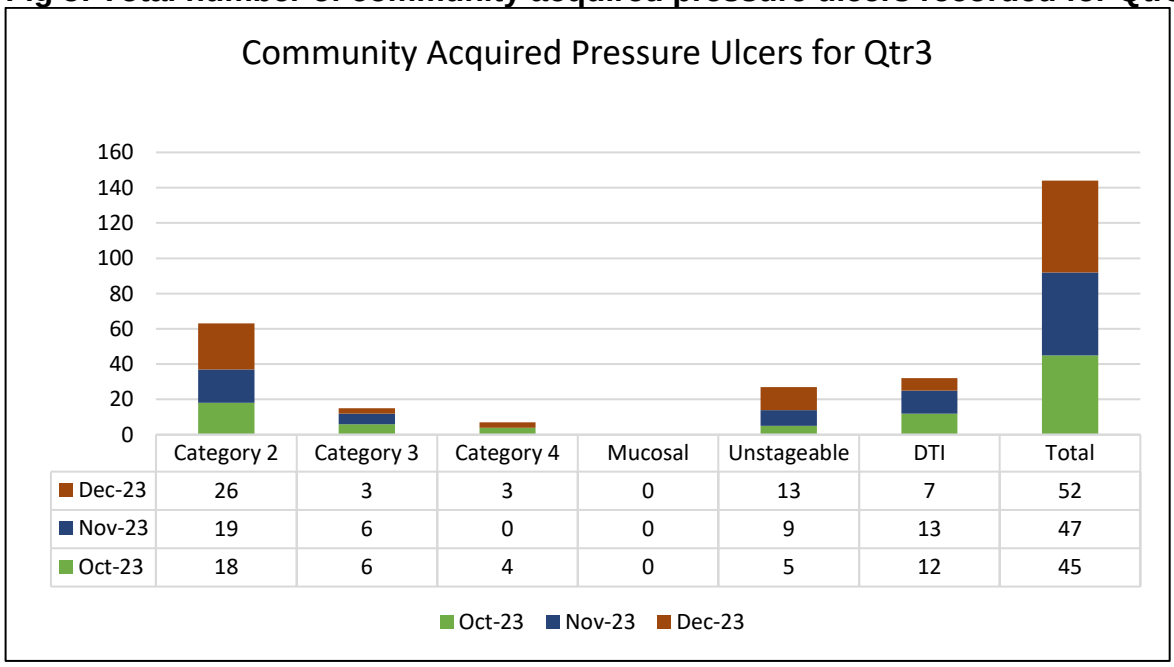


Fig 5: Total number of community acquired pressure ulcers recorded for Qtr3



	Category 2	Category 3	Category 4	Mucosal	Unstageable	DTI	Total
Dec-23	26	3	3	0	13	7	52
Nov-23	19	6	0	0	9	13	47
Oct-23	18	6	4	0	5	12	45

- There was a rise in community acquired pressure damage in the Qtr3 compared to Qtr2 in both overall pressure damage and more specifically full thickness pressure ulcers. The number of patients affected was relatively static from the previous quarter.

- An area of concern has been the increased incidence of full thickness category 4 pressure damage in the community setting (7); there have been a number of contributory factors for this including equipment implementation and utilisation issues, carer involvement (high turnover affecting training effectiveness) and patient engagement challenges.

- There are known issues with NRS, the company supplying equipment in the community, for a number of pressure relieving equipment types since the contract implementation. Concerns were escalated to the Integrated Care Board (ICB) and this is now improving although the issues still occur in regards to delivery times and communication with patients & family members. This is still recorded on the Trust risk register.

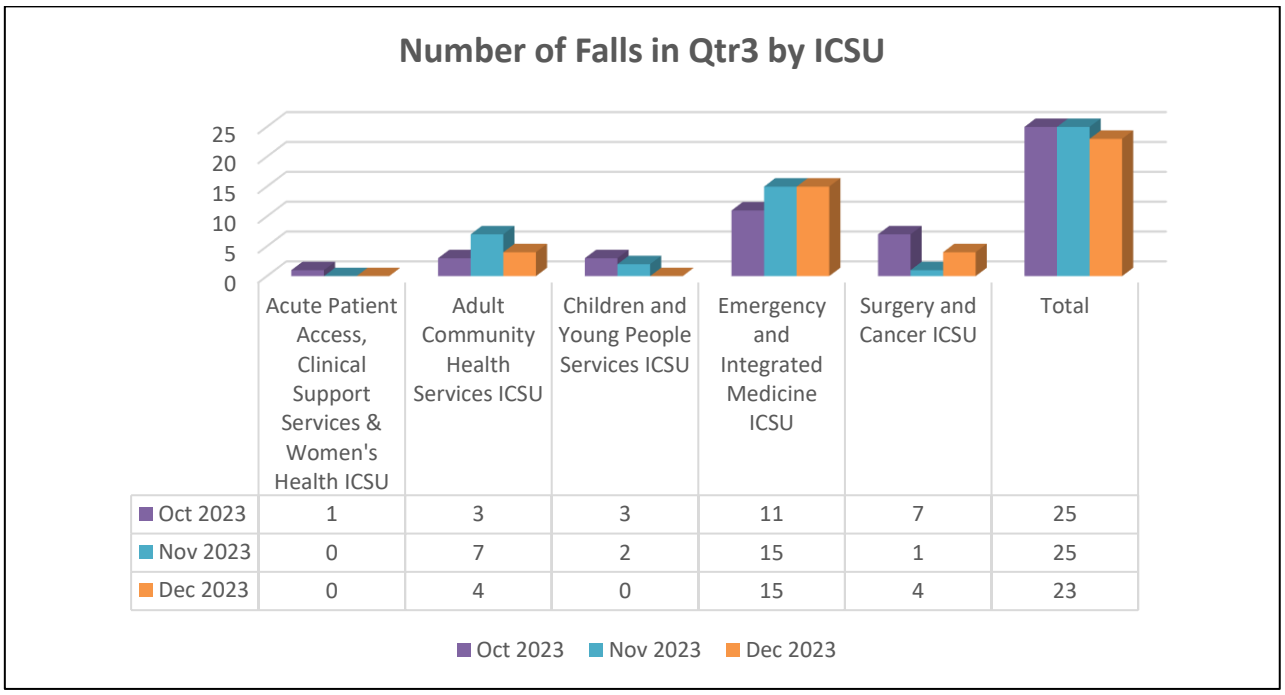
Actions to Recover

- Trust Pressure Ulcer Group to monitor and support recovery.
- There is a pressure ulcer improvement plan to prevent and reduce Trust acquired pressure ulcers which will be monitored by the Pressure Ulcer Group. There are five key aims:
  - Assessment
  - Planning care
  - Equipment
  - Education & Training
  - Quality & Risk:
- For all learning from Trust acquired pressure ulcers to be identified and shared widely
- Work on integrating pressure area care documentation into the Trust electronic platforms is progressing with a proposed electronic form completed and to be piloted on two clinical areas.
- Community acquired pressure ulcers will be the focus of the first Quality Improvement initiative under PSIRF expected to commence in March / April 2024.

2.1.2 Patient Falls

- There was a total of 73 falls reported in Q3, with EIM being the ICSU with the highest number reported (41).
- 2 of the falls were categorised as moderate physical harm and 1 as fatal (however the patient death was not as a direct result of the fall, rather from underlying health conditions).

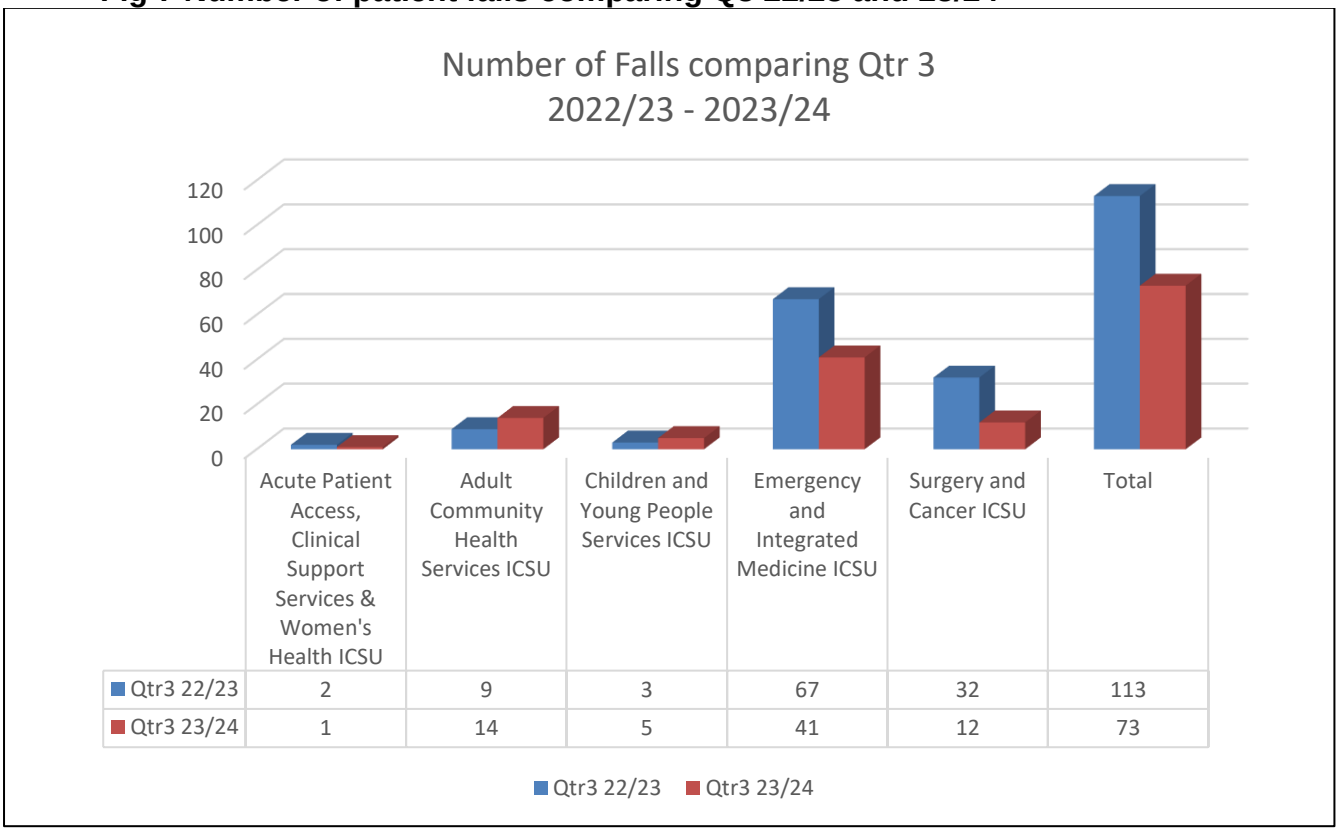
Fig 6: Number of patient falls during Qtr3 2023/24



	Acute Patient Access, Clinical Support Services & Women's Health ICSU	Adult Community Health Services ICSU	Children and Young People Services ICSU	Emergency and Integrated Medicine ICSU	Surgery and Cancer ICSU	Total
Oct 2023	1	3	3	11	7	25
Nov 2023	0	7	2	15	1	25
Dec 2023	0	4	0	15	4	23

- Compared to Qtr3 last year, the number of patient falls has decreased by 40 incidents with a decline in the number of falls recorded across all ICSUs.

Fig 7 Number of patient falls comparing Q3 22/23 and 23/24



	Acute Patient Access, Clinical Support Services & Women's Health ICSU	Adult Community Health Services ICSU	Children and Young People Services ICSU	Emergency and Integrated Medicine ICSU	Surgery and Cancer ICSU	Total
Qtr3 22/23	2	9	3	67	32	113
Qtr3 23/24	1	14	5	41	12	73

Table 1: Falls by department; Qtr3 23/24

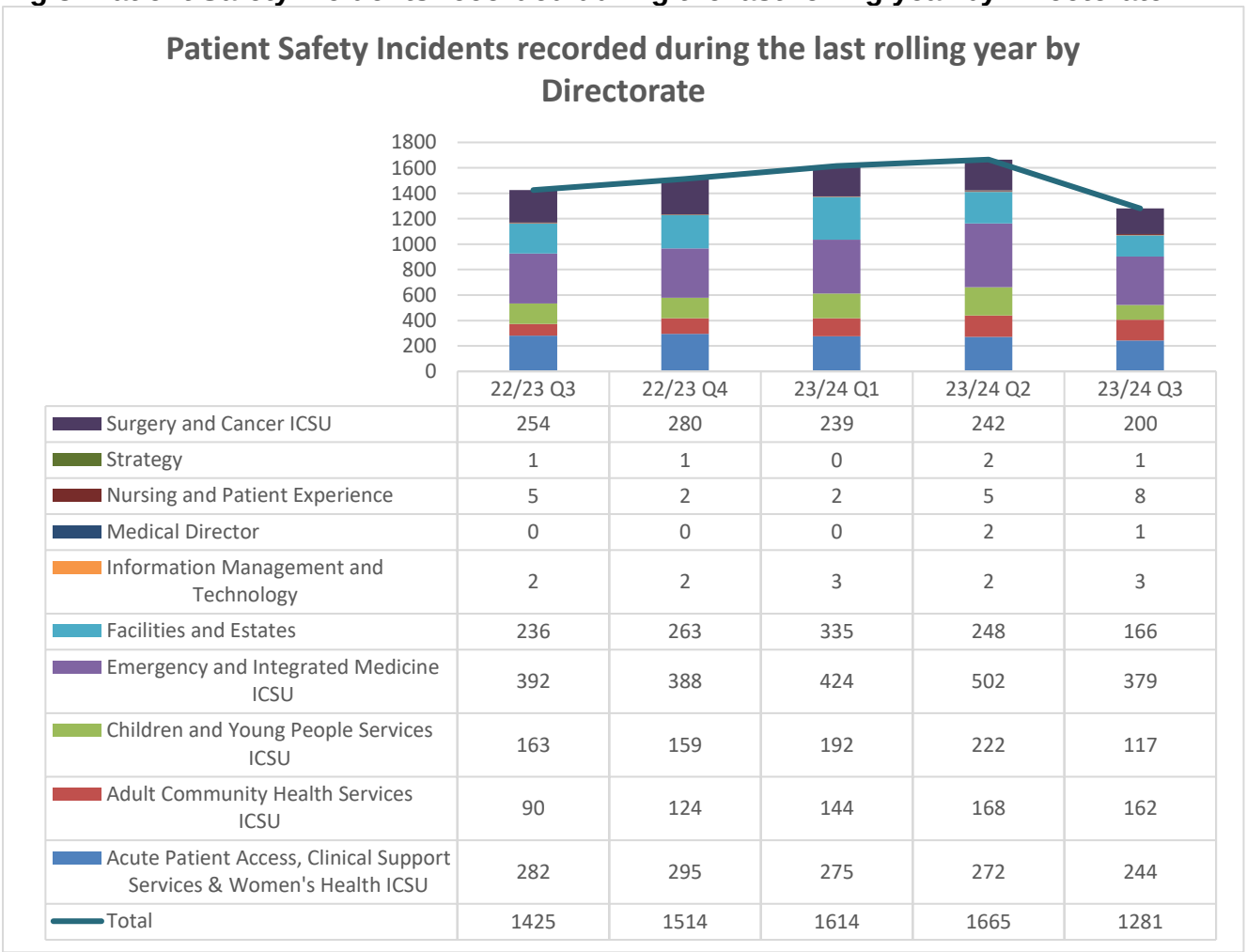
Department	Oct 2023	Nov 2023	Dec 2023	Total	Compared to Qtr2
Acute Medical Wards (Nightingale, Montuschi, Victoria)	6	5	8	19	↔ (0)
Care of Older People Wards (Cloudesley, Meyrick, Cavell)	5	2	5	12	↑ (1)
Surgical Wards (Coyle and Mercers)	6	1	4	11	↓ (5)
Emergency Department	1	6	1	8	↓ (8)

- The highest number of falls were on Acute Medical wards (19) however this remained the same number as Qtr2. The Emergency Department saw the largest decrease in falls compared to Qtr2 (8) 50%.

2.1.3 Patient Incident data and themes

- During Qtr3 there were 1281 patient safety incidents recorded on Datix which is a 27% (478) reduction compared to Qtr2.

Fig 8: Patient Safety Incidents recorded during the last rolling year by Directorate



	22/23 Q3	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3
Surgery and Cancer ICSU	254	280	239	242	200
Strategy	1	1	0	2	1
Nursing and Patient Experience	5	2	2	5	8
Medical Director	0	0	0	2	1
Information Management and Technology	2	2	3	2	3
Facilities and Estates	236	263	335	248	166
Emergency and Integrated Medicine ICSU	392	388	424	502	379
Children and Young People Services ICSU	163	159	192	222	117
Adult Community Health Services ICSU	90	124	144	168	162
Acute Patient Access, Clinical Support Services & Women's Health ICSU	282	295	275	272	244
Total	1425	1514	1614	1665	1281

Table 2 : Patient safety incidents recorded Qtr3 by Directorate

	Oct 2023	Nov 2023	Dec 2023	Total
Acute Patient Access, Clinical Support Services & Women's Health ICSU	107	82	55	244
Adult Community Health Services ICSU	69	47	46	162
Children and Young People Services ICSU	55	37	25	117
Emergency and Integrated Medicine ICSU	181	113	85	379
Facilities and Estates	117	27	22	166
Information Management and Technology	2	1	0	3
Medical Director	0	0	1	1
Nursing and Patient Experience	2	2	4	8
Strategy	0	1	0	1
Surgery and Cancer ICSU	97	58	45	200
Total	630	368	283	1281

**due to the way data are collected and analysed within Datix, the total excludes pressure ulcer data.*

- The top three categories remain the same as Qtr2 although in a different order due to number of reported incidents.
- The fourth category (medication) has changed compared to Qtr2 however the number of recorded medication incidents was lowered in Qtr3 (122) compared to Qtr2 but ranked in a different order.

Table 3: Top six categories of reported incidents for Qtr3

	Total for Qtr3	Share of Incidents as a %	Change in order compared to Qtr2
Pressure Ulcer / Moisture Associated Skin Damage	314	20%	↑
Security	213	13%	↓
Admission, Appointment, Discharge, Transfer, Transport	191	12%	↔
Medication	122	8%	↑
Accident that may result in personal injury	120	8%	**New**
Implementation of care / ongoing monitoring / review	107	7%	↓

Table 4: Top six categories for Qtr2

	Total for Qtr2	Share of Incidents as a %
Security	434	23%
Pressure Ulcer / Moisture Associated Skin Damage	218	12%
Admission, Appointment, Discharge, Transfer, Transport	206	11%
Abuse and Violence	144	8%
Implementation of care / ongoing monitoring / review	131	7%
Medication	126	7%

Table 5: Top six themes outlined in the Patient Safety Incident Response Plan

Theme	Key Theme
1	Patient Falls
2	Medication / Safety
3	Responding to a deteriorating patient
4	Pressure related skin damage
5	Delayed Treatment & Diagnosis
6	Unsafe discharge

- Table 6 below shows the breakdown of category by sub-category - accident that may result in personal injury. Falls are the top sub-category which aligns with the top six themes identified in the Patient Safety Incident Response Plan (PSIRP).

Table 6: Sub-categories for accident that may result in personal injury

Sub-categories for accident that may result in personal injury	Oct 2023	Nov 2023	Dec 2023	Total
Slips, trips, falls and collisions	30	25	24	79
Exposure to radiation, electricity, hazardous substance, infection etc	3	1	3	7
Manual Handling	4	0	1	5
Accident caused by some other means	9	8	7	24
Needlestick injury or other incident connected with Sharps	2	0	0	2
Injury caused by physical or mental strain	0	3	0	3
Total	48	37	35	120

- Table 7 below shows the breakdown of category by detail: Implementation of care/ ongoing monitoring/review which aligns with the PSIRP.

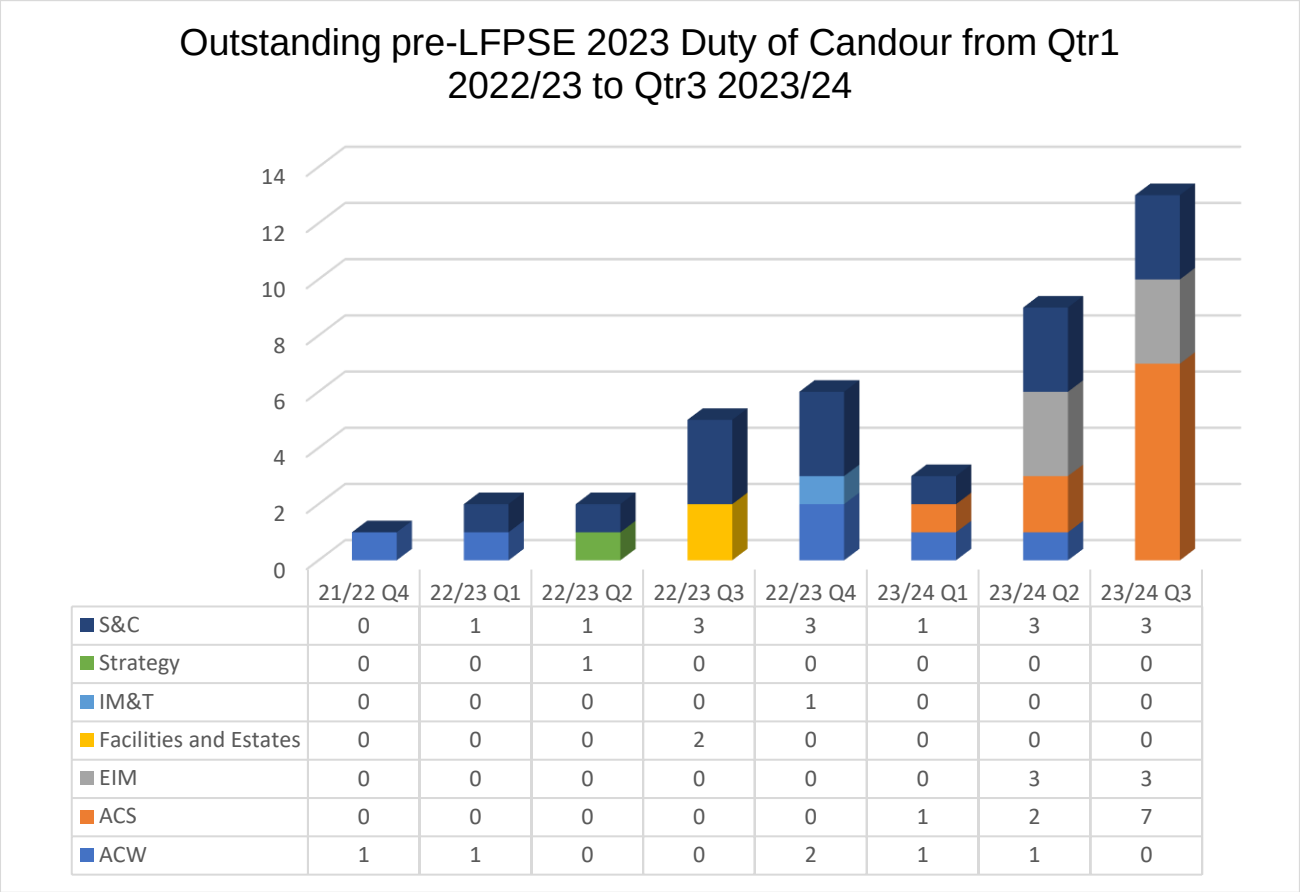
Table 7: Detail for Implementation of care/ongoing monitoring/review

Detail: Implementation of care/ongoing monitoring /review	Oct 2023	Nov 2023	Dec 2023	Total
Implementation & ongoing monitoring/review - other	30	25	25	80
Failure to act on adverse test results or images	1	0	0	1
Delay / failure to monitor	4	9	3	16
Delay/failure in acting on complication of treatment	0	2	0	2
Extended stay / episode of care	0	1	0	1
Failure to follow up	0	1	1	2
Failure to act on adverse symptoms	0	1	0	1
Insufficient Pain Relief	0	0	1	1
Missing, inadequate or illegible healthcare record	0	0	2	2
Diagnostic images or Lab tests not available when required	0	0	1	1
Total	35	39	33	107

- The Quality Governance Team continues to support staff to increase reporting through Datix training and sessions modelled on the Essentials of Patient Safety from the National Patient Safety Syllabus.

2.2 Duty of Candour

Fig 9: Outstanding pre-LFPSE 2023 Duty of Candour for incidents reported from Qtr4 2021/22 to Qtr3 2023/24



	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3
S&C	0	1	1	3	3	1	3	3
Strategy	0	0	1	0	0	0	0	0
IM&T	0	0	0	0	1	0	0	0
Facilities and Estates	0	0	0	2	0	0	0	0
EIM	0	0	0	0	0	0	3	3
ACS	0	0	0	0	0	1	2	7
ACW	1	1	0	0	2	1	1	0

- There are currently 41 pre-LFPSE (Learning from Patient Safety Incidents) 2023 incidents between Qtr1 2021/22 to Qtr3 2023/24 across the Trust that have outstanding Duty of Candour requirement.
- With the change in reporting on LFPSE, the level of harm will be categorised both as psychological and physical. This will result in capturing data differently, whereby a patient may trigger two DOC, one for each categorisation. This will be reported in the Q4 report.

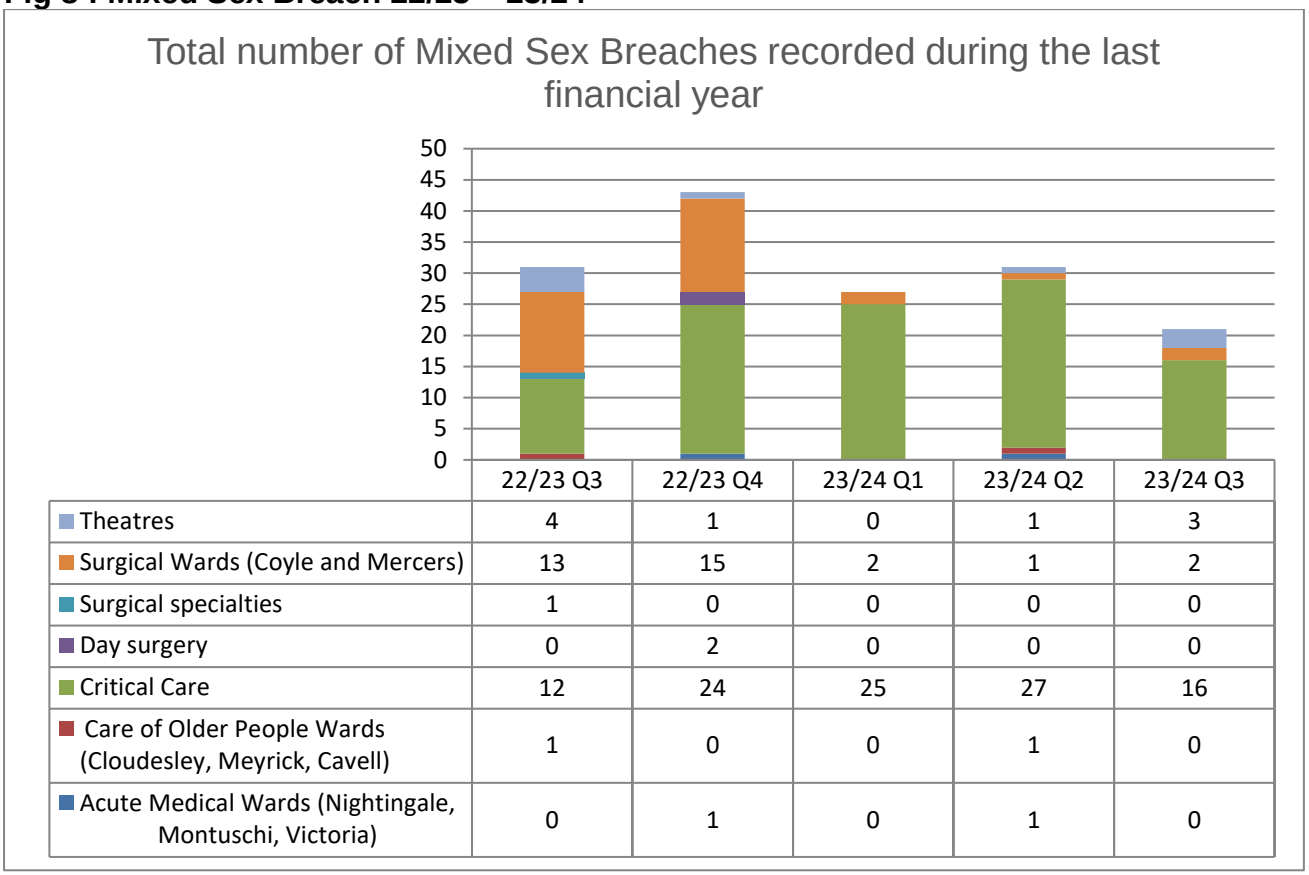
2.3 Mixed Sex Breaches

Table 8: Mixed Sex Breach data Qtr3 23/24

	Oct 2023	Nov 2023	Dec 2023	Total
Critical Care	12	3	1	16
Surgical Wards (Coyle and Mercers)	0	1	1	2
Theatres	2	1	0	3
Total	14	5	2	21

- There has been a decrease to 21 in the number of mixed sex breaches compared to Qtr2 (31).
- Care of the Elderly and acute medical wards had no reported breaches during Qtr3.
- Critical Care also saw a 41% decrease (11) in the number of recorded mixed sex breaches during Qtr3. The unit will continue to work on reducing this number further.

Fig 8 : Mixed Sex Breach 22/23 – 23/24



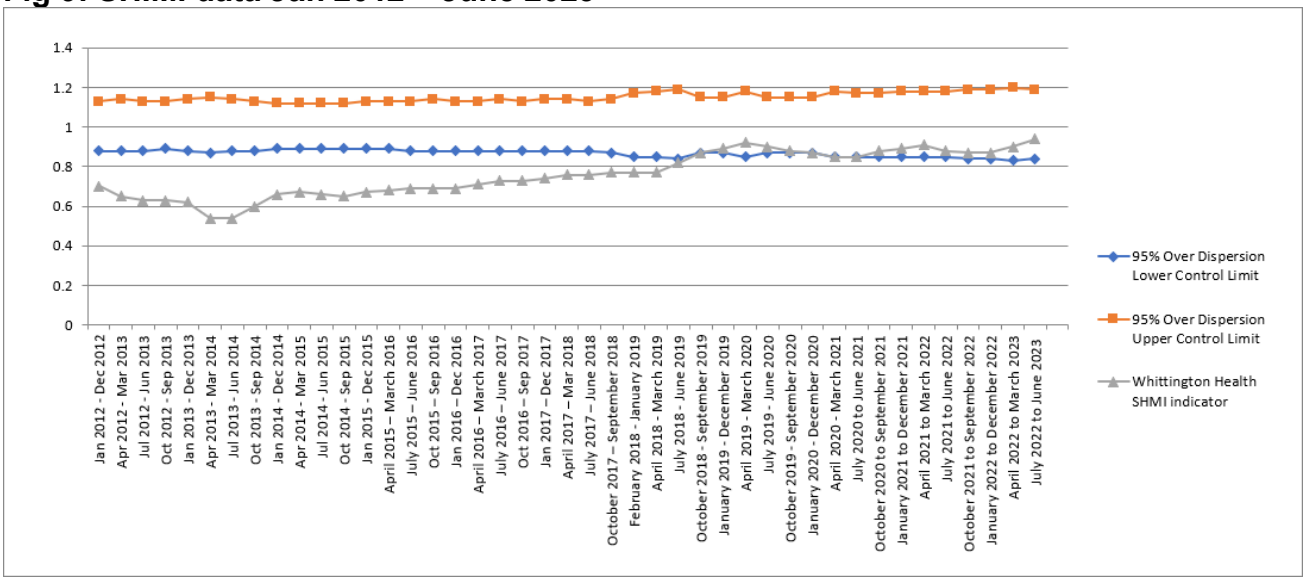
	22/23 Q3	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3
Theatres	4	1	0	1	3
Surgical Wards (Coyle and Mercers)	13	15	2	1	2
Surgical specialties	1	0	0	0	0
Day surgery	0	2	0	0	0
Critical Care	12	24	25	27	16
Care of Older People Wards (Cloudesley, Meyrick, Cavell)	1	0	0	1	0
Acute Medical Wards (Nightingale, Montuschi, Victoria)	0	1	0	1	0

2.4 Mortality

2.4.1 Summary Hospital-level Mortality Indicator (SHMI)

- The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. It covers all deaths reported of patients who were admitted to non-specialist acute Trusts in England and either die while in hospital or within 30 days.
- Please refer to additional paper to QAC for additional information.

Fig 9: SHIMI data Jan 2012 – June 2023



2.5 Infection Prevention and Control

2.5.1 Health Care Acquired Infections – COVID-19

May 2023 guidance introduced from 30th March UKHSA/NHSE letter. https://whittnet.whittington.nhs.uk/document.ashx?id=16528 which recommends no Covid19 test required if patient is asymptomatic (unless being discharged to care home-LFT then required). Patients who have respiratory symptoms should have a PCR.

Table 9: Overall case numbers of COVID--19 for Q3 this year

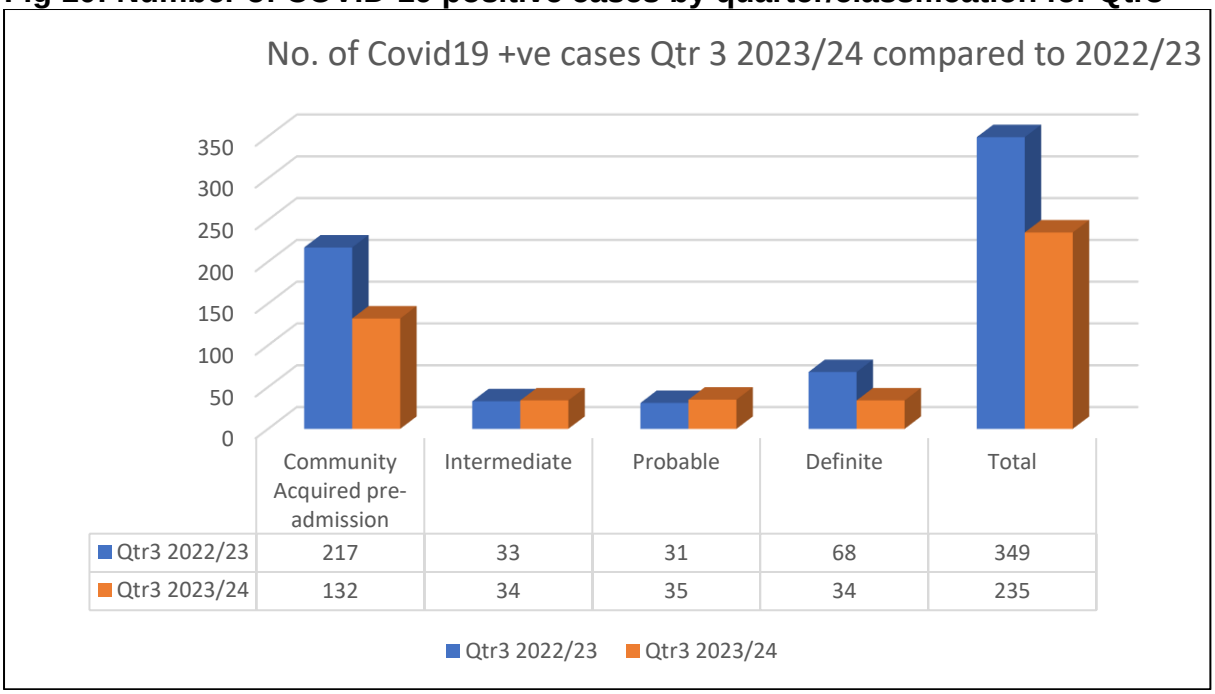
	Oct to Dec 22	Oct to Dec 23
Community Acquired Pre-admission or up to day 2	217	132
Intermediate HAI Day 3 – 7 (hospital onset)	33	34
Probably HAI Day 8 – 14 (hospital onset)	31	35
Definite HAI Day 15 or more (hospital onset)	68	34
Totals	349	235

- The number of overall cases of COVID-19 for Qtr3 is 235, 48% less compared to Qtr3 2022/23 (114).

- There were 13 outbreaks during Qtr3 mainly in acute medical wards and care of the elderly.
  - October: Coyle, Eddington, Nightingale, Victoria, Meyrick, Cavell,
  - November: Montuschi, Meyrick,
  - December: Coyle, Cloudesley, Cavell, Mercers

- There has been a 50% decrease in the number of recorded COVID-19 cases compared to this time last year in definite HAI (15 or more days)
- Probable HAI (8-14 days) is comparable to Qtr3 in 2022 along with Intermediate HAI (pre-admission or up to 2 days).

Fig 10: Number of COVID-19 positive cases by quarter/classification for Qtr3



2.5.2 Other Health Care Acquired Infections

- Trust attributable blood stream infection (BSI) Qtr3
  - MRSA = 1 (zero tolerance)
  - MSSA = 1 (There is no national threshold)

Findings from MRSA investigation

The most likely source of this bacteraemia is patients own colonisation status.

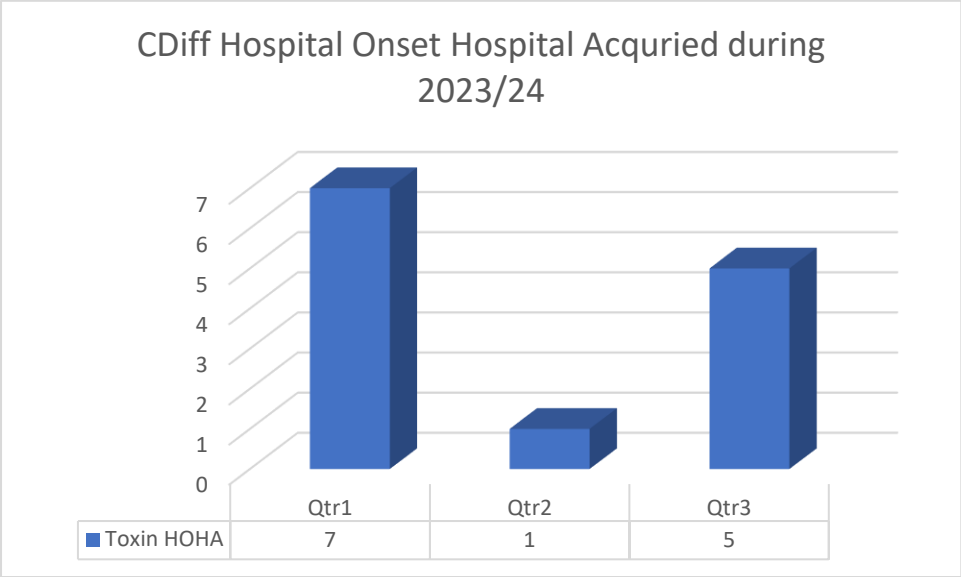
Good practice: The patient was screened for MRSA testing on admission (09.12.2023) as per trust policy which was positive. Blood cultures were taken on the 14/12/2023 as part of septic screen and were MRSA Positive.

Lesson learned: This is an unavoidable MRSA BSI incident.

Recommendation: No recommendations that would have prevented this case or a similar case in the future

- **Clostridium difficile**
  To end Q3 (23-24), there were 13 hospital acquired cases of Clostridium difficile infections (CDI) in the Trust.
- This brings to a total of 13 hospital acquired cases of Clostridium difficile infections (CDI) Q-Q3 in the Trust against an annual trajectory of 13

Fig 11: Clostridium Difficile Infections in the Trust



- There were five Clostridium difficile Infections hospital onset hospital acquired (HOHA). Cavelle, Victoria Meyrick, Critical Care Unit, and Coyle ward.
- All cases were discussed in the multidisciplinary team (MDT) meeting and the following learning points were identified.
- A deep dive on all the cases across the year to date are being undertaken

Clostridium difficile key learning points

- Antibiotics were appropriate but antibiotic course could have been shorter, antibiotics to be reviewed after 5 days.
- To promote enhanced cleaning.
- Glutamate Dehydrogenase (GDH) +ve patient also on ward, specimen sent for ribotyping, result c. diff not grown.
- Delays in sending stool sample
- Patient not isolated until C.diff result available
- CDI patient leaflets to be updated
- Further education sessions on C.diff required

- There were two E. coli Blood Stream Infections (BSI) during Qtr3, one on Montuschi ward in November and one on Meyrick ward in December. This is a total of 17 cases for this year to date.

Escherichia-coli plans to improve

- Each case is reviewed by the Infection prevention and Control team (Microbiology and IPC) to determine if there is any line, catheter, surgical, Ventilator related infections.
- There is surveillance, preliminary reviews and shared learning for any Blood Stream Infections that are related to catheter (vascular or urinary), ventilator, surgery. All cases are discussed with microbiology.

2.6 Clinical harm reviews

- Harm reviews give assurance to patients, carers, commissioners, and the public as to whether patients have been harmed, or at risk of harm, as well as helping to avoid future harm to patients (NHSE, 2016)
- Reports submitted to the ICS re priority 2 or above patients on admitted pathways show no patients waiting over 78 weeks.
- December's performance (Q3) was published mid February and following analysis and will be reported on in the next quarter.
- Cancer harm reviews are shown below

Fig 12: Quarter 2 23/24 Cancer harm reviews

Speciality Pathway	How many 104-day breaches Patients on admitted pathways only	How many harm reviews were completed	Number outstanding	How many resulted in harm to the patient	What level of Harm (Please insert number)		Action taken
July	Breast – 1 Colorectal – 2 Gynaecology – 1 Urology – 4	Breast – 1 Colorectal – 2 Gynaecology – 1 Urology – 0	Breast – 0 Colorectal – 0 Gynaecology – 0 Urology – 4	Breast – 0 Colorectal – 0 Gynaecology – 0 Urology – Un-Known	No harm Minor harm Moderate harm Severe/ Catastrophic/ Death	4	All urology harm reviews escalated to Clinical director
August	Breast – 2 Colorectal – 1 Gynaecology – 1 Lung – 1 Skin – 1 Urology – 4	Breast – 2 Colorectal – 1 Gynaecology – 1 Lung – 1 Skin – 1 Urology – 0	Breast – 0 Colorectal – 0 Gynaecology – 0 Lung – 0 Skin – 0 Urology – 4	Breast – 0 Colorectal – 0 Gynaecology – 0 Lung – 0 Skin – 0 Urology – Un-Known	No harm Minor harm Moderate harm Severe/ Catastrophic/ Death	6	Gynaecology – Delay to 1st OPA due to capacity challenges – WLI NCL funded W/E to support capacity
September	Breast – 2 Haematology – 1 Urology – 1	Breast – 2 Haematology – 1 Urology – 0	Breast – 0 Haematology – 0 Urology – 1	Breast – 0 Haematology – 0 Urology – Un-Known	No harm Minor harm Moderate harm Severe/ Catastrophic/ Death	3	

2.7 Safety Alerts

- The Patient Safety Team have oversight of all Central Alerting System (CAS) alerts, however responsibility for actioning and monitoring progress sits with the respective responsible

meeting groups/committees. In addition to National Patient Safety Alerts, which are monitored via the Patient Safety Group, these include Estates and Facilities Alerts (EFAs) and medical devices and supply alerts (monitored via Health and Safety Group), Medicines and Healthcare products Regulatory Agency (MHRA) alerts (monitored via Drugs and Therapeutic Committee).

- The Trust received four new National Patient Safety Alerts (NatPSAs) in Qtr3.

Table 10: National Patient Safety Alerts received in Qtr3 2023/24

Date Issued	Reference	Alert Title	Status	Deadline
08/12/2023	**NatPSA/2023/016/DHSC**	Potential for inappropriate dosing of insulin when switching insulin degludec (Tresiba®) products	Alert closed	22/12/2023
Date Issued	**Reference**	**Alert Title**	**Status**	**Deadline**
07/12/2023	**NatPSA/2023/014/NHSPS**	Identified safety risks with the Euroking maternity information system	Alert with action lead to complete.	07/06/2024
28/11/2023	**NatPSA/2023/013/MHRA**	Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients	Alert with action lead to complete.	Closed

- During Qtr3 there was three new Safety Alerts.

Table 11: Safety Alerts received in Qtr3

Date Issued	Reference	Alert Title	Status	Deadline
14/12/2023	**CEM/CMO/2023/003**	Influenza season 2023/24: Use of antiviral medicines	Alert closed	N/A

24/11/2023	**DSI/2023/11**	Specific brands of carbomer eye gel: recall of AACARB eye gel, AACOMER eye gel and PUROPTICS eye gel: potential risk of infection	Alert closed	N/A
Date Issued	**Reference**	**Alert Title**	**Status**	**Deadline**
10/10/2023	**DSI/2023/010**	SteriFeed Colostrum Collection device and risk of choking due to infant airway occlusion	Alert closed	N/A

- At the end of Qtr3, four safety alerts remain open.

Table 12: Open Safety alerts at the end of Qtr3

Date Issued	Reference	Alert Title	Status	Deadline
07/12/2023	**NatPSA/2023/014/NHSPS**	Identified safety risks with the Euroking maternity information system	Alert with action lead to complete.	07/06/2024
28/11/2023	**NatPSA/2023/013/MHRA**	Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients	In progress. A working group is in place involving paediatrics, pharmacy, neurology, and the Associate Medical Director for patient Safety Related policies being updated Chief Pharmacist has met with ICB moving the alert forward at NCL level	31/01/2024
31/08/2023	**NatPSA/2023/010/MHRA**	Medical beds, trolleys, bed rails, bed grab handles and lateral	Anthony Rafferty leading on alert.	01/03/2024

		turning devices: risk of death from entrapment or falls		
Date Issued	**Reference**	**Alert Title**	**Status**	**Deadline**
29/01/2020	**EFA/2020/001**	Allergens Issues - Food Safety In The NHS	Action plan sent to E&F leads on 11/05/2023, however only 2 actions from the alert are complete, 4 ongoing (to be monitored via audits) and 2 actions unassigned. February 2024 F/U has been undertaken by the Associate Medical Director for Patient Safety: Due to unexpected change in catering manager. the action has been passed onto the new catering manager .	**12/02/2021**

- Nine safety alerts were closed in Qtr 3.

Table 13: Safety alerts closed in Qtr3

Reference	Alert Title	Date issued	Closed
NatPSA/2023/016/DHSC	Potential for inappropriate dosing of insulin when switching insulin degludec (Tresiba®) products	08/12/2023	21/12/2023
NatPSA/2023/01	Potential contamination of some carbomer-containing lubricating eye products with Burkholderia cenocepacia – measures to reduce patient risk	07/12/2023	15/12/2023

NatPSA/2023/012/DHSC	Shortage of verteporfin 15mg powder for solution for injection	28/09/2023	04/10/2023
NatPSA/2023/011/DHSC	Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and guanfacine prolonged-release tablets.	27/09/2023	17/10/2023
NatPSA/2023/008/DHSC	Shortage of GLP-1 receptor agonists	18/07/2023	16/10/2023
NatPSA/2023/007/MHRA	Potential risk of underdosing with calcium gluconate in severe hyperkalaemia	27/06/2023	28/11/2023

Reference	Alert Title	Date issued	Closed
CEM/CMO/2023/003	Influenza season 2023/24: Use of antiviral medicines	14/12/2023	14/12/2023
DSI/2023/11	Specific brands of carbomer eye gel: recall of AACARB eye gel, AACOMER eye gel and PUROPTICS eye gel: potential risk of infection	24/11/2023	24/11/2023
DSI/2023/010	SteriFeed Colostrum Collection device and risk of choking due to infant airway occlusion	10/10/2023	11/10/2023

2.8 Headlines from Patient Safety Group sub-groups

The following groups reported to the Patient Safety Group in November with key headlines from their reports highlighted below:

2.8.1 Deteriorating Patient/Resuscitation

- 262 reported ITU admissions for 2023/24, 65 met inclusion criteria and 27 have not met the metrics. There were 99 admissions from ED, only 11 met the criteria but 9 of these did not meet the metrics, due to lack of National Early Warning Score (NEWS) at triage.
- New Critical Care Outreach team (CCOT) metrics since March 2023 = NEWS 5-6 seen within 1 hour of abnormal observations & NEWS 7+ seen within 30min of abnormal observations. (Previously the target was to review patients within 1 hour of referral).
- Since CCOT have regularly fed back to the wards individually and raised awareness of new timeframes the team have seen a significant change from later referrals with higher NEWS to referrals with lower NEWS. Most CCOT referrals do not have raised NEWS (e.g. Oct total referrals of 121 with only 27 ward pts for escalation with high NEWS).
- There were no SI's related to delayed escalation or review in 2023/24. There is ongoing work to reduce all delays. All delays are fed back to the wards by CCOT link nurses. As a result of this CCOT are getting more engagement with all the educational opportunities that they offer.
- Patients with stage 3 Acute Kidney Injury (AKI) reliably referred by the lab and seen by CCOT immediately (consistently above 95%, May – October 100%, 100%, 95%, 100%, 96%, 95% respectively). On average 21 patients with AKI 3 for this period, 129 patients total and only 3 patients missed. Some of the patients missed are due to a protocol issue (lack of historic creatinine level data for comparison)
- May- Oct there were 1109 admissions to medical/surgical wards. Treatment Escalation Plan (TEP) on medical wards filled out (fully or partially) in 95% of patients, on surgical wards in 88% of patients. Ward-based ceiling of care (WBCOC) is present in 32% of medical patients and 8% of surgical patients. Do not attempt cardiopulmonary resuscitation (DNACPR) present in 426 out of 1109 patients (38%). The presence of fully or partially filled out TEP has improved, next step would be to audit quality of TEP (more challenging).

2.8.2 Nutrition Steering Group

- Identification of nutritional risk through screening is a CQC requirement. The Trusts compliance is monitored monthly through audit and the results remain erratic. Categories are:
    - Screening on admission (within 48 hours)
    - Screening weekly
- Nutritional Screening in the community – there is an annual MUST screening audit in nursing homes.

- Following discussion between clinical nutrition department and medical directorate and Electronic Prescribing and Medicines Administration (EPMA team), enteral feeds have now been removed as an option for doctors to prescribe on the Comprehensive Medication Management system (CMM). This should ensure increased safety for these patients and reduced clinical incidents.
- Members of the Nutrition Steering Group (NSG) have contributed to an educational, training session for ward staff, to support better understanding of nutrition in relation to textured diets and improve patient safety.
- Nutrition is now an option to categorise clinical incidents on DATIX, relating to feeding, referrals, and screening, with further detailed options under each of these areas. Once this has been disseminated to all areas, the nutrition team should be able to get improved oversight of all incidents that are connected to nutrition.
- There is a joint SLT/Dietetic Project ongoing with members from acute and community settings contributing, to investigate the thickening of nutritional supplements. It is important that the recommendations staff give patients fit with the International Dysphagia Diet Standardisation Initiative (IDDS)I criteria and evaluation process and that they are consistent across all settings.

2.8.3 Medical Devices Group

- Medical physics are piloting a system that can store medical devices training records centrally, the company that provide this system have recently created a platform which allows clinical staff access so they can see and update their records while also allowing managers and other appropriate staff to view and approve these records.
- The pilot system is already in use theatres and the pre-assessment clinic, which has taken their training percentage from around the 25% mark to above 80%. The PDNs in theatres can now clearly see who requires training and plan accordingly. The plan is now to begin the rollout of the system around the trust, starting in Surgery and Cancer ICSU.
- Devices should always be appropriately cleaned/decontaminated as to avoid risk of cross-contamination between patients. However, Cloudesley, Coyle, and Victoria wards are being reported with the highest numbers of devices not decontaminated correctly.
- An urgent review was requested regarding the devices not being cleaned/decontaminated correctly.
- Paediatrics are doing risk assessments for every admitted patient and putting it in their admission packs.

2.8.4 Blood Transfusion

- Contract now signed with HSL staff will be TUPE'd over to HSL from 1st April 2024. A new laboratory will be built on level 5.
- Laboratories had a UKAS inspection for 20th February to 29th February
- Re-audit of major haemorrhage blood collection, Aug 23, showed improvements 7/8 porters followed the protocol. Face to face porter training compliance is above 90%
- Trust wide BT e-learning compliance is 74%
- Audit of Blood Administration Procedures in Practice, Nov 23, showed 50% of staff follow the recommended standards for checking blood components. Independent and double

independent administration checks was presented to Back to the Floor in Dec to gage practice and raise awareness amongst senior staff and filter the message to all staff.

- Blood Policy updated Dec 23, to clarify independent administration procedures for one and two person checks.
- Reviewing the protocol for the release of Prothrombin complex concentrate (PCC) in ED to prevent delays as recommendation by Serious Hazards of Transfusion (SHOT)-CAS Alert, Jan 22.

2.8.5 VTE and Thrombosis

- VTE risk assessment (RA) consistency above 90%, however national requirements are for Trusts to achieve >95% compliance. Over the last year, we achieved >95% compliance in 9/12 months (75%).
- General medicine consistency >95%. Currently working with surgical (general surgery, spinal surgery and T&O) and maternity teams to improve compliance.
- E&T: training for HCA development programme, VTE training for trainee pharmacists completed. In process of arranging training for FY1/2.
- QI project with IT and pre-assessment to convert pre-op bridging plan from paper to an electronic proforma - VTE lead/thrombosis consultant on maternity leave. We currently have a locum for one day a week to provide support to the thrombosis service during maternity leave.

2.8.6 Point of Care Testing (POCT)

- Samba II module (point of care viral test) will have an upgrade to Samba III module Spring 2024 which will have shorter run time. ITU have the quadruplex kit which tests for RSV, COVID-19, FluA, and FluB. Results are recorded on Medway.
- COVID-19 testing in ED with the Abbott machine 'ID NOW' needs authorisation from medical staff.
- Eddington ward; 2 blood glucose meters installed

2. Clinical Audit and Effectiveness

2.1 Q3 2023/24 clinical audit and service evaluation project status.

- The table below shows the progress for 2023/24 as at completion of Q3:

Table 14; Project progress as at end Q3 23/24

*Project Category:	Complete	Completed - report outstanding / data submitted	On target	Not on Target	Not Participating	Not due to start	Total
Mandatory National Audits		9	50		1	1	**61**
National Audits		4	9	2			**15**
Local Audits	42	10	44	7		2	**105**
National Service Evaluations	1	2	5				**8**
Local Service Evaluations	15	2	9	4			**30**
Total	**58**	**27**	**117**	**13**	**1**	**3**	**219**

**All projects are quality and assurance checked upon registration. National data opt out status is verified for each national audit. Caldicott Guardian approval is organised as appropriate, to include completion of a Data Impact Assessment form where relevant for local audit and service evaluations).*

2.2 Mandated National Audit 2023-2024: KEY NOTES

2.2.1 National Audit on Dementia; Care in general hospitals – Round 6

The data for Round 6 has now been submitted. This was led by Dr Rebecca Sullivan and supported by, Clinical Audit & Effectiveness Officer, who undertook the data entry onto the national portal.

It was acknowledged that due to the late publication of the previous round, there was no opportunity for quality improvement initiatives to be commenced in response to Round 5 results prior to Round 6 data collection occurring.

2.2.2 National Diabetes Inpatient Safety Audit (Harms)

The primary objective of this national audit is to record the details of any adult inpatient experiencing one of the following four avoidable diabetic complications:

- Hypoglycaemic Rescue
- Diabetic Keto Acidosis (DKA)
- Hyperglycaemic Hyperosmolar State (HHS)
- Diabetic foot ulcer

In Q3, the Clinical Audit & Effectiveness Officer provided support to ensure completion of this mandated national audit with clinical leadership provided by the Diabetes Nurse Consultant, there was no consultant leadership assigned to the project.

A single harm was identified for the entirety of the audit period.

Moving forward, the diabetes nurse lead will undertake a monthly review of the data and update the system accordingly. A clinical lead is still to be identified to work with the diabetic nurse, and this has been raised with the consultant group.

2.2.3 National Early Inflammatory Arthritis Audit (NEIAA) Outlier Notification

On 25 September 2023, the Trust received notification of 'Alarm level' outlier status confirmed for: **NICE quality standard 33** (2013 version, stating that patients referred with suspected persistent synovitis should be seen within three weeks of referral).

The CQC also wrote to the Trust expressing their concerns.

In Q2, the CEO, Executive Medical Director, and relevant clinical and operational leads were immediately informed upon outlier status notification. The Trust complied with the 10 working days permitted to identify any data inaccuracies, of which there were none.

For Q3, action planning is being led by the Clinical lead for Rheumatology Director of Operations, EIM/ Deputy Chief Operating Officer.

Current status and action planning: Currently, there is 1 clinic per week which is protected and dedicated to these patients. This requires three-fold expansion with additional follow-up slots required.

Plan: Business case to recruit more consultants, Clinical Nurse Specialists (CNSs), pharmacist, advanced practitioner with USS skills and admin support is in review.

Actions: In the interim, a locum consultant is being funded.

A senior registrar has also joined the Trust for a few months to work in the outpatient clinics and a second CNS has commenced in post.

2.2.4 IBD Registry Closure

Notification has been received from the IBD Registry that they are closing on the 31 March 2024 and data will no longer be submitted to the Improving Quality in Crohn's and Colitis national audit.

2.2.5 Mandated National Audit Demand & Capacity

The problems associated with the above examples of the Dementia and Diabetes Audits are noted in other areas, with the ability to meet the Mandated National Audit work demand being impacted by reduced staff capacity to undertake and support mandated audit work.

Additionally, there are large volumes of data entry and associated administration involved with NCEPOD studies impacting on staffing capacity (see section 2.6 for further details of NCEPOD studies).

2.2 Q3 national audit report publications

Table 15 national audit publications

Quarter	Published	Responses received to date	Comments
3	14	4	9 responses overdue and being chased. 1 response due February.

Q3 National Clinical Audit Report publication: Examples with overall assurance rating and proposed actions

- **NNAP (National Neonatal Audit Programme): Your Baby's Care - Summary Report on 2022 data**

The overall assurance from this report is Green/Amber.

Green Assurance: For 10 of the 12 NNAP measures included in the 2022 results, the Whittington performed at a higher standard than the national average, and for some of the measures the performance was considerably better.

Amber Assurance: For 2 of the 12 measures, the Whittington's Neonatal Unit performed at a lower standard than the national average. These included:

- Deferred cord clamping (although no longer a negative outlier, with results showing significant improvement from previous years)
- Temperature on admission (slightly below national average although improving in 2023 NNAP data year to September)

Both amber measures are undergoing Quality Improvement work. For deferred cord clamping, a Concord resuscitation trolley to enable resuscitation with cord intact has been purchased, and a request has been submitted for inclusion on the CYP risk register.

- **National Pregnancy in Diabetes (NPID) Audit 2021 and 2022**

During 2021 and 2022 nationIslinally there were 10,055 pregnancies recorded for women with type 1 diabetes and type 2 diabetes. Most women with diabetes have a healthy baby, but having diabetes means that both mother and baby are more at risk of serious health complications during pregnancy and childbirth.

Green Assurance was given following the review of Whittington Health data as below:

NPID Whittington Summary (2020-2022)			
Criteria	**WH Result**	**London Average**	**National Average**
Pre-existing T1 Diabetes	25 patients	720 patients	6, 585 patients
Pre-existing T2	35 patients	1,865 patients	8140 patients
Average age T1 at delivery	34 years	32 years	30 years
Average age T2 at delivery	35 years	35 years	35 years
1st trimester patients HbA1c <48 mmol/mol	46%	35%	31%
Patients on FA 5mg pre-pregnancy	42%	28%	31%
Women were seen at <10/40 gestation	83%	67%	68%
Women were well-prepared for pregnancy	18%	14%	13%
Women who had 3rd trimester HbA1c <43 mmol/mol	55%	52%	43%
Women who had LGA baby	27%	27%	36%
Women who had preterm delivery	27%	29%	32%

2.4 Q3 Local audit: Examples of good practice/ identified actions

- **Central Venous Catheter Audit in Critical Care**

Bloodstream infections associated with central venous catheter (CVC) insertion are a major cause of morbidity, associated with a longer stay in Critical Care and significant cost burden. A 2006 study showed that 42% of blood stream infections are CVC-related. The aim of this audit was to establish the level of compliance with the Department of Health (DoH) guidelines.

Results:

The audit demonstrated a good level of compliance with the following:

- 100% compliance with HMGG, hand hygiene, skin preparation and drapes
- 93% use of Ultrasound
- 91% correct tegaderm dressing applied
- 86% connection to bioconnectors
- Good confirmation of line insertion using multiple methods

An area for improvement was identified that there is little representation of subclavian lines, indicating a need for training, with potential for change in culture regarding use of subclavian lines.

Actions to be taken:

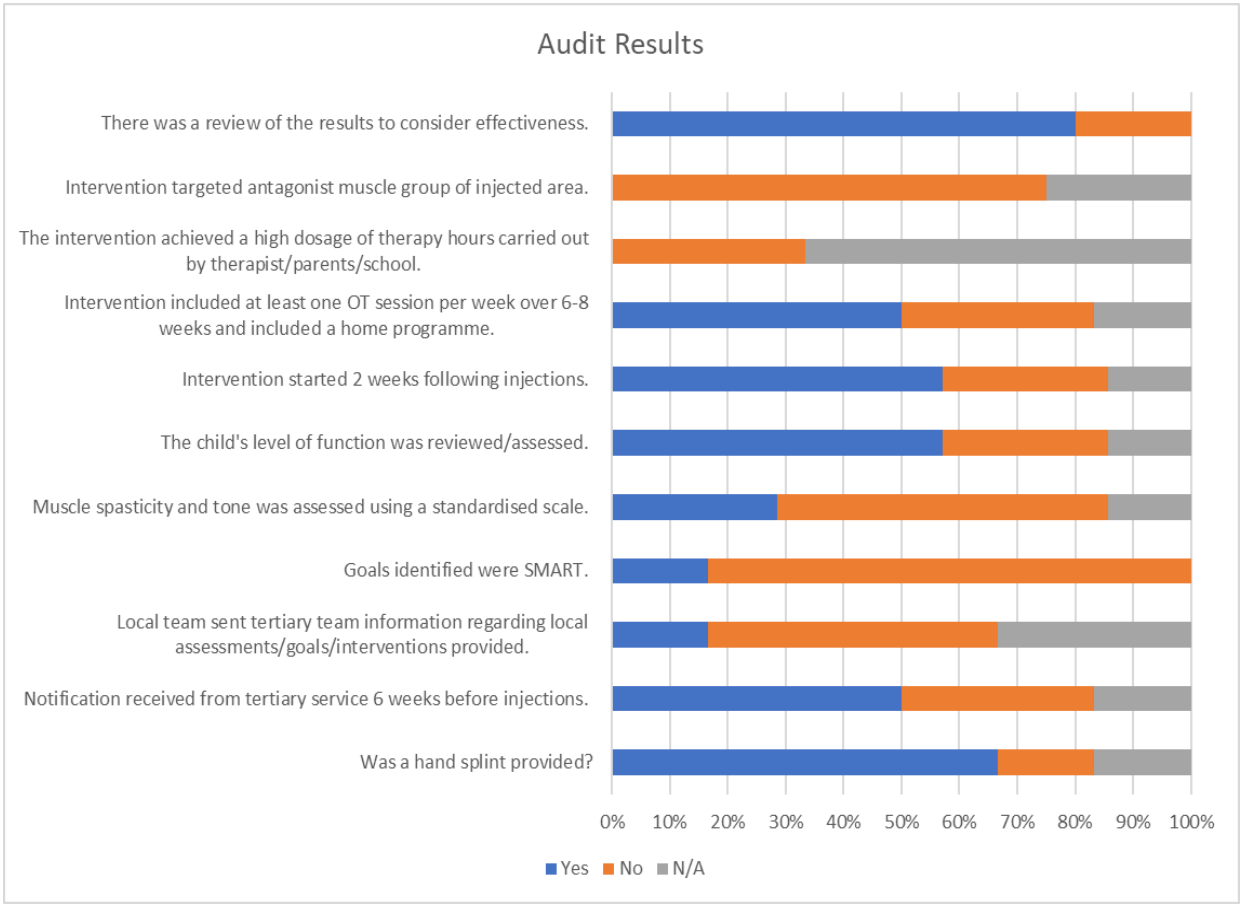
- Continued use of Local Safety Standards for Invasive procedures (LocSSIPs) for documentation of line insertions
- Continued adherence to CVC insertion guidelines: Hand hygiene, maximal barrier precautions, chlorhexidine 2% antisepsis, optimal catheter site insertion, daily review of catheter and prompt removal of unnecessary lines
- Support F1/F2s on Critical Care to gain experience with line insertions.

- **Upper Limb Botulinum Toxin Operational Procedures in Islington Services for Children with Additional Needs**

Children with cerebral palsy under the Islington Additional Needs and Disability Service (IANDS) Occupational Therapy service may receive Botulinum Toxin A injections as part of management of their high muscle tone and spasticity in upper limbs. This toxin allows for a window of opportunity with reduced spasticity to work on functional goals and/or comfort. The Upper Limb Rehabilitation Network published Clinical Guidelines in 2019 to guide procedures in line with evidence.

This audit evaluated whether pathways are in line with the guidelines and best available evidence.

Fig 13: Upper Limb Botulinum Toxin Operational Procedures in Islington audit results



The results demonstrated several areas for improvement for the pathway, including:

- SMART goal setting for children to support their therapy input.
- Communication and information sharing between tertiary and local services

- Dosage tracking to ensure alignment with the evidence

Action Plan:

Recommendations	Actions Taken	Progress
All children to have an annual upper limb assessment which includes identification of clear upper limb goals documented on Rio. Annual upper limb report.	Upper limb clinics to be started with 2 therapists in each one, to complete upper limb ranges, functional review, review of splints and goal setting. New report template to be piloted to summarise key information.	Pilot Completed by Dec 2023
Meet with GOSH OT to improve communication sharing from both sides.	GOSH OT to present at OT study afternoon. OT to stay in touch regularly by email.	Completed
Improved access to specialist hand splinting.	IANDS to commission specialist OT to support splinting on bank.	Ongoing

2.5 Clinical Audit Training and shared learning

Clinical audit reporting to the ICSUs continues on a rolling programme. This provides an important mechanism to capture care quality across the organisation. Learning from clinical audit has continued during Q3, to include the multidisciplinary audit and effectiveness afternoons, clinical audit workshops and bespoke training of staff as requested.

In Q3, 2 joint Clinical Audit and QI training sessions were undertaken by the QI lead and Clinical Audit & Effectiveness Officer, one session presented to the Obstetrics & Gynaecology Clinical Audit & Effectiveness afternoon, and another held virtually on Teams over lunchtime and advertised via the staff e-newsletter. The training sought to support staff in understanding the relationship between Clinical Audit & QI and provide the opportunity to answer any queries about undertaking both project types. The sessions were well received, with the following feedback:

"The presentation was great and super helpful… I would definitely like to include something similar for... when we have new starting juniors so they can get all the tips in early! Many thanks again!"

The Clinical Audit workshops have been scheduled for 2024, offering a combination of both virtual and in-person sessions.

2.6 National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

The following 8 NCEPOD studies are 'live':

Study	Status
Transition from child to adult health services: to explore the barriers and facilitators in the process of the transition of young people with complex chronic conditions from child to adult health services.	Report published. Disseminated with table of key recommendations. Response outstanding.
Crohn's disease: to review of remediable factors in the quality of care provided to patients aged 16 and over	Case submission complete, the organisational and clinical questionnaire

with a diagnosis of Crohn's disease who underwent a surgical procedure. This is the first NCEPOD study to proactively investigate the effect of COVID-19 on the service.	returned. Report published, appropriately disseminated, and awaiting response.
Community acquired pneumonia: to identify and explore avoidable and modifiable factors in the care of adults presenting to hospital with a presumed diagnosis of community acquired pneumonia.	Case submission complete. Report published December 2023. Disseminated with table of key recommendations. Response in progress.
Testicular Torsion: To review the complete pathway and quality of care provided to children and young people 2 – 24 years of age who present to hospital with testicular torsion.	Case submission complete. Organisational questionnaire completed and submitted. Local Trust guideline reviewed and updated.
Endometriosis: To review remediable factors in the quality of care provided to patients aged 18 and over with a diagnosis of endometriosis between the 1st February 2018 - 31st July 2020.	Case submission completed. Organisational questionnaire completed in advance of deadline.
Juvenile Idiopathic Arthritis: To review the quality of care in children and young adults (0-24 years) with Juvenile Idiopathic Arthritis (JIA).	Patient spreadsheet population complete. Case submission completed.
End of Life Care: To identify and explore areas for improvement in the end-of-life care of patients aged 18 and over with advanced illness, focusing on the last six months of life.	Patient spreadsheet population complete. Cases have now been identified and disseminated to the clinicians for data entry.
Rehabilitation following critical illness: This study will evaluate the rehabilitation provided to critically ill adults within intensive care units, as well as throughout the recovery pathway to encompass both ward based and community care.	Patient spreadsheet populated and returned.

Further to the above 'live' studies, the following study is in the design phase for launch later this year:

- Blood sodium

Three further new studies have been chosen for next year:

- Acute lower limb ischaemia
- Acute illness in people with a learning disability*
- Emergency surgery in children

* The Trust has also registered for the NHS England Learning Disability Improvement Standards Benchmarking project for NHS Trusts - Year 6, and this should both align with, and inform our returns for the later NCEPOD study.

2.7 Intensive Care, National Audit and Research Centre (ICNARC): Quarterly Quality Report for Whittington Hospital, Critical Care Unit (April – June 2023)

The above titled report was published on 5 November and results demonstrate outstanding practice, including the Critical Care Unit being 3 standard deviations outside the norm for risk-adjusted acute hospital mortality. This is a true marker of excellence.

2.8 Quality Account (QA):

Q3 updates on the QA Priorities are reported below 1. 5 Priorities are reported as achieved, 3 partially achieved and 3 at risk of not being achieved.

Priority & Stream		Targets	RAG rating	Q3 Update
Reducing harm from hospital acquired de-conditioning	Pressure Care	To ensure 100% of patients have documentation of a full pressure ulcer risk assessment within 6 hours of admission, and an action plan (including all required pressure relieving equipment required) to manage risks identified in place within 24 hours of admission.		Updated nursing documentation, including Pressure Care Assessment was presented to the Nursing Leadership Group in November for approval. Electronic documentation template for Pressure Ulcer Plan has been drafted. Progression with implementation of documentation and care plans has been impacted by new NHSE guidance released in November that will change the current Pressure Ulcer management and documentation, with changes affecting categorisation, reporting, pressure ulcer assessment. Based on data from Q1-3 the Trust will not achieve it's 23-24 target of reducing full thickness pressure damage or overall by 20%. Overall, a downward trajectory is noted for Trust acquired pressure damage across the year to date. 2 hospital wards achieved 129- & 140-days pressure ulcer free. World "Stop the Pressure" Day was held in November, with events including hosting a stand in the Atrium to raise awareness, making pledges to make every contact, and free educational webinars were available. A Stop the Pressure Conference was held, with topics including: Assessing skin (including in dark skin tones), Learning Disability and Mental Capacity, Nutrition, Podiatry, OT and Physio. The conference finished with a Patient Story about their experiences of Pressure Ulcers and the impact it has on their life. Talks were given by a range of MDT members and the conference was fully booked by a range of clinical frontline staff.

	Discharge & Reducing Admissions	To manage 4 patients per month (2 from Islington borough, 2 from Haringey borough) via the delirium discharge pathway. To reduce medically optimised patients that are unable to be discharged by 50% daily. To implement pathway for 'Trial without Catheter' (TWOC) at home, reducing the length of stay by at least one day. To utilise up to 28 Virtual Ward beds daily, including 8 technology enabled virtual ward patients and those on the delirium pathway. For Urgent Response and Recovery Care Group to ensure patients are seen within the national guidance of 2 to 24 hours for >80% of referrals		Slow progress with the TWOC project. Q2 report indicated Islington are achieving target of 2, whereas Haringey have encountered delays. Meeting with the Associate Director for Quality Governance (ADQG), the adult community ADON and Lead District Nurse for Professional Development and Quality Improvement to progress this project. A lead doctor has been identified to promote community discharge for patients requiring TWOC within the criteria. Work will be carried out with the Virtual Ward team and promotional sessions via the CEO briefing and Back to the Floor sessions. Additional goals highlighted at the Clinical Effectiveness Group (6th February) to ACS senior representatives, with planned further discussion to determine goal progression prior to end of year.
	Nutrition	For patients with Dementia & Learning Disability (LD) who are admitted to hospital to have eating and drinking preferences and information about support required available within 24 hours of their admission. This requires 100% of this cohort to have accurate and up-to-date next of kin and emergency contacts who will be able to supply this information, and for them to be contacted in regard to the individual's care needs within 24 hours of admission.		LD: In Q3, there were 121 EPR Alerts for those with LD attending ED or admitted to hospital. These Alerts are reviewed daily (Mon-Fri) by LD CNS and accepted as referrals. The LD CNS provides support in the ED environment, which includes ensuring that hospital passports are available, and awareness is raised to staff to ensure this is referred to. Hospital Passports include specific eating, drinking and assistance levels required. It also includes information about people important to the individual, including NOK and emergency contacts. Dementia: A retrospective Q2 audit of 25 patients diagnosed with Dementia was conducted. 24/25 had recorded NOK contact details, with 1/25 having no known NOK contact details (NOK details updated after social worker allocated and identified as key contact). Contact with NOK within 24 hours of admission was achieved for 64% of patients, with an overall average of contact with NOK within 0.63 days of admission. No contact was recorded for 2 patients. Of those contacted, longest time between admission and documented contact was 5 days. Reference to eating/drinking/assistance was recorded in 100% of notes, however lack of detail often noted (e.g., "eating and drinking" without further detail). Specific dietary advice was recorded for 7 patients (covering diet/fluid texture, diabetic and cultural diet preference), and 6 were highlighted to require some level of assistance with feeding. Further detailed advice and reference to preferred foods was provided following specialist input (SLT, Dietetic, Dementia CNS) for 14 patients during their admission.

Improving Access and Attendance for Appointments	**Zesty**	For 60% of outpatients to be using Zesty by end of March 2024. For DNA rates reduced in line with booking amendments functionality being introduced by end of March 2024		94,951 invitations for Zesty have been sent from Q1 to Q3 to 70,467 unique patients, with 30,059 registrations completed. Patient engagement for Q1-3 is between 30-34%, with adoption between 41-44%. Definitions & Calculations: Invitations: Refers to the total number of invitations sent to patients (See N.B below for more info) Registrations: The aggregate number of registrations, encompassing both invited and uninvited patients who have registered to the portal. Unique Patients: The number of unique patients who have been sent an invitation. Engagement Rate: A percentage reflecting the effectiveness of invitations in generating registrations, calculated by dividing the total number of registrations by the total number of invitations sent. Patient Adoption Rate: The number of patients who have registered against the number of patients invited, calculated by dividing the total number of registered patients by the total number of unique Patients Uninvited Registrations: The total registrations from patients who did not receive an invitation. Invited Registrations: The total registrations from patients who received an invitation.
	Transport	For patients to be able to complete single eligibility criteria for multiple transport requests by end of March 2024. For clear communication and guidelines on how to access Transport to be developed in conjunction with the transport provider, demonstrating an impact of reducing the number of patient complaints relating to Transport being received by March 2024.		Transport working group established with service provider -Requirement to submit eligibility criteria for each journey reduced to monthly, where there are recurring transport requirements. This has reduced the number of complaints from patients and carers

	Letters	For outpatient letters to be reviewed and updated to ensure location correctly matches hospital signage.		All locations in the hospital referred to in appointment letters (48 locations) have been reviewed and a new map has been produced for hospital wayfinders to ensure locations match. One location was identified as no longer in use, and IT are working with the relevant service to remove this clinic location. Feedback from wayfinders, who frequently support visitors that are unable to find locations, is that often visitors miss signs due to them being overhead rather than in the line of sight. Further Quality work will continue to look at letter processes on a wider scale, with IT undertaking process mapping and Operational teams reviewing the administration process for contact with patient about appointments.
	Woodgreen CDC	To improve uptake and attendance of Wood Green CDC walk-in and booked appointments through offering a range of patient information (in different languages and different formats such as easy read, Braille, electronic and written formats) and by improving wayfinding to the CDC within the Mall, by end of March 2024. To improve accessibility of booking appointments by introducing an electronic self-booking system for Wood Green CDC services by end of March 2024. Success will be measured via improvements in patient surveys, uptake of electronic app & booking rates of appointments.		The new lower ground floor of Wood Green CDC work was completed on 24th November, with MRI and CT diagnostic testing. Since opening, 55,000 local people have been tested at the CDC since it's opening in August 2022. A recent patient story, celebrating the opening of the new floor, highlighted the ease of finding the CDC with signs visible on entering the shopping centre directing him to the lower ground floor and said “It was very easy to get here and I was seen straight away. I would 100% come back to the CDC in the future if I needed to. I would tell others that they should come here too straight away, there were no problems”. Through community engagement and assertive outreach, the CDC was supported to achieve its ambition of increasing diagnostic access for traditionally underserved communities. Over 72% of activity at Wood Green CDC comes from the 30% most deprived areas of north central London. SwiftQ has been introduced during Q3, with 60% of patients able to book appointments online and 84% of patients able to book appointments less than 2 weeks away.

	Accessible information for LD	Accessible information for those with Learning Disabilities (in the form of leaflets and videos) is currently in development for the following areas: Outpatients (generic); Outpatient check in stations; Going to Emergency Department; Going to Theatres; Having an operation; Having an anaesthetic; Going Home from Hospital; Compliments and Complaints; Appointment letters. By the end of March 2024, this accessible information will be fully implemented, and accessible information will be further rolled out to other areas & topics required. Success will be measured via audits of how many information leaflets have been distributed, how often videos have been used, as well as reviewing patient experience feedback to determine the impact on their care and treatment.		Communications are currently working with LD team on developing new Learning Disability website pages, to increase accessibility of information (leaflets and videos) previously created. The Patient Information Group is now implemented, with representation from LD CNS, to ensure accessible information is considered. A new readability checklist has been introduced as part of the review and approval process for patient information leaflets.

Reducing health inequalities in our local population	**Sickle Cell**	Deliver training to 60% of ED staff to educate on the condition, ensuring unconscious bias does not exist in the treatment of patients with sickle cell anaemia by end of March 2024. Ensure 80% of sickle cell patients receive 1st dose of pain relief within 30mins of attendance to ED by end of March 2024.		During December the Sickle Cell lead Nurse alongside a patient shared her experience at Back to the Floor. The questions focussed on: • What is the NICE-recommended time between ED admission and first injection for treatment of sickle cell crisis? • How would you recognise and treat pain in a sickle cell patient compared to non-sickle patients with pain? • What are the 3 most important elements that ensure a good patient journey outcome for a patient with sickle cell? The session was well received, the group discussed opportunities to improve the sickle cell pathway for patients when attending ED and raise awareness of the NHS England's Sickle Cell card. A ward location has been identified for 8 Haematology beds, which is planned to open during Q4. Plans are in place to ensure staff receive appropriate training and competency to work in this area. The data collection tool remains under review, as information continues to be recorded on paper as well as electronically, creating duplication of data. Q3 data demonstrates that between 58.97% - 76.81% of eligible patients received their first dose of analgesia within the 30-minute target. The Sickle Cell Matron reported that subjectively she has noticed a slight improvement in time to analgesia being reported by service users.

	Learning Disabilities & Autism	To develop and implement training packages by end of March 2024 for all clinical staff about: 1. Treating and supporting those with Learning Disabilities 2. Treating and supporting those with Autism Success in the project will be measured by implementation of package, uptake of training and reviewing patient experience within these populations to determine whether the training delivered shows a positive impact on experience and care. To improve patient experience by offering 100% of patients with Learning Disabilities access to care bags (including items aimed to improve this patient cohort's comfort within this environment) when attending ED by August 2023.		Oliver McGowan training is in the process of being implemented, with roll out to commence at the start of Q4, with Elev8 virtual training to be rolled out in phase 1 (mandatory for all staff), with further roll out of face to face sessions to be delivered for clinical staff. Following the success of the LD Care Bags in ED, resources have been ordered to support those with Dementia who attend ED.
	Prostate Cancer	To expand on the previous success of Prostate cancer events, we will hold up to 6 specific cancer events by the end of March 2024.		Target of 6 sessions achieved in previous quarters.

2.9 Quality Improvement Programme, Q3

33 new QI Projects (QIPs) were registered in Q3, with representation from all 5 ICSUs. This included 3 QIPs that are being conducted across multiple ICSUs.

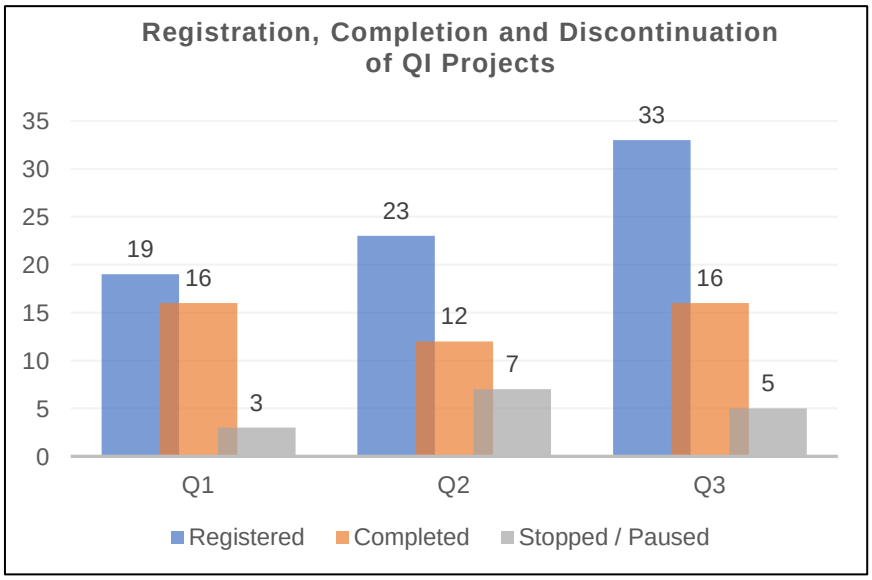
In Q3, 16 QIPs were completed, and 5 were stopped or paused.

Reasons for stopped projects include:

- Project workers not responding to multiple requests for updates
- Project workers leaving the Trust without uptake from new staff
- Project discontinued in favour of more holistic approach to care, involving wider MDT in new project
- Issues with app preventing project progression

When projects are stopped or paused, the information is retained on the Register, under Stopped/Paused heading, so they can be re-activated in future as indicated.

Fig 14: QI project status Q1-Q3



2.9.1 Quality Improvement Project Results & Achievements

Results for completed project in Q3 include:

- ***QR codes for educational and training resources:*** This project, undertaken by Paediatrics Allergy team, demonstrated a positive response, with 95% reporting an improved experience of accessing resources. Project recognised the need to continue with a multi-modal approach to resources to prevent digital exclusion.

- ***Paediatric Naso Gastric Tube (NGT) project:*** The Children's Community project was carried out, with 100% of eligible parents learning how to pass their child's nasogastric tube safely at home, increasing their competence and confidence,

resulting in saving travel and nursing costs and preventing unnecessary hospital admissions in order to re-pass NGT.

- ***Improving medical handover:*** Medics developed a new handover format implemented for weekends, mornings & evenings, with data demonstrating an improvement in handover and satisfaction of junior doctors.

- ***Improving awareness of Peri-natal mental health services available:*** The project resulted in increased engagement with training and increased knowledge of services available.

- ***Improving the investigation and management of patients with suspected Cauda Equina Syndrome (CES) who present to the Whittington ED:*** The project resulted in reduced waiting time for MRI from 3h19mins to 1hr7 mins. Baseline measures identified 3 CES features that were not regularly documented all of these features were explicitly outlined in new MEDL guideline.

- ***Improve VTE compliance in the Paediatric inpatient ward:*** Introduction of VTE mandatory fields in Paediatric clerking note increased VTE recording from 62% to 95-100%.

- ***Documentation of Assault in ED:*** Achieved documentation targets for both submission volume (1.25% of total presentations) and Geolocation (94.7%). Geolocation reporting percentage is best in London according to GLA.

- ***MDT Complex Care Clinic Improvements:*** The Haringey Community Paediatric project sought to improve shared decision making, increase person-centred care and support and improve access to information and understanding of diagnosis and conditions. Following an initial feedback questionnaire completed by parents, they reviewed their booking process, increased MDT presence, designed new information leaflets and report format. As a result of these changes, they noted increased use of joint appointments, increased MDT representation and clinics becoming more patient centred. They plan to continue to embed these changes and re-evaluate to determine whether further improvements can be made.

- ***Autism and anxiety group:*** In order to reduce Islington CAMHS waiting list, a new group was introduced to offer Cognitive Behavioural Therapy (CBT) anxiety intervention for young people with autism. Many groups that are run in CAMHS come with an exclusion criteria which often excludes neurodiversity. The group aimed to reduce this health inequality, supporting this population with their anxiety as well as allowing them to meet other young people with autism and have a shared experience. Pilot sessions demonstrated 60% attendance and a reduction in anxiety scoring. The young people reported really appreciating the space to meet others like them alongside supporting management of their anxiety.

In addition to the QI Results listed above, 2 Whittington QI Projects have been invited to present their Posters at the International Forum on Quality & Safety in Healthcare, held in London in April:

- Leading Change and Improvement in Antenatal Education at Whittington Health (Dacil Hernandez-Gomez)
- District Nursing Service moving from paper to electronic record keeping (Rhea Edes Martins)

2.9.2 QI Training & Support

- QI Enabled workshops were delivered in Q3 to an audience of 27 staff for a total of 9 hours, with additional joint sessions with Clinical Effectiveness as outlined in section 2.5 above.
- Due to reduced QI capacity (cover currently at 0.6 WTE rather than 1.0 WTE), there are currently no QI enabled training sessions planned for Q4. To mitigate this, the QI intranet pages have been updated, signposting people to NHS Elect webinars and modules relevant to QI that are available through the Trust's NHS Elect contract. QI will continue to be taught on the Preceptorship courses.
- QI support sessions continue to be offered on an ad-hoc basis, with 39 sessions attended during Q3. The sessions offer staff the opportunity to discuss QI projects at any stage, providing advice on methodology, data analysis and interpretation, write-up for internal and external presentation.

2.10 Sub-Committee updates

2.10.1 Clinical Guidelines, Q3

- **COVID-19 Guidelines**: remain quality assured and categorised as 'current', 'archived' and 'obsolete'. The Hub remains 'Live' and receptive to new requirements in the event of emergence of a new variant or increases in case presentation.

2.10.2 Clinical guideline speciality reviews complete, Q3:

The following guidelines have been reviewed with no or minor change:

- Bacterial meningitis and Septicaemia in Children
- Cardiac Tamponade: Emergency Management
- Seizures in children – Guideline for use in Emergency Department
- Oxygen Therapy and saturation monitoring in NICU
- Neonatal hypothermia - Prevention
- Diabetic Ketoacidosis (DKA) in Adults

2.10.3 Drug & Therapeutics Committee guideline ratifications, Q3:

- Pollinex® _ Clinical Guideline for administration of Pollinex® Grass & Tree Subcutaneous Immunotherapy in children >6 years
- Supply and administration for NRT for inpatients by Tobacco Dependency Specialists

- Subcutaneous Immunotherapy for Paediatric Allergy Clinic
- Talc For Pleurodesis In Adult Patients - Guideline for use

2.10.4 Clinical Guidelines Committee reviews, Q3:

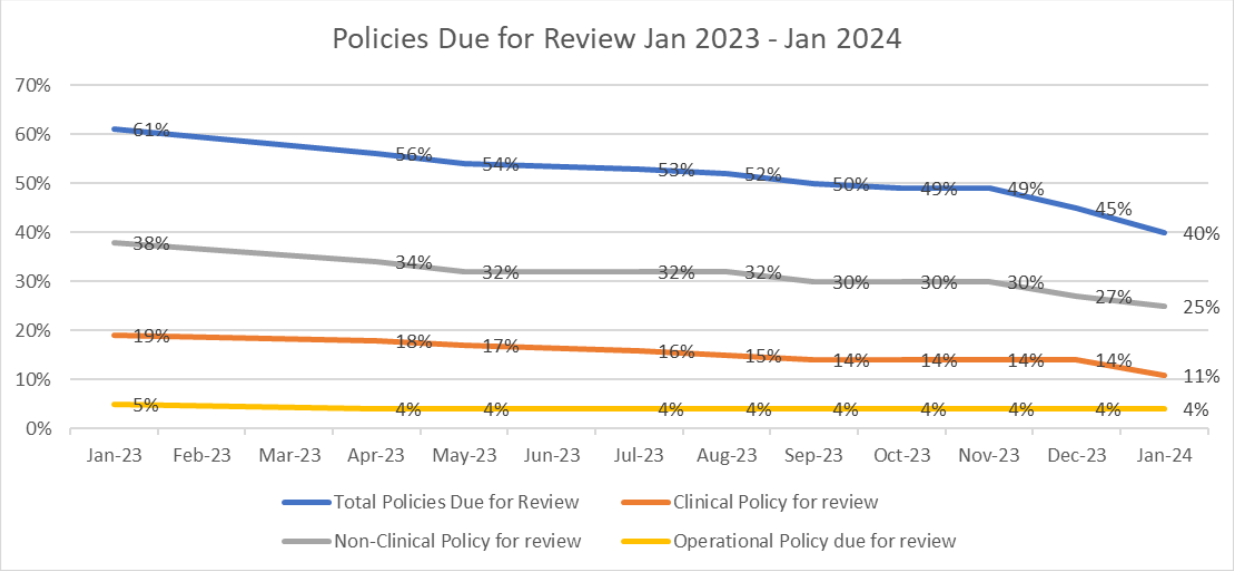
- MEDL: Bradycardia
- MEDL: Decompensated liver disease
- MEDL: Lumbar puncture
- MEDL: Hypercalcaemia
- MEDL: Last Days of Life
- MEDL: Acute Coronary Syndrome
- MEDL: Disclaimer

2.10.5 Policies, Q3

There are currently 280 online documents. 358 documents have been taken offline.

Of the 280 online documents the following chart shows the volume of Policies due for review by category.

Fig 15 Policies due for Review by category



Overall, policies requiring review have reduced from 61% in January 2023 to 40% (N=113) in January 2024, with a reduction in the number of Clinical policies from 19% in January 2023 to 11% (N=32) in January 24, non-clinical polices from 38% to 25% (N=69) over the same period.

While recognising the improvement in the number of overdue policies being reviewed, it is recognised that further work still needs to be done to ensure all policies are reviewed and updated in a timely way.

Actions taken in 23/24:

- Monthly reminder sent to ICSUs and Corporate areas with list of overdue policies.
- Discussion held with ICSU and Corporate senior staff, that if there is no new guidance or changes to procedures, the review can be completed quickly as information in the policy will not have changed.
- Top 3 urgent documents highlighted to ICSU's to update in response to feedback that the full list was too much, and a concentrated approach would be more useful
- Corporate teams have been prompted by the corporate secretary to update overdue policies.
- Employment of additional staff member in the Quality Governance Team to assist with formatting policy documents, sending reminders and meeting with authors to encourage policy reviews.
- The IT team have reconstructed the intranet pages in order to align policies with service pages as well as at ICSU level.
- The Policy Advisory Group chaired by the Deputy Chief Nurse.

2.11 List of NICE publications, Q3

During Q3, a total of 65 guidelines have been published with 16 necessitating a formal response. This demonstrates a notable increase on Q2 and follows the expected trajectory of publications following a decrease during the summer months.

Q3 2023/24	October	November	December	Total
NICE Guidance	9	4	3	**16**
COVID Guidance		1		**1**
Highly Specialised Technology Guidance			1	**1**
Diagnostic Guidance				
Interventional Procedure Guidance	2	4	1	**7**
Medical technology guidance				
Technology Appraisal Guidance	14	8	9	**31**
Health Technology Evaluation	2	1	2	**5**
Quality Standard	1		2	**3**
Evidence Summary				
MIB - Medtech innovation briefing		1		1
Total	**28**	**19**	**18**	**65**

(Reporting status: NICE clinical guidelines are mandated for a formal response. HTAs mandatory for formulary addition if service applicable).

3 Quality Assurance

3.1 External Quality Reviews

- There was a Paediatric Hearing Services Review conducted in Q3. A national audit and improvement programme has been established by NHS England to support providers and ICBs to improve the quality of paediatric audiology services.
- From a preliminary report for Whittington Audiology Paediatric services, received a score rating of 72%

Strengths:

- Equipment is appropriately calibrated.
- Robust Incident reporting and risk management
- Participation in Audiology Brainstem Response (ABR) external peer review
- Clinical staff are registered.

Areas for improvement:

- Review of clinic room set up for Visual reinforcement audiometry (VRA) to ensure compliant with British Society of Audiology (BSA) recommendations.
- Document control e.g., version numbers, approved/review dates, owners and standardisation across services.
- Further development and standardisation of some existing documentation e.g., deviation from BSA procedures, urgent referral guidance
- Robust audit/QA plan required to give assurance for the whole pathway.
- Completion of self-assessment against British Academy of Audiology (BAA) Quality Standards

3.2 CQC

3.2.1 CQC action plans

CQC action plan 2019/2020

- 34 actions now closed, with ongoing monitoring via ICSU Quality meetings and via walk rounds to ensure quality standards are maintained.

CQC action plan Maternity 2023

- There were 21 actions from the 2023 Maternity CQC inspection identified. Of these 20 are now closed with regular monitoring by Maternity. The remaining action for completion relates to restructure of the Maternity workforce and triage cover. The aim is for this action to be closed by the end of April 2024.

Simmons House MHA monitoring action plan 2023

- There were 5 actions identified from the mental health act monitoring action plan from the CQC visit in March of 2023. Of these actions 2 remain in progress due to audits that need to be monitored for a period of six months (Rights of young people documented and empowerment and involvement of young person evidenced in care plans) . The remaining two actions are due to be completed by the end of April 2024.

3.2.2 CQC Engagement Meetings Q3

- There were a number of CQC engagement meetings in Q3. These were in relation to incidents at the Simmons house adolescent unit. The unit is currently closed to admissions and the patients that remained in the unit were transferred to other care providers on the 22nd December. The CQC is currently considering the concerns around ligature risks due to the death of a young person in the unit.

3.2.3 CQC Readiness

- An external contractor has been brought in to assist with CQC preparedness, to support with the peer review program and evidence gathering ahead of a potential CQC visit.
- A schedule of 'Quality visits' has been developed for 2023/2024. ICSU's have been asked to identify their areas of concern and these areas will be the initial focus for review, however all trust and community areas will be visited in due course.
- The CQC prep meetings (Formerly Better Never Stops) have been refreshed and occur monthly to enable the focus on CQC preparedness.
- An evidence base is being developed to ensure that any required evidence from previous inspections is kept centrally and is easy to locate should a CQC inspection occur.
- The CQC are developing a new regulatory model based on a single assessment framework, implementation began in November and is expected to be completed in Q4.

3.3 Quality Reviews Q3

Quality visits are an opportunity for staff, both in the area being visited and those in the review team, to learn more about CQC inspections and the lines of enquiry used. They are intended to be informative and supportive and help prepare ahead of a CQC inspection.

In Q3 8 quality visits were conducted in the following areas:

- Victoria Ward

- Paediatric Emergency Department
- Ifor Ward
- Simmons House adolescent unit
- District Nursing (Lordship Lane Health Centre)
- Leg Ulcer Team (Lordship Lane Health Centre)
- CAMHS and Paediatric Services (The Northern Health Centre)
- Critical Care Unit

The findings from the quality visits have been fed back to the areas in a report form for action. They have also been compiled into an overarching action plan which will be monitored at the CQC prep meetings (Formerly Better Never Stops).

Emerging recurrent themes from the quality visits were:

- Cleaning standards – General cleanliness of areas was found to be poor this has been raised with the facilities team for action.
- Medicines management – Medicine security and storage
- IPC standards - Hand hygiene and IPC practices not being followed correctly (Such as bare below the elbows)
- Equipment not being IPC compliant (Fabric chairs not cleanable, torn chairs not IPC compliant)
- Equipment maintenance – A number of community sites had equipment that was overdue for yearly review and PAT testing.

3.3 Tendable Audits

Fig 16: Audit scores by ICSU

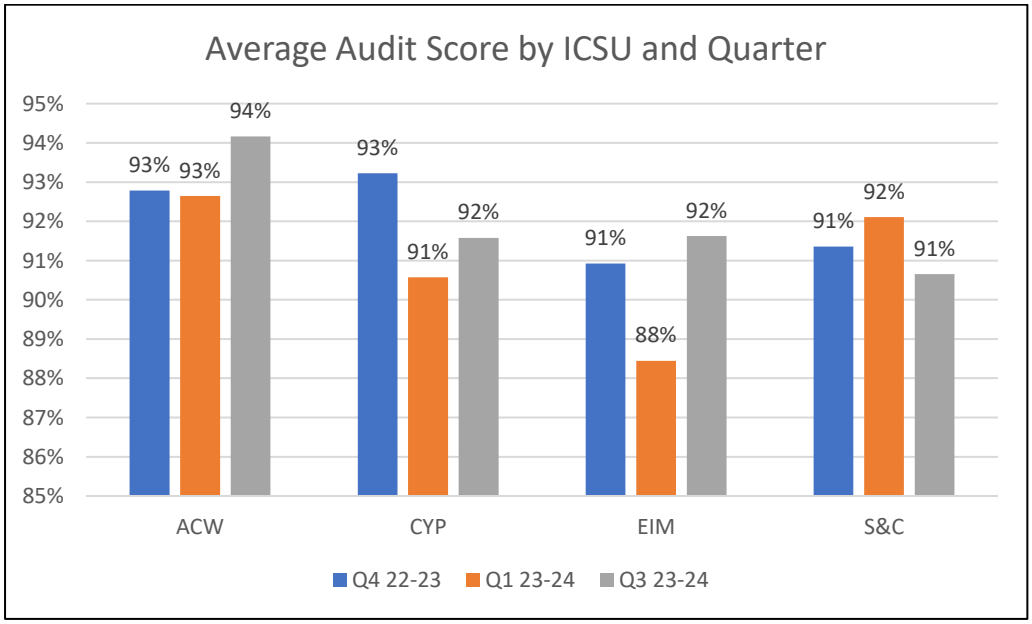
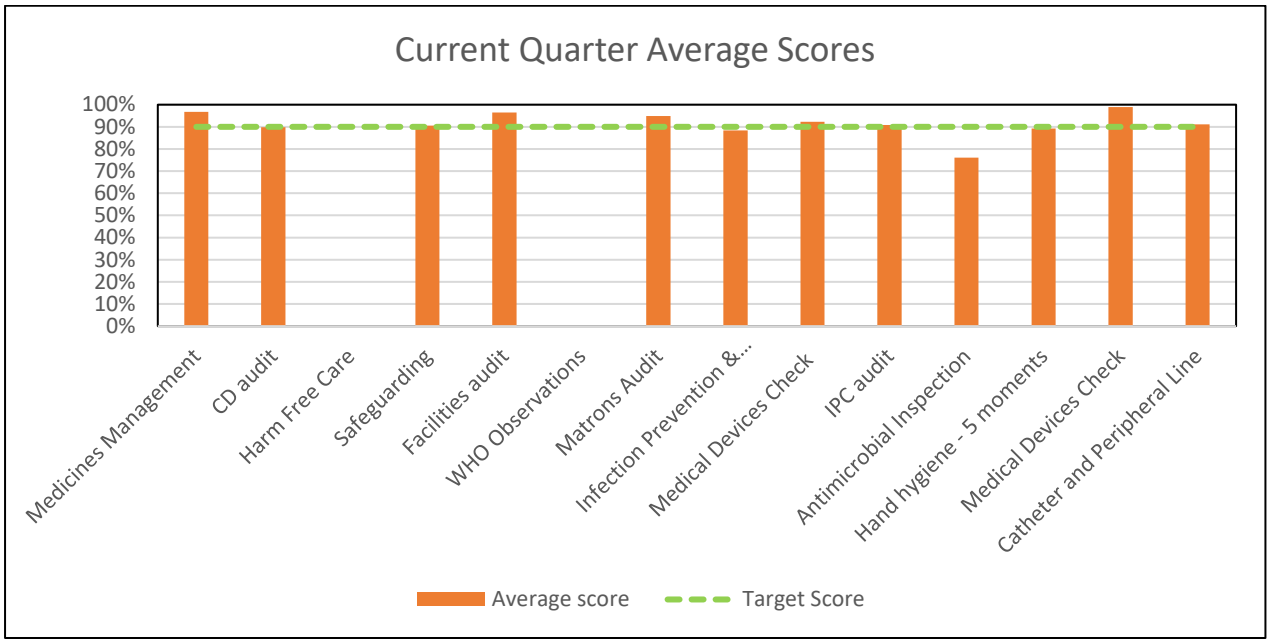


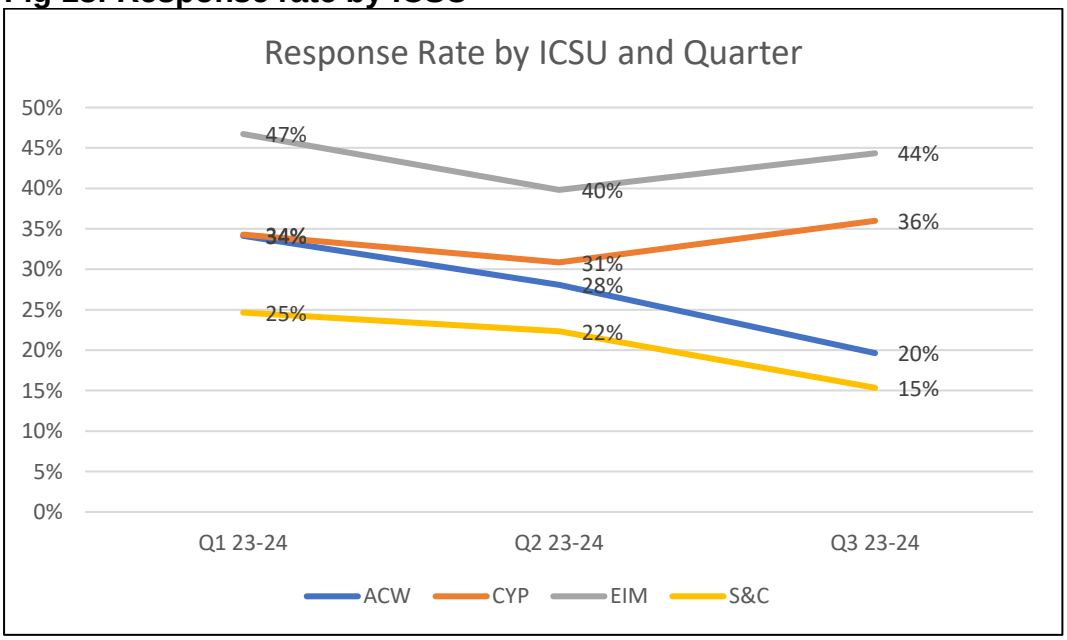
Fig 17: Audit scores Q3



* *Note WHO audits are not currently captured on Tendable*

- Hand hygiene and anti-microbial audits not achieving a score over 90% will need to redo their audits on a weekly basis until the recommended score is achieved. Targeted support from the IPC and Pharmacy teams is offered to areas of low compliance.
- The other suite of audits (minus hand hygiene and anti-microbial) generates actions for improvement, these actions must be completed ahead of a re audit to increase the overall score.
- Named managers assigned to actions, will enable Matrons to monitor progress against improvements.

Fig 18: Response rate by ICSU



* *Tendable roll within ACS to commence April 2024*

- Completion of audits varies across the ICSU's, with a particular decline noted within S&C and ACW. A Task and finish group will be established in March to look at the barriers to completing the audits.

4.0 Recommendations

The Quality Assurance Committee is asked to note the three key quality messages from the Q3 Quality report:

- The incidence of full thickness pressure damage remains a concern in the community (7).
- 5 C. Diff cases in Q3. This brings to a total of 13 hospital acquired cases of Clostridium difficile infections (CDI) Q-Q3 in the Trust against an annual trajectory of 13
- National Early Inflammatory Arthritis Audit Outlier Notification

Meeting title	**Quality Assurance Committee**	**Date: 13th March 2024**
Report title	**Patient Experience Report: Q3 2023/24**	**Agenda item: 4.4**
Executive director lead	Sarah Wilding, Chief Nurse and Director of Allied Health Professionals	
Report author	• Nicola Sands Deputy Chief Nurse • Anne O' Connor; Associate Director of Quality Governance • Antoinette Webber, Head of Patient Experience	
Executive summary	This quarterly paper will provide an overview of patient experience and covers Q3 2023/24, key highlights include: • Overall, the Trust maintained a score above the 85% NHS benchmark at 88.39% for positive responses during Q3. We continue to be an outlier for negative responses above the 5% NHS benchmark at 7.39% • Complaint response timescales remain below the 80% target at 47% • National Inpatient 2022 survey results highlight a number of areas for improvement. A task and finish group has been created to work through an action plan which builds into a wider Trust action plan on patient experience. The group closed in December. • During Q3 an additional 13 new volunteers were recruited, taking the total number of volunteers to 53	
Purpose:	Update Committee members	
Recommendation(s)	Members are asked to note the contents of the report.	
Risk Register or Board Assurance Framework	Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.	
Report history	This report brings together all patient experience elements that have been report to the Quality Governance committee in one report	

1. Introduction

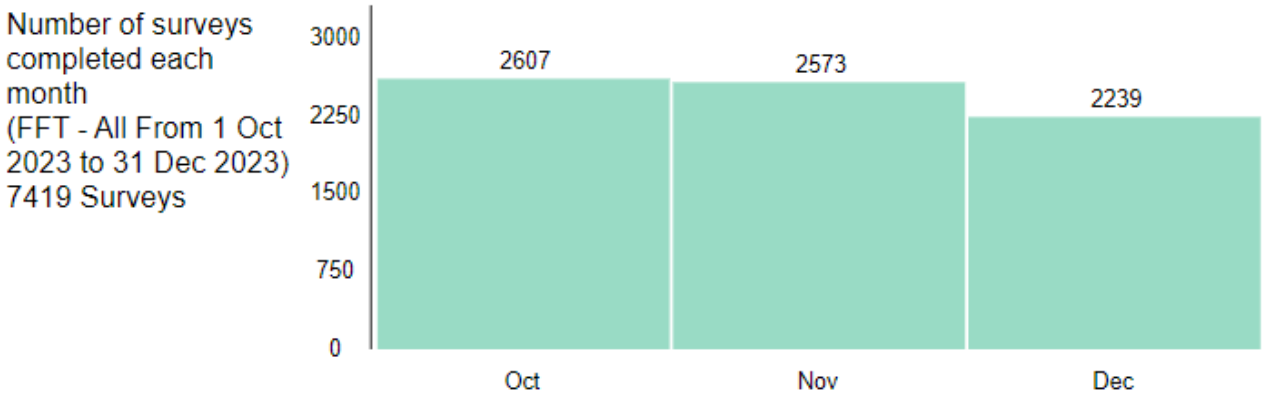
The Patient Experience quarterly report is designed to demonstrate Whittington Health's commitment to continuous learning, improvement, and patient experience. This report provides a systematic analysis of intelligence from patient experience, including key performance metrics, as well as themes and trends for Q3 2023-2024.

2. Patient Experience

2.1 Friends and Family Test (FFT)

Overall, the Trust maintained a score above the 85% NHS benchmark at 88.39% for positive responses during Q3. We continue to be an outlier for negative responses above the 5% NHS benchmark at 7.39% an increase of 1.31% on Q2 (6.08%).

The number of responses has seen a slight increase in Q3, to 7419 from 7,246 in Q2, an increase of 173. The late submission of paper forms on completion of the FFT survey impacts on responses rates and performance.



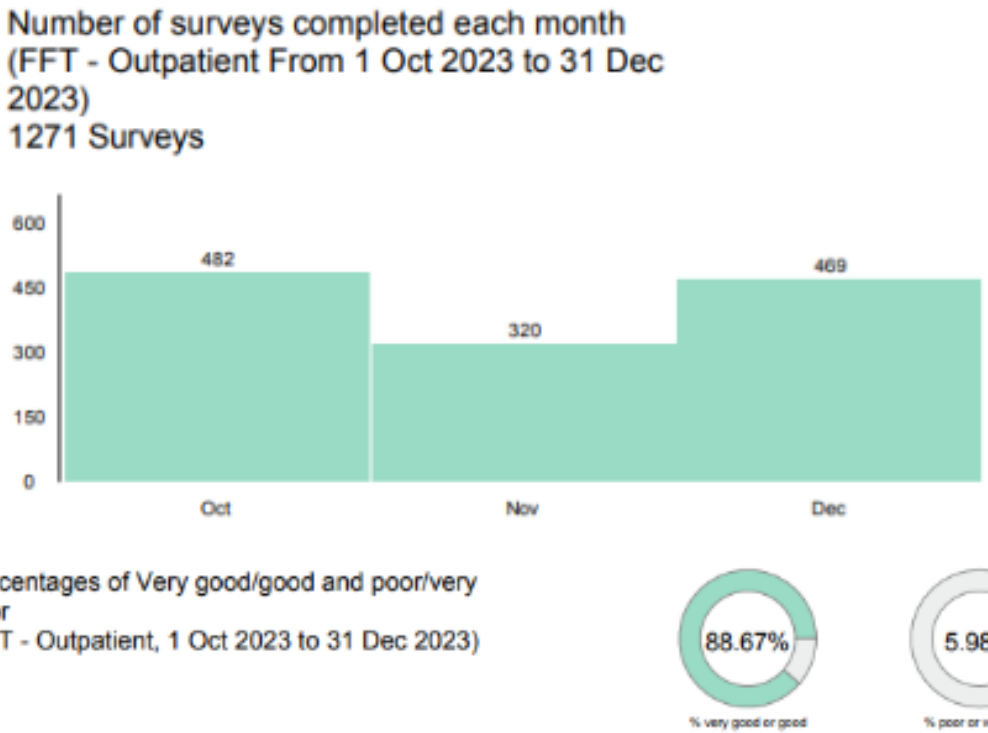
Action

- Patient Experience team to support a Trust wide awareness of FFT submission dates for paper forms and the importance of having these uploaded by the last day of the month. A communication notification was shared through the Trust's

noticeboard reminding staff of the importance of submitting paper forms in a timely manner.

2.1.2 Outpatients

Response rates for Outpatients FFT in Q3 (1,271) a slight increase of 150 on Q2 (1,121). "Very good and good" remains above the national NHS 85% benchmark at 88.67%. Both "poor and very poor" for Q3 was 5.98% above the national NHS 5% benchmark.



Actions:

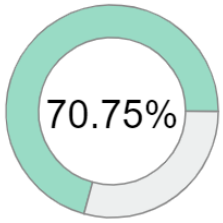
- Patient facing posters have been reintroduced to outpatient areas, placed in a more prominent position, including on reception desks.
- Volunteers continue to provide focussed support on gathering FFT feedback via iPads within the outpatient department.

2.1.3 Emergency Department

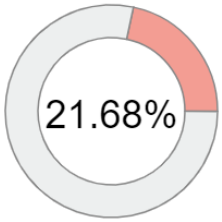
During Q3, ED experienced a significant increase in "poor and very poor" responses at 21.68% (Q2 13.86%), it remains an outlier at 16.68% over the NHS benchmark of 5% and an increase of 7.88% on Q2. The results were significantly impacted by

winter and operational pressures within ED and industrial action by junior medical staff . Survey comments consistently highlight concerns regarding waiting times. “Very good and good” remains below the national NHS 85% benchmark at 70.75%. This is 2% below the same quarter of 2022-2023 for “Very good and good”.

Percentages of Very good/good and poor/very poor
(FFT - ED, 1 Oct 2023 to 31 Dec 2023)

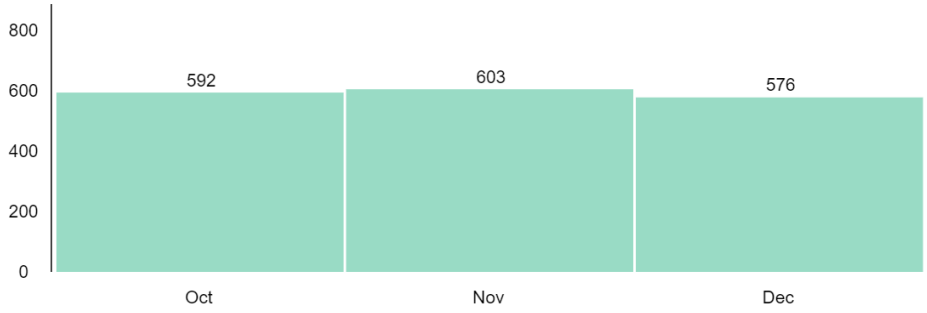


% very good or good



% poor or very poor

Number of surveys completed each month
(FFT - ED From 1 Oct 2023 to 31 Dec 2023)
1771 Surveys



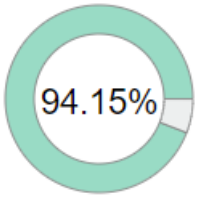
Actions:

- Work is taking place with the support of an action plan for the National UEC survey which addresses areas of concerns around cleaning and waiting times.
- The Patient Experience team are working with the Facilities team to address concerns around cleanliness. An external audit is being carried out in relation to the National Cleaning Standards, the results of which will be shared are expected late March 2024, and actions monitored through the Patient Experience Group.
- Communications team are working with ED on a joint project on the development of a suite of patient information posters to include.
    - Please be patient!
    - If patients arrive who are seriously ill, we will see them first.
    - You may have a longer wait if you are less ill.
    - You can always ring 111 for advice.

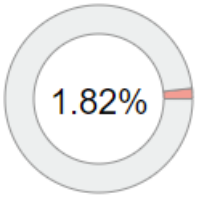
2.1.4 Inpatient

Inpatient results saw an increase of 603 responses in Q3 with 1,539 compared to 936 in Q2. Positive response rates have seen an increase from (92.78% Q2) to 94.15% Q3 above the NHS benchmark. Negative feedback was below the national NHS benchmark of 5% at 1.82% Q3.

Percentages of Very good/good and poor/very poor (FFT - Inpatient, 1 Oct 2023 to 31 Dec 2023)



% very good or good



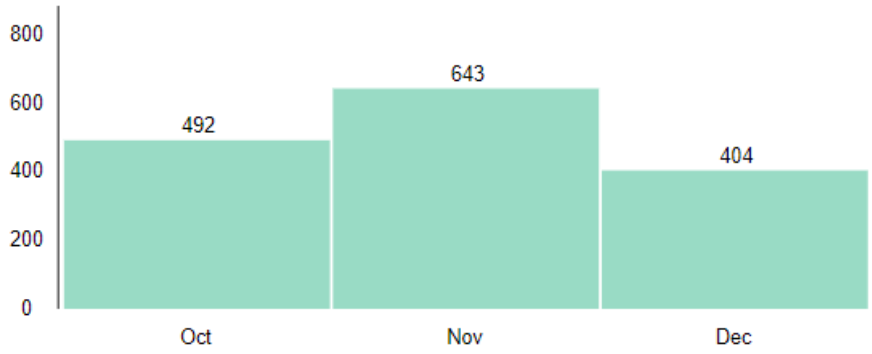
% poor or very poor

FFT response breakdown (FFT - Inpatient, 1 Oct 2023 to 31 Dec 2023)

Response	Percentage	Number of times response selected
Very good	78.69%	1211
Good	15.46%	238
Neither good nor poor	2.79%	43
Poor	0.78%	12
Very poor	1.04%	16
Don't know	1.23%	19

Export

Number of surveys completed each month (FFT - Inpatient From 1 Oct 2023 to 31 Dec 2023) 1539 Surveys



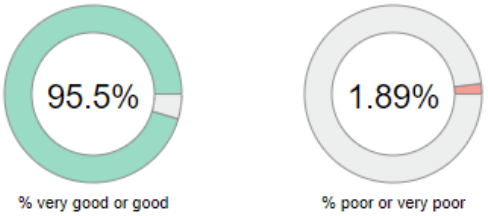
Actions:

- The Patient Experience team will reintroduce posters on the wards ensuring that they are placed in prominent areas.
- Welcome to the ward boards are in the final draft. The Suite of three will include a patient facing board placed on the ward, which will display FFT results, and "you said we did", which will act as a reminder to staff to offer patients the opportunity to provide feedback.

2.1.5 Community

Community FFT response rates had seen a slight increase of 18 on Q2 (2,316) to 2,334 in Q3. Issues related to the late submission of FFT paper forms which are to be uploaded to the IQVIA portal means that some FFT responses are not recorded at the end of the month in our data and submission to NHSE. The patient experience team worked with the communications team to promote a Trust wide awareness of the importance of timely submissions of paper FFT forms.

Percentages of Very good/good and poor/very poor (FFT - Community, 1 Oct 2023 to 31 Dec 2023)

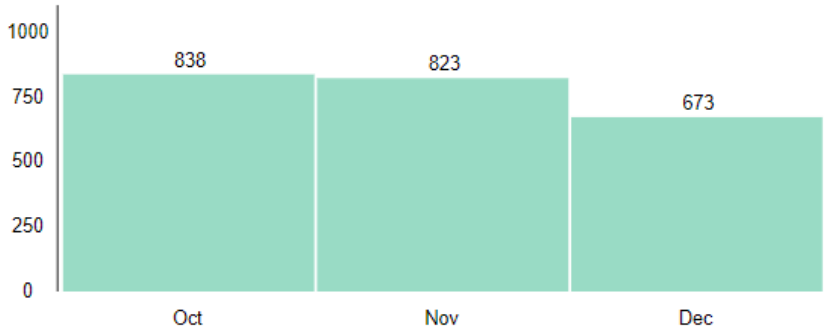


FFT response breakdown (FFT - Community, 1 Oct 2023 to 31 Dec 2023)

Response	Percentage	Number of times response selected
Very good	78.41%	1830
Good	17.10%	399
Neither good nor poor	2.23%	52
Poor	0.73%	17
Very poor	1.16%	27
Don't know	0.39%	9

Export

Number of surveys completed each month (FFT - Community From 1 Oct 2023 to 31 Dec 2023) 2334 Surveys

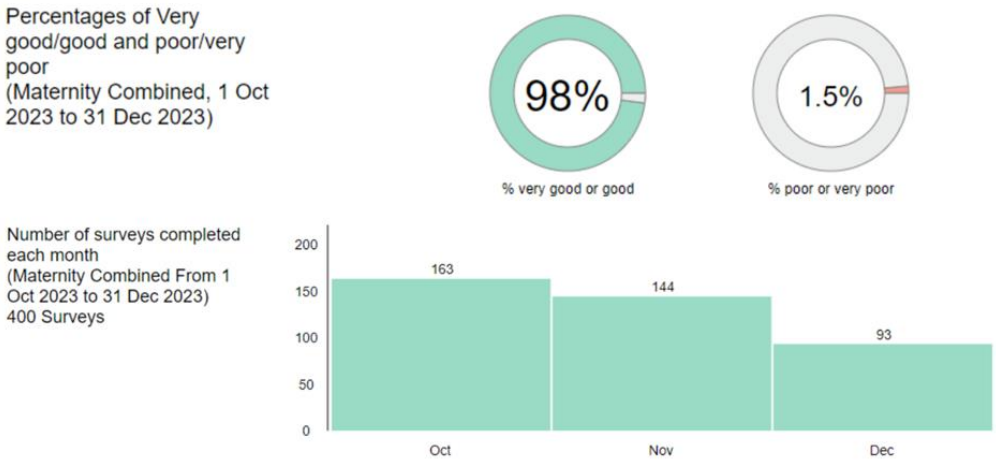


Actions:

- The patient experience team met with the ADON for ACW and discussed options to improve FFT feedback response rates within community settings. iPads are the preferred option to collect data followed by QR cards, these will be discussed with the community teams as they already have access to iPads when working in the community. SMS is not considered a popular option, however, will be explored.

2.1.6 Maternity

Q3 saw a slight improvement for positive response rates at 98%, an increase of 2.33% on Q2 and a decrease in “very poor and poor” response rates from 1.85% (Q2) to 1.5% in Q3.



Actions:

- The patient experience team met with the Head of Maternity regarding the implementation of FFT SMS for community postnatal. In addition to the FFT question the survey will include a question “were you provided with enough information about feeding your baby?” following the National Maternity Survey 2023 results, where areas of improvement centred on providing enough support and advice with feeding your baby.

	PATIENT EXPERIENCE DASHBOARD		Target	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
FFT	Overall Positive experience	Emergency and Integrated Medicine (EIM)	>85%	85%	83%	79%	82%	78%	86%	82%	80%	87%	82%	83%	81%	86%	84%	78%	80%	77%
		Children and Young People (CYP)	>85%	95%	97%	94%	95%	99%	97%	96%	96%	99%	97%	99%	95%	100%	98%	95%	95%	97%
		Surgery and Cancer (S&C)	>85%	98%	97%	97%	98%	97%	96%	95%	96%	97%	97%	97%	97%	98%	93%	96%	95%	95%
		Adult Community Services (ACS)	>85%	94%	81%	95%	92%	90%	91%	90%	89%	95%	93%	92%	91%	91%	93%	93%	94%	92%
		Access Clinical Support & Women's Health (ACW)	>85%	99%	95%	98%	97%	96%	95%	98%	95%	89%	95%	94%	93%	95%	94%	93%	92%	89%
		Trust	>85%	92%	89%	88%	89%	87%	91%	89%	89%	93%	90%	91%	89%	92%	90%	89%	89%	87%
	Overall Negative Experience	Emergency and Integrated Medicine (EIM)	<5%	11%	10%	14%	13%	16%	9%	12%	12%	9%	13%	12%	14%	9%	10%	16%	13%	17%
		Children and Young People (CYP)	<5%	3%	2%	3%	2%	0%	0%	3%	2%	1%	0%	0%	0%	0%	1%	2%	2%	1%
		Surgery and Cancer (S&C)	<5%	1%	1%	2%	1%	1%	2%	3%	3%	2%	2%	2%	1%	1%	3%	2%	2%	1%
		Adult Community Services (ACS)	<5%	4%	11%	3%	4%	6%	3%	5%	6%	2%	0%	3%	3%	6%	4%	4%	3%	4%
		Access Clinical Support & Women's Health (ACW	<5%	1%	2%	1%	3%	3%	2%	2%	4%	6%	4%	4%	5%	2%	4%	5%	5%	6%
FFT Focussed areas	Overall Positive experience	ED	>85%	80%	80%	70%	75%	73%	83%	75%	76%	84%	79%	78%	77%	83%	81%	69%	73%	70%
		Maternity	>85%	99%	98%	99%	99%	98%	98%	100%	99%	95%	98%	100%	0%	97%	96%	98%	99%	98%
		Outpatients	>85%	88%	90%	96%	89%	96%	90%	92%	91%	95%	88%	95%	94%	96%	93%	90%	86%	86%
	Overall Negative Experience	ED	<5%	15%	14%	21%	19%	20%	11%	17%	16%	12%	16%	16%	16%	12%	14%	23%	19%	23%
		Maternity	<5%	0%	0%	0%	1%	1%	0%	0%	1%	0%	2%	0%	100%	0%	2%	2%	1%	2%
		Outpatients	<5%	10%	9%	3%	9%	3%	6%	6%	5%	4%	6%	3%	3%	2%	4%	6%	9%	6%
Complaints Performance	Complaints	Emergency and Integrated Medicine (EIM)	>80%	20%	50%	75%	67%	50%	67%	33%	0%	33%	40%	60%	63%	50%	57%	71%	57%	60%
		Children and Young People (CYP)	>80%	50%	N/A	100%	100%	75%	100%	100%	100%	100%	83%	50%	100%	50%	50%	100%	50%	0%
		Surgery and Cancer (S&C)	>80%	50%	25%	0%	25%	33%	17%	0%	50%	33%	17%	40%	44%	0%	20%	44%	17%	8%
		Adult Community Services (ACS)	>80%	100%	100%	N/A	60%	100%	N/A	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%
		Access Clinical Support & Women's Health (ACW)	>80%	0%	66%	N/A	67%	33%	50%	50%	67%	71%	50%	67%	75%	100%	63%	60%	33%	100%
		Corporate	>80%	100%	N/A	100%	N/A	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A	N/A	N/A	100%	N/A	0%
		Estates & Facilities	>80%	0%	0%	N/A	0%	0%	N/A	100%	50%	33%	67%	100%	N/A	0%	100%	0%	N/A	100%
		Trust	>80%	35%	47%	62%	50%	45%	56%	56%	65%	50%	49%	61%	63%	48%	54%	63%	45%	30%

2.2 National Surveys

NHS England produces and uses a range of different surveys as a valuable source of feedback directly from patients, service users about the care that they receive or provide. Information from patient experience surveys is one way to understand what service users think about their recent care and treatment. Survey results can be used to check progress and quality of care, and to hold us accountable. Some national programmes run annually, bi-annually (2 years) or every three years.

Following back to the floor in October, the PET have created a national survey webpage which shares information on the national programme, which areas are surveyed, when and current results and can be viewed here. The webpage was promoted through coms and at the B2F celebration for staff awareness and education.

2.2.1 National Urgent & Emergency Care 2022

This survey is undertaken every two years and looks at the experiences of people who attended Type 1 or Type 3 urgent & emergency care (UEC) services during September 2022. The 2022 survey involved 122 trusts with a Type 1 accident and emergency (A&E) department and the results were published nationally in July 2023.

UEC had 29 questions in which they scored “about the same” with other trusts, 3 better than expected,” 4, “somewhat better than expected” and 1 “worse than expected,” with none being “much worse than expected”.

Successes

Whittington Health’s Urgent & Emergency Care Survey results 2022 were top of the league table for the region nationally in two questions in the categories waiting and doctors and nurses. UEC were also in the top five for care and treatment, tests and respect and dignity.

Bottom five scores

Q42. Before you left the hospital, did a member of staff discuss your transport arrangements for leaving A&E?

Q43. Did hospital staff discuss with you whether you may need further health or social care services after leaving?

Q31. In your opinion, how clean was the A&E department?

Q18. Did doctors or nurses talk to each other about you as if you weren’t there?

Q44. After leaving A&E, was the care and support you expected available when you needed it?

Actions:

- A task and finish group including EIM leads and the patient experience team, have reviewed the bottom 5 areas for improvement, and actions against each question created. An action plan is in place which is worked through monthly. Governance is through EIM Quality Board and the Patient Experience Group.
- Patient Experience and Facilities working group meets quarterly and reviews feedback from national surveys and FFT to include food, cleanliness, and signage.
- Facilities providing an additional cleaning provision in ED.
- Facilities undertaking an external audit against the National Cleaning Standards.

2.2.2 National Cancer Patient Experience survey 2022

The National Cancer Patient Experience survey (CPES) takes place annually and is conducted by NHS England, involving 133 NHS Trusts. The sample for the survey included all adults (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2022. The fieldwork for the survey was undertaken between November 2022 and February 2023 with results being published in July 2023.

Questions Above Expected Range

	Case Mix Adjusted Scores			National Score
	2022 Score	Lower Expected Range	Upper Expected Range	
Q7. Patient felt the length of time waiting for diagnostic test results was about right	**89%**	69%	88%	**78%**
Q8. Diagnostic test results were explained in a way the patient could completely understand	**90%**	69%	88%	**78%**

Questions Below Expected Range

	Case Mix Adjusted Scores			National Score
	2022 Score	Lower Expected Range	Upper Expected Range	
Q9. Enough privacy was always given to the patient when receiving diagnostic test results	**88%**	89%	100%	**95%**
Q19. Patient found advice from main contact person was very or quite helpful	**90%**	91%	100%	**95%**
Q33. Patient was always involved in decisions about their care and treatment whilst in hospital	**52%**	53%	86%	**70%**
Q37. Patient was always treated with respect and dignity while in hospital	**73%**	76%	100%	**88%**
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment	**78%**	78%	94%	**86%**

Actions:

1. A volunteer has started conducting FFT with cancer patients weekly on the chemotherapy unit, providing an increase in FFTs, more rich data to analyse and listen to what our patients are saying.
2. Oncology and breast cancer now to carry out joint patient and staff surveys.

3. Clinic 4a quiet room available. Engaging with an interior design company to carry out improvement works to any patient comfort areas with the aim of creating a more therapeutic space that is dignified and comfortable.
4. Secret shopping CNS telephone and feeding back to CNS group at our staff meetings has been undertaken by the Associate Director of Nursing, for Cancer & Surgery.
5. Recurrent funding of Acute Oncology Lead Nurse approved this role is essential to provide the link and coordination from our patients on the ward or in ED to the tumour specific team.
6. UGI pathway development for patients with a suspected UGI malignancy. The CNS is already developing this with acute medicine.
7. Discussions re cancer at 'back to the floor', to really emphasise across the wards needs of cancer patients and how to meet them.
8. Oncology clinical contact list has been circulated with ward teams, ED, and clinics to help our colleagues across the trust contact the team.
9. Complimentary therapies approved by WH Charity; we are developing a patient feedback form to monitor the quality of this.
10. CNS posters in wards, clinics, and ED with contact details

2.2.3 National Adult Inpatient Survey 2022

The National Adult Inpatient survey is held every year, the patient cohort for the 2022 were patients who had spent one night or more in hospital during November 2022 and fieldwork in January – April 2023. The findings were published nationally on 12 September 2023.

It is worth noting that this survey took place while there were significant challenges with nursing vacancies on the wards and large numbers of escalation beds that were opened and not substantively funded. A recruitment drive has resulted in filling most of these positions.

<u>Highlights</u>

- Medication on discharge
- Views sought on the quality of care.
- Self-administration of medication
- Information relating to condition.
- Communication from doctors

<u>Areas for improvement</u>

- Accessing food outside of mealtimes
- Noise at night (being disturbed by other patients)
- Communication post procedure
- Cleanliness

- Inclusion in conversations with nursing staff

The patient experience team have supported the action plan during Q3 to address areas for improvement, including the introduction of sleep well packs to address noise at night. Monitoring of the associated action plan will be within the task and finish group, which consists of matrons, facilities, the patient experience team, AHP's and is chaired by the Deputy Chief Nurse and meets fortnightly. The Patient Experience Group (PEG) will have oversight of the action plan and assurance through the Quality Governance Committee (QGC). The groups remit will form part of the Trust's response to improving patient experience.

Actions:

- Sleep well packs have been delivered to all wards with an accompanying poster for patients notifying them that if they are disturbed at night by noise, they can request a "sleep well pack" and promoted for staff through the communications team.
- The patient experience team made successful charities bid to purchase additional sleep well packs to ensure that there is a constant supply available to our patients. The sleep well packs include a postcard of tips to aide a restful night's sleep.
- Ward patient information leaflets have been developed and placed at the bedside of each patient. During Q4 we will speak to our patients to understand if they have found the inpatient leaflets useful. The inpatient ward leaflet is available at every patient bedside and includes who to contact if they have a concern, how to obtain food outside mealtimes, carers information, sleep well packs, bedside handovers, and staff uniforms.
- Welcome to the ward boards will be implemented for patients and visitors, which includes information on falls, IPC, staffing levels, complaints, compliments, FFTs, national surveys and "you said we did". The welcome to the ward boards comprises of 3 boards, and include meet the team, get involved and a staff quality board for the staff areas. The patient experience team have created a draft ward board and are obtaining quotes from companies to produce these boards.
- Following a Back to the Floor session in October to discuss the National Inpatient 2022 results and raise awareness of the patient cohort for the 2023 survey, feedback following that session resulted in the patient experience team creating a dedicated survey page. The page has been created specifically to raise staff awareness and knowledge around the national surveys programme and can be found here

2.2.4 The National Adult Inpatient Survey 2023

The National Adult Inpatient survey programme started in November 2023 for the patient cohort for the 2023 survey. Dissent posters were displayed in November on inpatient wards. Sampling will take place in December 2023 and January 2024, and the field work will happen between January and April 2024.

National Survey Programme

2023 Surveys

- 2023 Maternity: fieldwork April – June 2023, publication 9 February 2024
- 2023 Adult inpatients: fieldwork January – April 2024, publication August 2024 (TBC)
- 2023 Cancer Patient Experience – patient sample April -June 2023, publication date, August 2024 (TBC)

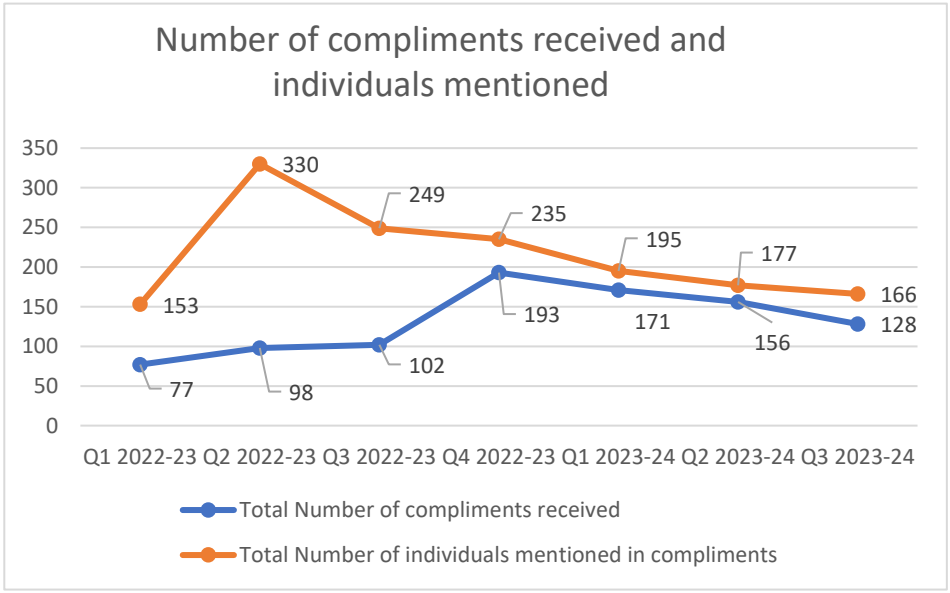
2024 Surveys

- 2024 Urgent and Emergency Care: fieldwork April – July 2024, publication October 2024 (TBC)
- 2024 Maternity: fieldwork April – June 2024, publication December 2024 (TBC)
- 2024 Children and young people: fieldwork July – October 2024, publication March 2025 (TBC)
- 2024 Cancer Patient Experience - April -June 2024, publication date, August 2025 (TBC)
- 2024 Adult inpatients: fieldwork January – April 2025, publication August 2025 (TBC

2.3 Compliments and Complaints

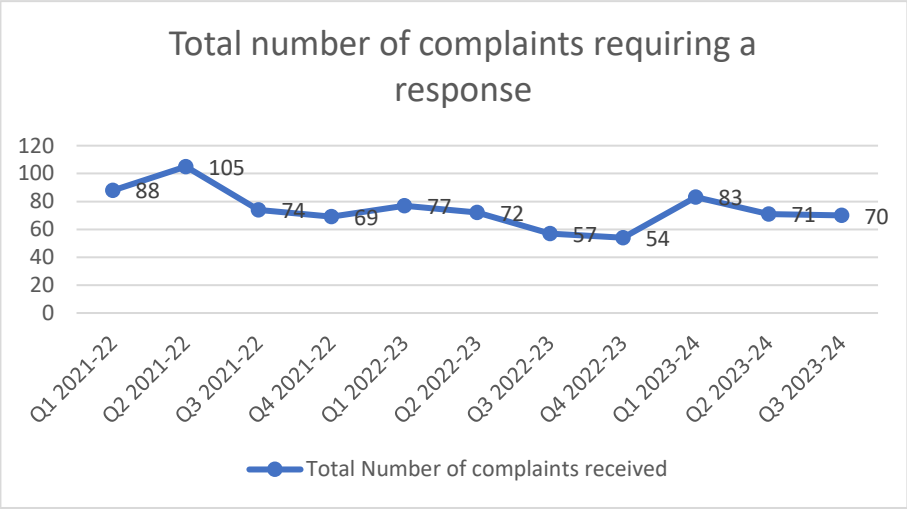
2.3.1 Compliments

In Q3 the Trust received 128 compliments a reduction of 28 on Q2, thanking 166 areas/individuals. It should also be noted that each ICSU receive a large number of compliments directly from patients and families, that are not captured in this report. The compliments in Q3 were received for S&C (38%), E&IM (19%), ACS (17%), ACW (11%), CYPS (8%), Corporate (inc. PALS) (6%) & Estates & Facilities (1%)

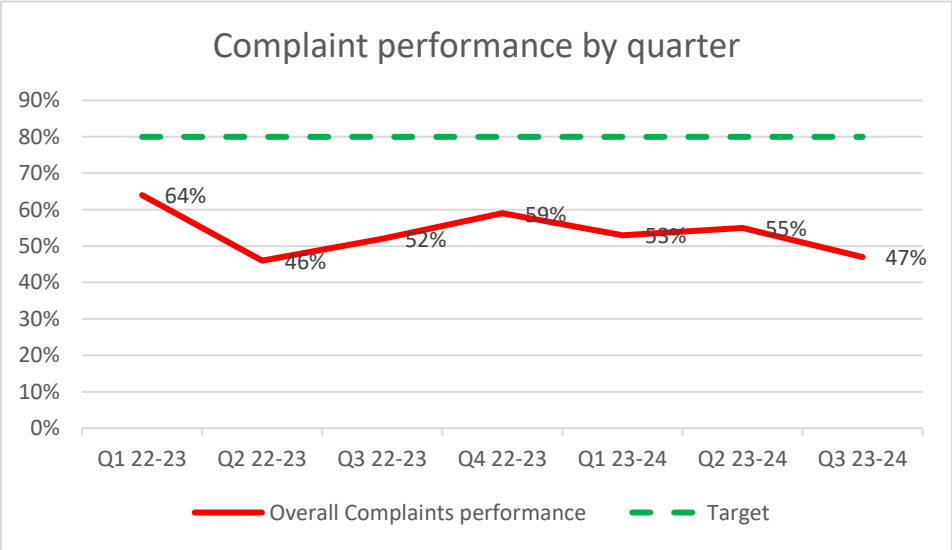


2.3.2 Complaints

During Q3 the Trust had 77 complaints. 7 of these were de-escalated leaving 70 complaints where a response was required. This is in line with Q2 volume.



Performance against the 80% target has continued to be adversely affected during Q3, due to winter pressures and a number of outstanding historical complaints. The performance figure for Q3 was 47%, a reduction of 8% on Q2 (55%). The annual performance against the 80% target can be seen in the graph below. Of the complaints received during Q3, 99% were acknowledged within the required 3 working days, exceeding the Trust target of 90%.



Of the complaints that closed during Q3, 18% (6) were fully upheld, 58% (19) were partially upheld and 24% (8) were not upheld, meaning that 76% of complaints were upheld in one

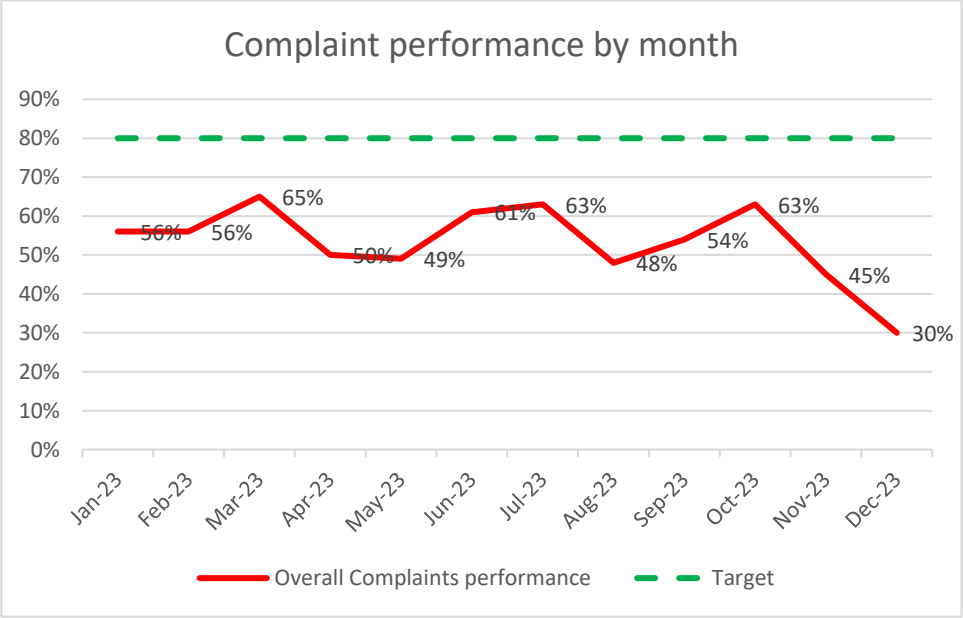
form or another. This is broadly in line with previous quarters where around 80% of complaints were upheld.

The three main themes identified from complaints during Q3 were as follows:

- 17 complainants raised concerns about 'attitude' with the main theme that the attitude displayed was 'inconsiderate/uncaring or dismissive'.
- 17 complainants raised concerns about 'communication', with the main themes being complainants concerned about 'clarity & confusion' & 'poor or lack of communication between professionals or patients.
- 16 complainants raised issues about 'medical care', with the main theme being 'inadequate treatment'.

Complaint response timescales

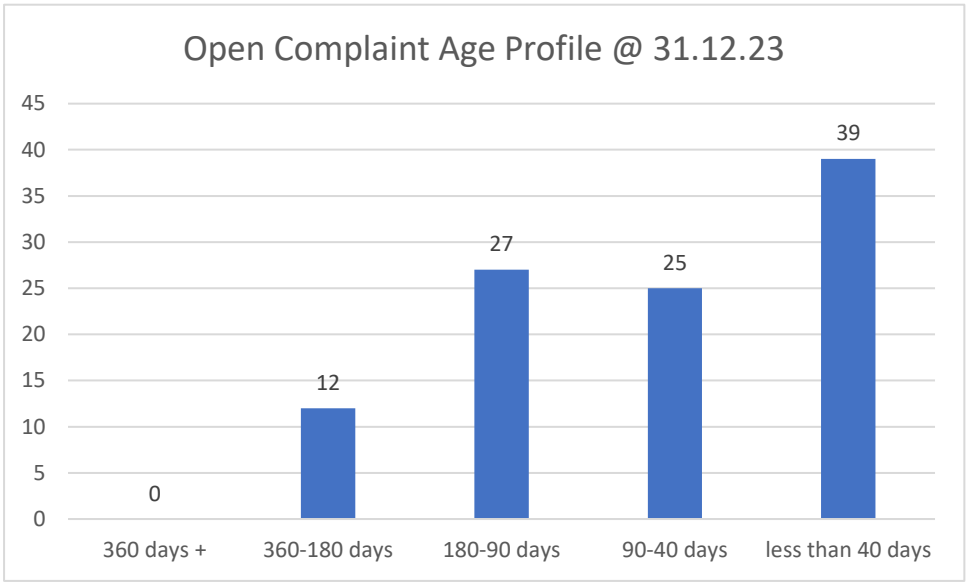
The Trust target for complaints requiring a response is set at 80% irrespective of whether the response is due within 25 or 40 working days. Of the complaints requiring a response in Q3 overall performance was 47%. Between Oct – Dec we saw a decline in performance from 63% to 30% in Dec, performance was affected by winter pressures and industrial action. The graph below shows the monthly performance from January 2023.



Complaint backlog

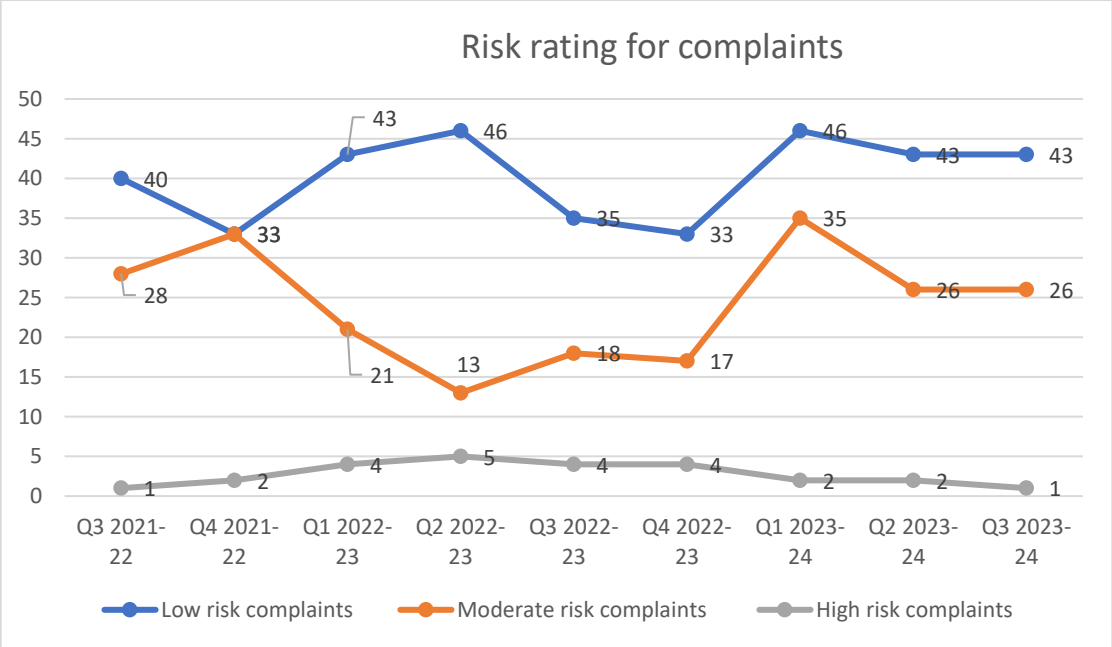
The graph below gives a summary of the position of open complaints awaiting a response and shows a number that are 180 – 360 days old. The PALS & Complaints team are working closely with colleagues in the ICSU to manage the backlog, currently concentrating

on the oldest complaints, in line with the external complaints audit. Additional support is being provided to S&C for complaint responses.



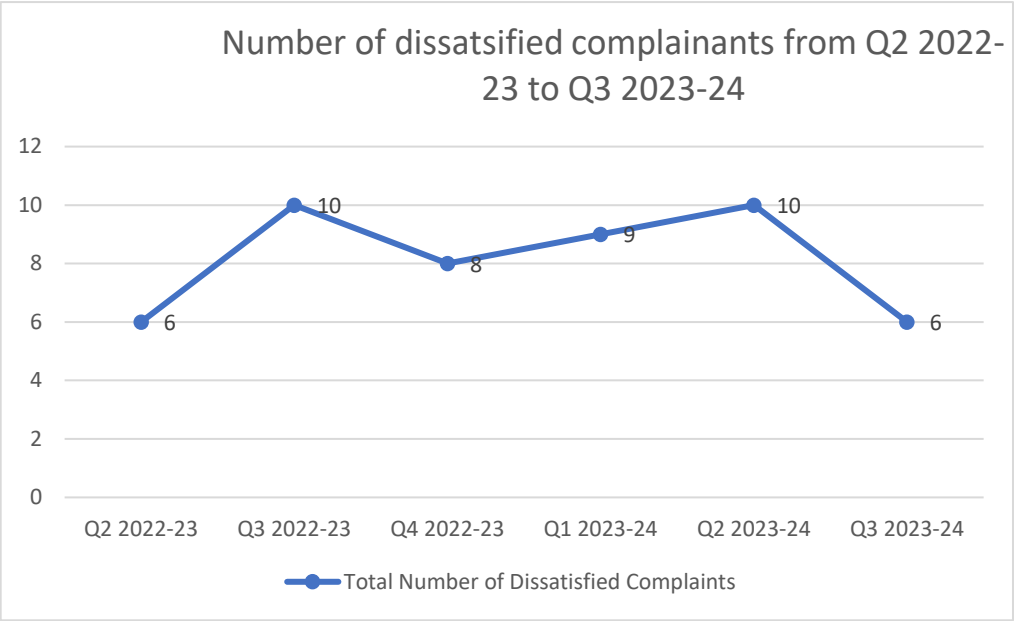
Risk-rating

The graph below shows the risk rating split for complaints in Q3. When a complaint is received which include NICU or references a staff allegation the Pals & Complaints Manager raises awareness to the Chief Nurse, Deputy Chief Nurse and HoPE.



Dissatisfied complaints

The graph below shows the number of 'dissatisfied' complainants who asked for further comment or clarification during Q3, a reduction of 4 from Q2.



Learning from Complaints

All complaints that are either upheld require actions taken to be outlined in the response in the complaint response and logged on Datix to demonstrate any learning that has been identified.

By way of example, we received a complaint that a patient who attended the Day Treatment Centre (DTC) for a procedure who was not accompanied by a relative even though English was not their first language, and they were hard of hearing.

As a result of the complaint, DTC staff have been reminded of the importance of advising patient and relatives that patients cannot be accompanied into the DTC, that an interpreter needs to be arranged as required (with an alert being added to the patient record if needed). DTC are also updating its patient information leaflets to reflect that patients cannot be accompanied into the DTC.

<u>Actions:</u>

- As part of the external complaints audit and associated action tracker, a template has been created for the complaints process, starting with the PALS through to completion, with any outstanding actions recorded. The complaints facilitators discuss outstanding actions with the ICSU leads to ensure that these are completed, updated onto Datix and incorporated for learning.

- Weekly ICSU meetings include an agenda of outstanding complaints, investigators provide an update on responses. The meetings are also an opportunity to review complaints and discuss any queries/questions.
- From Q4, the Pals and complaints team to monitor de-escalated complaints and to be included in performance, provided that the complaints is de-escalated within original investigation timeframe.
- Weekly status report reviewed to include a simpler way to provide information and includes those complaints that are sitting with the complaint facilitators for quality checks.
- Deputy Chief Nurse and HoPE providing additional support on reviewing draft complaint responses.
- When a complaint is received which include NICU or references a staff allegation the Pals & Complaints manager raise awareness to the Chief Nurse, Deputy Chief Nurse and HoPE.

Parliamentary & Health Service Ombudsman (PHSO)

The Trust received 6 requests for information during Q3. Two of these have not proceeded further. We are awaiting further updates from the Ombudsman service on the other four cases as to whether these cases will proceed to a full Ombudsman investigation.

Complaint Audit

An action plan is being worked through following a recent external audit of the complaints process to identify areas for improvement, any duplication or bottle necks. The action plan provides an opportunity to improve performance and support the ICUS investigation leads with the complaints process, training, and weekly complaints meetings with an agenda to discuss outstanding complaints, with an aim to mitigate delays.

Closed actions:

A. The Complaints Handling Policy will be fully drafted and updated to reflect current practice in relation to the management of complaints within the Trust. Once drafted, the Complaints Handling Policy will be ratified by the ICSU Management Team prior to approval by the Policy Approval Group.

The complaints policy has been reviewed, amendments include reference to the Allegations Against Staff policy, updated references, and all complainants to receive a call from investigators prior to an investigation taking place to discuss concerns, as an opportunity to de-escalate a complaint and update the complainant of the investigation process and expectations. The updated policy went to TMG and has been ratified at the policy ratification group, and is now available online complaints policy.

B. Management at ICSU level will introduce peer review of complaint case file data to ensure that all required information has been uploaded to the Datix file towards the complaint.

C. To facilitate this, the central Complaints team will establish a checklist of all required information to be uploaded to the Datix complaint portal to be distributed to the ICSU leads to utilise when reviewing complaint files.

Produce a checklist to ensure all relevant complaint data is uploaded to Datix - complaint facilitators to work with the ICSUs to ensure compliance. A template has been created and currently being used by the complaint's facilitators, the PALs and Complaints manager to monitor compliance.

D. Management will ensure that for any delays which are internally driven within the Trust such as capacity and resourcing issues, action plans are put in place at ICSU level to support with the management of delays to complaint case reviews. The action plans will be updated and presented at the weekly meetings by the ICSU Lead Investigator to the Complaint Facilitators to support with the identification of mitigations towards avoiding further delays.

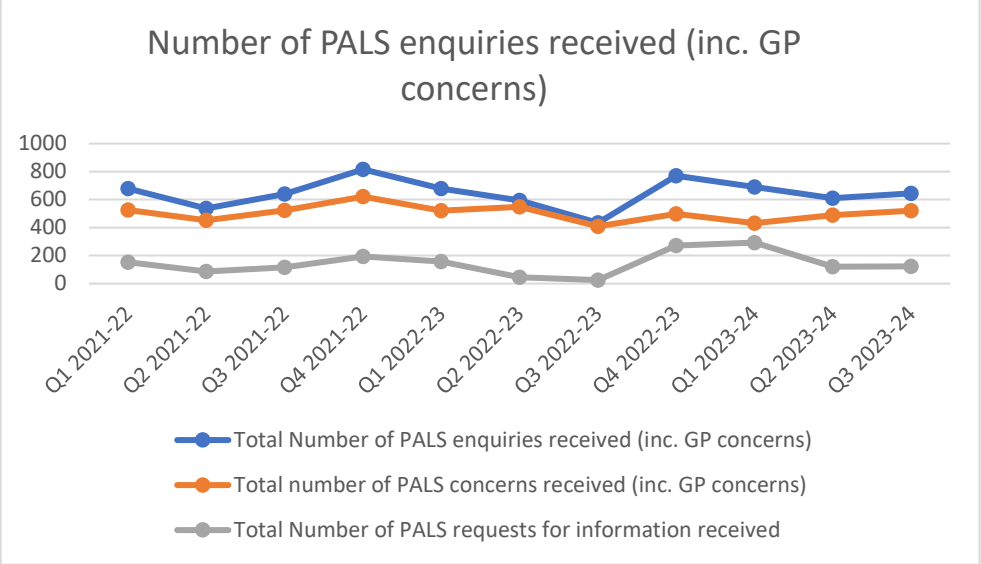
As part of the review and associated actions the complaints facilitators hold weekly meetings with an agenda, followed up with actions to support the timely completion of investigations. The agenda allow for the ICSU's to prepare in advance of the weekly meetings and provide the complaints facilitators with an update on complaints and discuss changes to timeframes if needed.

E. The PALS and Complaints Team will develop revised training materials in line with the updated Complaints Handling Policy. Once updated the PALS and Complaints Team will establish a training programme which outlines the frequency of training and undertake a comprehensive training needs analysis to identify all staff who are required to complete the training. Once all staff required to complete the training have been identified, the PALS and Complaints Team will establish a training log which captures all staff who have completed the training in order to facilitate the tracking of complaint training compliance. Compliance of training completion will be reported as part of the Complaints Monitoring Report.

The PALS & Complaints team have reviewed and updated the training materials and delivered two face-to-face training sessions in Q3, which were attended by 30 members of staff. Further training has been scheduled for January, February & March 2024 and will continue as business as usual. The complaints handling training sessions support improvements in the standard of investigations being conducted, responses being drafted, and action plans being highlighted in complaint responses. Individual training continues to be provided on a 1:1 basis and through 'Teams' meetings as and when required.

2.4 Patient Advice and Liaison Service (PALS)

During Q3 the Trust received 645 PALS contacts (including 32 concerns from GP Practices). Of the contacts received, 522 (81%) related to concerns and 123 (19%) related to requests for help/information.



During Q3 the PALS & Complaints team continued to resolve issues through prompt intervention without the need for a complaint investigation. PALS concerns are received largely via email or telephone, although a walk-in service is also available.

The pressure on the PALS service remains very high, particularly around appointments and not being able to contact services directly. All concerns or requests for information are shared promptly with the relevant service.

As seen in previous quarters the most common themes raised in the PALS concerns (inc. those from GPs) related to 'communication (251)' 'delays (138)' and 'appointments (88)'. These themes are broadly in line with previous quarters.

Actions:

- Complaints training continues for staff on how to investigate complaints and the addition to the policy to ensure that all complainants receive a telephone call before the investigation commences as an opportunity to de-escalate and clarify concerns, and expectations.
- Clerical volunteer to provide administration support within the PALs team from Q4

2.5 Voluntary Service

Volunteering continues to be a good way to support our patients and communities' engagement.

- During Q3 we recruited 13 new volunteers taking the total number of active volunteers to 54. We had no volunteers leave in Oct – Nov, with 4 leaving in December.

- Volunteers have been placed in the following roles (ward befrienders, FFT and clerical with 1 in the chaplaincy team). We continue to actively recruit volunteers with a particular focus on supporting FFT and ward befrienders.

Good news story

Volunteers' International Day celebration

December marked International Volunteers Day, with a special event for the volunteers to thank them for their contributions and dedication to our patients. It was an opportunity for volunteers to come together and share experiences. Food was kindly donated from Wenzel's and Greggs in Archway. During the thank you event we unveiled the new volunteer uniforms, made possible with the support of Whittington Charity. The volunteers' uniforms provide branding for our volunteers making them easily identifiable to patients' carers and visitors and was an opportunity to show our existing and new volunteers we value them.

Volunteer to Career

Volunteering has always been a good way for our community to update and acquire new skills. Many people who apply to volunteer have been out of work for some time and volunteering allows them to engage in the routine of employment and helps build their confidence and knowledge. For the trust as an anchor organisation in the community it is very much a positive advertisement for the Trust and further demonstrates the value of volunteering at Whittington Health. During Q3 4 volunteers secured full-time paid positions in the hospital, namely in health records and healthcare support work on the ward.

2.6 Interpreting

The number of interpreting referrals received inhouse as prebooked Telephone Interpreting (TI), Face to Face (F2F) and Video Interpreting (VI) during Q3 was 5,666 and increase of 511 on Q2 (5,115). 15% of these (845) were received with less than 72 hrs notice.

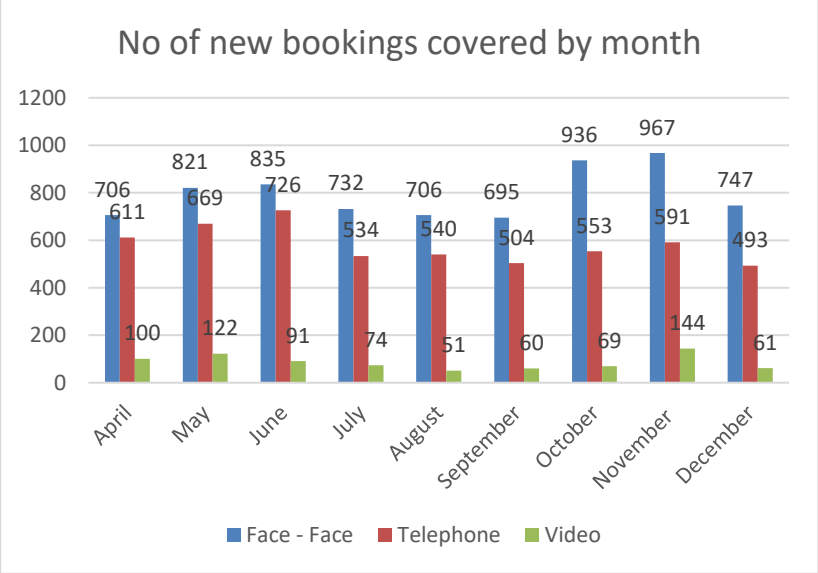
The number of bookings fulfilled, where we were able to provide an interpreter, either inhouse or outsourced was 4,561 (1,558 in October, 1,702 in November and 1,301 in December).

This includes:

F2F – 2,650 (Q2 2,133)

TI – 1,637 (this is only prebooked appts) (Q2 1,578)

VI – 274 (Q2 185)



Triumphs

- Video Interpreting (VI) has increased this quarter, as a result of the work the admin team has undertaken to promote the benefits, and the support we are getting from our secondary provider, DA Languages.
- The new interpreting booking system for staff (eLangServ) has now been fully implemented across the Trust.
- The interpreter feedback form has had a very poor uptake. During Q3 only 1 response was received.
- During Q3 we received two compliments for two of our bank interpreters.
- The service undertook 16 translations of medical records, appointment letters, questionnaires, and leaflets.

Challenges

- Despite the benefits and the cost effectiveness of video interpreting, face to face is still the preferred method for clinicians within the acute setting.
- During Q3 we received 30 complaints an increase of 3 on Q2 (27). Of these, 17 (57%) related to our secondary provider DA Languages and the remaining 13 (43%) for our inhouse services. The main issues were around the lack of availability of both F2F and TI interpreters (especially in hard to recruit languages) and interpreter DNAs.

Actions

- Work to increase feedback from clinicians is a current focus for the interpreting services. During Q4, raising awareness of the feedback form will be shared with staff through coms.
- Work will take place with our secondary provider, DA Languages to support a transition from F2F as the preferred choice of interpretation to VI. This work will commence in Q4.
- The interpreting services team will be introducing an on-demand VI platform. The team are working with maternity services to provide them with 3 Interpreter on Wheels devices which run this platform.

2.6.2 Patient Information Leaflets

The Patient Information and Leaflets Group (PILG), which includes representation from the Trust Library, Communications, Healthwatch Haringey, Adult Learning Disabilities and the Patient Experience team meet monthly. The group has now developed Terms of Reference and an MS Teams channel, as well as a Proposal Form and a Readability checklist which is completed and submitted by authors together with each proposed leaflet. The PILG review each leaflet,10 leaflets were reviewed in Q3. The Patient Information Standard Operating Procedure (SOP) is under review.

- 26 requests for a patient leaflet were received during Q3, 29 were ratified.

Meeting title	**Trust Board Quality Assurance Committee**	**Date: 13th March 2024**
RReport title	Bi-Annual Safeguarding Report (April 2023 to October 2023)	**Agenda item: 4.6**
Executive director lead	Sarah Wilding Chief Nurse & Director of Allied Health Professionals	
Report author	Stella Balsamo, Named Nurse, Safeguarding Children(Islington) Sara Earlle, Named Nurse, Safeguarding Children(Haringey) Theresa Renwick Head of Vulnerable Adults.	
Executive summary	This report provides a summary of the work undertaken across adult and children's safeguarding and covers the period between April 2023 to October 2023. 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. **Children & Young People** • Safeguarding training compliance continues to improve with the on line training offer and the consistency of reporting data via Elev8. Level 1 is currently 83%, level 2, 91% and level 3 86%. The respective Safeguarding Children's Partnerships have a diverse multi agency training offer, including gambling awareness, child sexual abuse, disproportionality and intersectionality as well as the core training. all training relates to the partnership priorities and any learning from case reviews. • The complexity of safeguarding cases has increased. Higher incidences of mental health, substance misuse and domestic abuse feature in the referrals. • Adolescent mental health remains a key issue within safeguarding with high levels of mental health and neurodiversity being a feature of Ifor ward admissions. New mandatory training is being rolled out across the trust for all staff. • 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 increased across the boroughs and remains the primary reason for referrals to social care. There is an acknowledgment of domestic abuse across all genders, and raising awareness of specialist services has been shared. • 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. • There are calls for evidence in the national debate around mandatory reporting of child sexual abuse. Should there be a change to the legislation, there will be a legal requirement for anyone in a regulated activity relating to children, including teachers or healthcare professional to report if they know a child is being sexually abused. The change in legislation will be as a result of the independent inquiry into Child Sexual Abuse(IICSA) • Working Together to Safeguard Children, 2023 has been revised. The revision focuses on strengthening multi agency working across the whole system of help, support and protection. There are updates around multi agency expectations for all staff, multi-agency practice standards, support for disabled children and tackling harm outside the home (contextual safeguarding) • Local Safeguarding Practice Review (LCSPR) as they are now known under new legislation (previously known as Serious Case Reviews SCR) activity at this time indicates eight active reviews in progress. Whittington Health has a robust action plan in place to address the learning from SCR's, with most actions already completed before publication of the SCR/SPR. There has been an increase in Rapid Reviews; those reviews which do not reach the threshold for a LCSPR. These case reviews require a quick response to establish whether there is immediate action needed to ensure a child's safety and the potential for practice learning. • Staff supervision compliance has remained high. Ad hoc supervision sessions to discuss complex cases are very helpful to staff. • Ad hoc supervision and safeguarding consultation are readily accessed across both boroughs. • These are from a wide range of health practitioners, including talking therapies, dentists in Hillingdon, newborn screeners in audiology ,CAMHS and PIPS.

	• 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. There will be an increase in the children's skill mix workforce in Islington, following a successful bid, a plan is in place to deliver safeguarding supervision. • Following a Serious Incident Investigation in January 2023, revised guidance has been introduced and rolled out. This relates to the introduction of a multi-agency protocol for managing observed bruises and marks on non-mobile babies. Haringey have started an audit to evidence the impact of the training and implementation of the protocol. Islington have commenced a multi-agency audit supported by the Named Consultants for both the community and the Whittington Hospital. Reports can be shared when made available. **Safeguarding Adults.** • During the period included in this report, the National Learning Disability Awareness week was held. • Whittington Health premiered our suite of learning disability awareness films co-produced with patients and family members at an invite only event including patients, families and carers, members of the wider learning disability community, representatives from • NHS England learning disability and autism team, the Trust executive, and Trust staff involved in producing the films. • Three films are aimed at people with learning disabilities and their families and carers, and focus on a visit to the Emergency Department, Outpatients, and Theatres. • We have also created a bespoke training film for staff, which has been used in safeguarding adult level 2 training since June 2023. • We have also launched 'Care Bags' for use in the hospital for people with learning disabilities, which includes items to reduce anxiety. • We have included autism awareness training in the safeguarding adult level 2 training since August 2023. • Training compliance for L1 was 84% and L2 had increased to reached 85% at the end of September 2023.

	• WRAP 3 compliance stands at 91% and basic awareness of PREVENT at 91% at the end of March 2023. • Urgent DoLS applications have continued the upward trend, and this quarter has seen also an increase on Q3. • The weekly drop-in session to discuss safeguarding and/or Mental Capacity Act concerns for community staff continues. • There has been no change this quarter in 'own home' being the most commonly recorded location of abuse. • Neglect continues to be the highest category of abuse. • There has been an increase in cases where concerns have been raised about care agency staff, and this has been shared with the two Safeguarding Adult Boards. • There has been a slight increase in numbers of pressure ulcers reported as safeguarding adult concerns by Trust staff.
Purpose:	Review and approve
Recommendation(s)	The Trust Board is asked to: - (i) To receive assurance that there are systems in place to protect children and young people 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 young people 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	None
Appendices	None

BIANNUAL SAFEGUARDING REPORT
April 2023 to October 2023

1. Safeguarding Children and young people.

1.1 This bi-annual report for safeguarding informs the Trust Board of activity and progress in improving and strengthening the safeguarding arrangements for children across Whittington Health NHS Trust. The report has been recommended by the Trust Quality Committee for approval by the Trust Board on recommendation from the Quality Committee. It covers the period from April 2023 to October 2023. The report provides assurance around the following:

- Adoption of national and local policy changes
- Responding to and learning from safeguarding concerns raised from internal incidents and serious incidents, Safeguarding Practice Reviews, Safeguarding Adult and Domestic Homicide Reviews and regulatory inspections.
- Work plan and objectives for the coming period of review
- Whittington Health response to domestic abuse.

2.0 SAFEGUARDING CHILDREN

2.1 The Serious Case Review process has been replaced with National Child Safeguarding Practice Review Panel. This is hoped to streamline the process and implement a system of national learning in a timely way. Eight cases are currently open to Whittington Health.

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

This work is further supported by revised guidance to support national guidance on identification and actions from observed marks or bruises in non-mobile babies. This guidance has been written in response to a Serious Incident investigation.

Communication remains a core theme of learning from Serious Practice Reviews. Systems for communication are evaluated continually with encouragement that staff should always try to speak to staff to escalate their concerns rather than relying on systems and email. This remains a core element of safeguarding supervision and training.

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. There are currently gaps in safeguarding supervision for midwives due to capacity issues within the service.

2.3 Safeguarding referral rates have increased, and this is reflected in the workload for both the borough MASH Health Advisors. There is a marked increase in the complexity of cases presenting. Excellent engagement with our multi agency partners has helped in the response to this issue. All the MASH checks are completed in the expected timeframes despite the increase in cases.

There has been an increase in complex strategy discussions in both the community and on the paediatric ward for both boroughs. The MASH health representatives are pivotal to decision making at these meetings in order to decide whether or not the case meets the threshold for a child protection investigation. The Named Nurse(Islington) has secured additional fixed term funding for a 0.8 MASH health representative to support the current post holder. Consideration will need to be made for this post to be made permanent as the trend shows that referrals to children's social care have increased and are growing in complexity. There is a review of the increased work pressures for the Haringey MASH and the potential for additional staffing.

2.4 Attendances to Emergency Departments (ED) for paediatrics have increased at both NMUH and the Whittington. There is an increase in adolescent mental illness, with presentations for serious mental health occurring in younger age groups. Youth violence continues to be a feature of attendances. There continues to be a weekly ED safeguarding meeting to review attendances of concern at both NMUH and the Whittington Hospital. This is well supported by St Giles youth workers who follow up children at risk of contextual harm at the Whittington, while NMUH have commissioned Oasis who perform the same function.

When children are admitted to the ward, the paediatric liaison health visitors are effective at triaging cases of concerns and following up ongoing concerns. There is ongoing attendance at the paediatric ward psychosocial meetings.

2.5 Domestic abuse remains the most common reason for referrals into social care. An increased incidence of men/fathers and same sex relationships presenting as the victims. It 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 mental health. This has resulted in the provision of a dedicated midwifery role to support both clients and professionals in managing the risks presented by maternal mental health.

3. Safeguarding Adults.

3.1 The co-produced resources for our learning disability patients were launched during learning disability awareness week in June 2023. Including a film premier for the three films for people with a learning disability, and a training film for staff, we also held a 'meet the team' event for patients with learning disabilities and their families and carers to meet members of the multi-disciplinary team.

3.2 New care bags, which aim to reduce any anxiety for patients with a learning disability were advertised, and we held an awareness stall in the Atrium joined by colleagues from community services.

3.3 These last two quarters have been busier than the previous two in terms of numbers of safeguarding adult referrals received.

3.4 The team have continued to offer additional support to Adult Community Services by running the weekly drop in for safeguarding and Mental Capacity Act questions, as well as attending the 72 our report meetings where possible.

3.5 Training compliance figures are given in section 5, and figures for level 2 Safeguarding Adults also include learning disability awareness, using the new Trust co-produced training video. Autism awareness now also forms part of safeguarding adults' level 2 training.

3.6 There has been a slight reduction in numbers of urgent DoLS authorisations, which it is suggested is attributable to the industrial action by medical staff, who overwhelmingly complete these.

3.5 The tables below show a selection of data collected in relation to Safeguarding Adults activity, with neglect remaining the most identified category of alleged abuse.

3.6 'Own home' is consistently the category with the highest numbers for location of alleged abuse.

3.7 Numbers of pressure ulcers identified as safeguarding adult concerns in these last two quarters are similar to the first two quarters.

3.8 Below are a selection of tables representing some of the data collected in relation to safeguarding adults' activity, including numbers of Urgent DoLS applications.

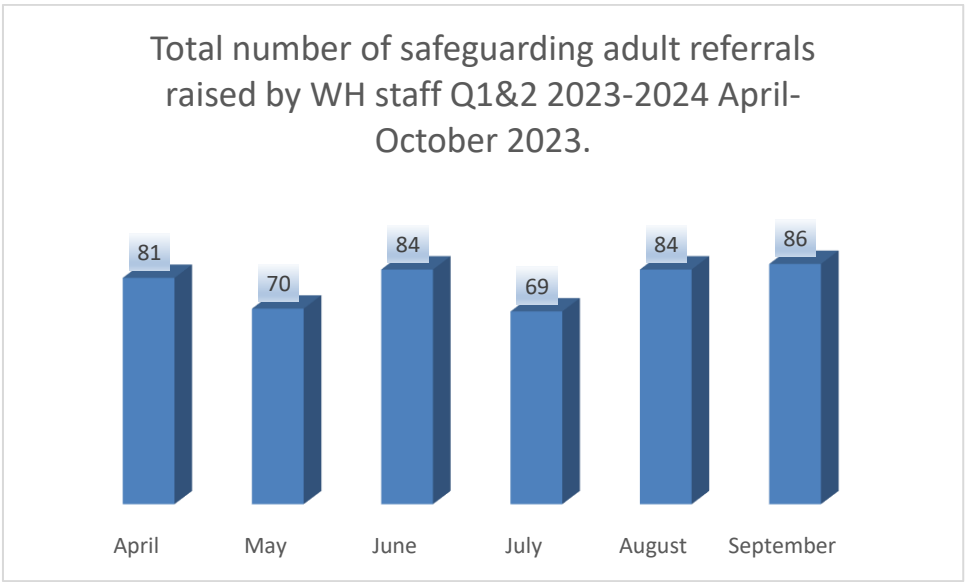
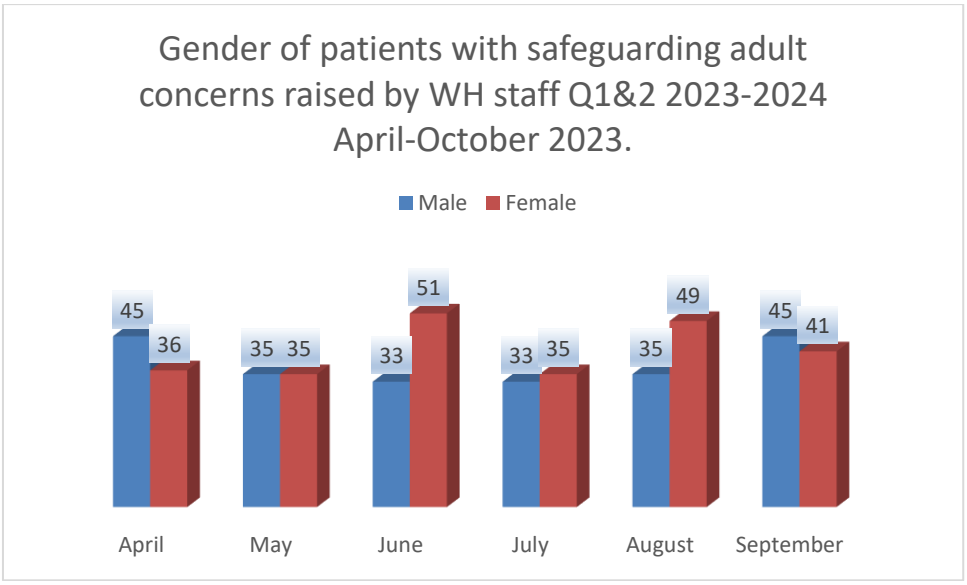


Table 1



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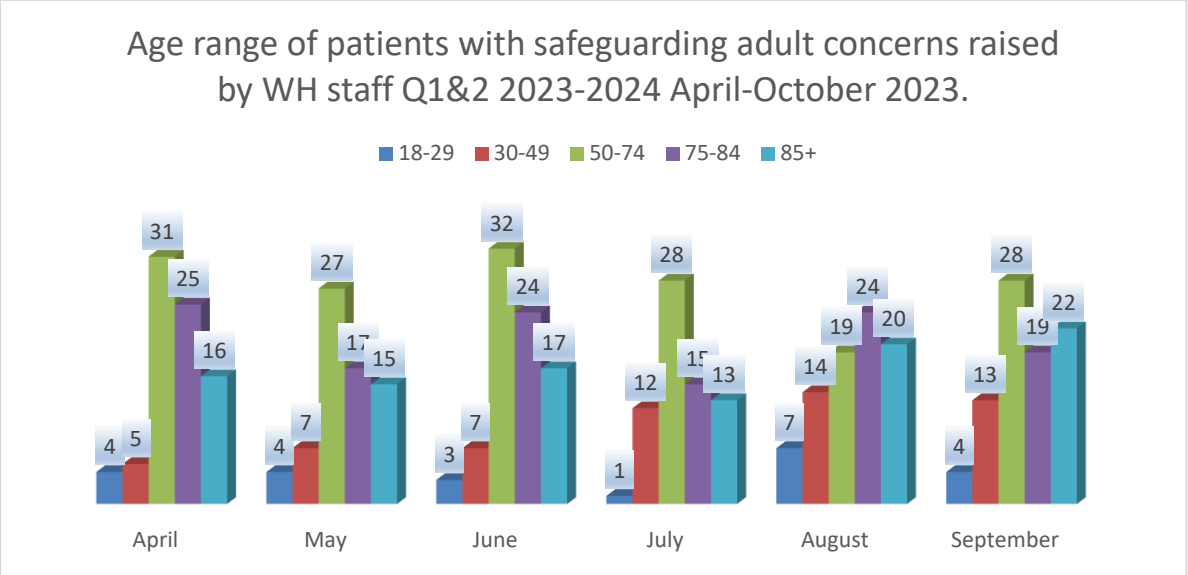

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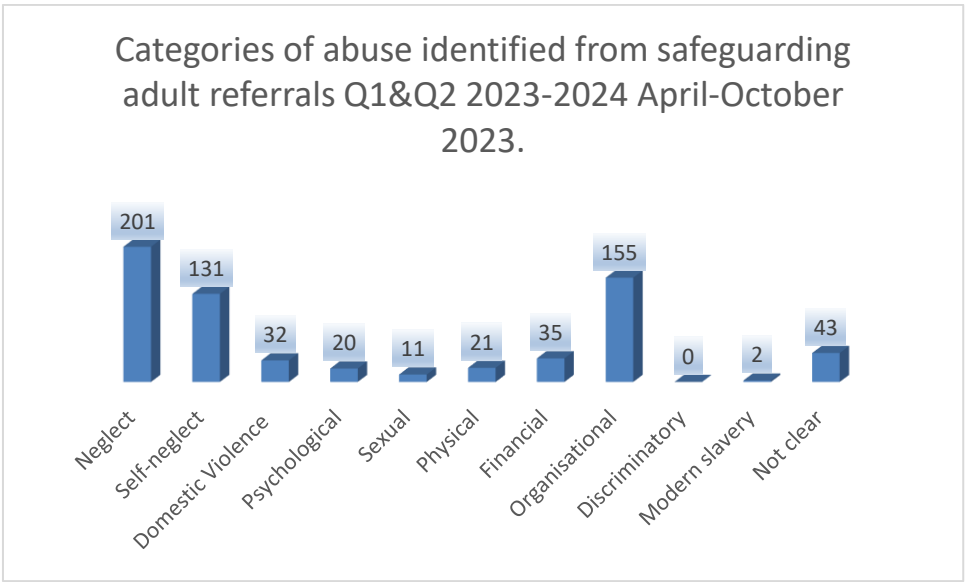

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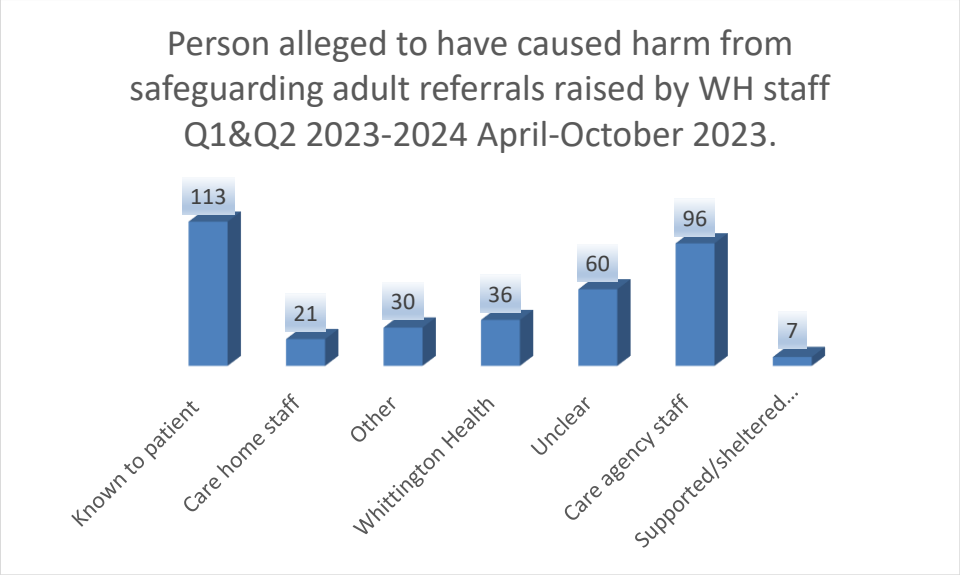

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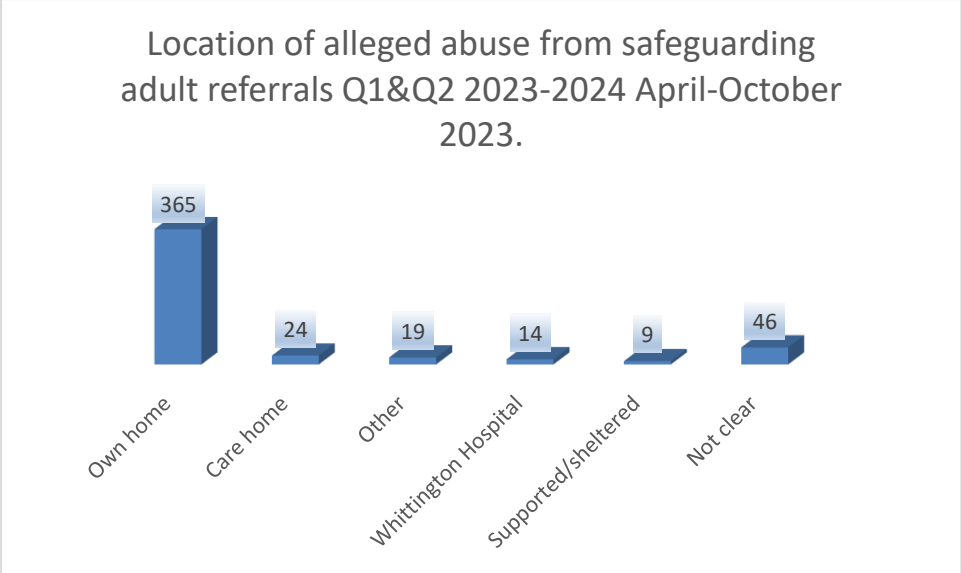

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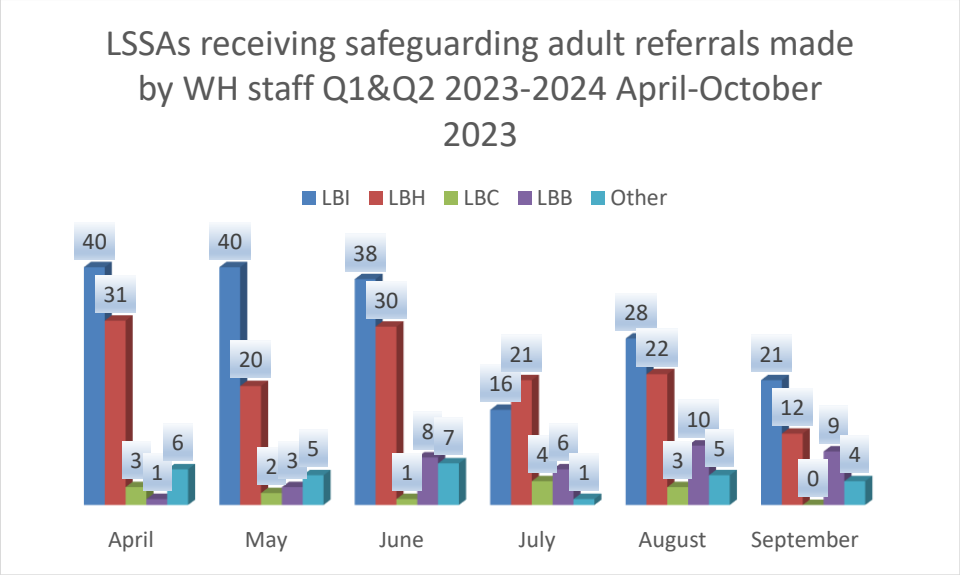

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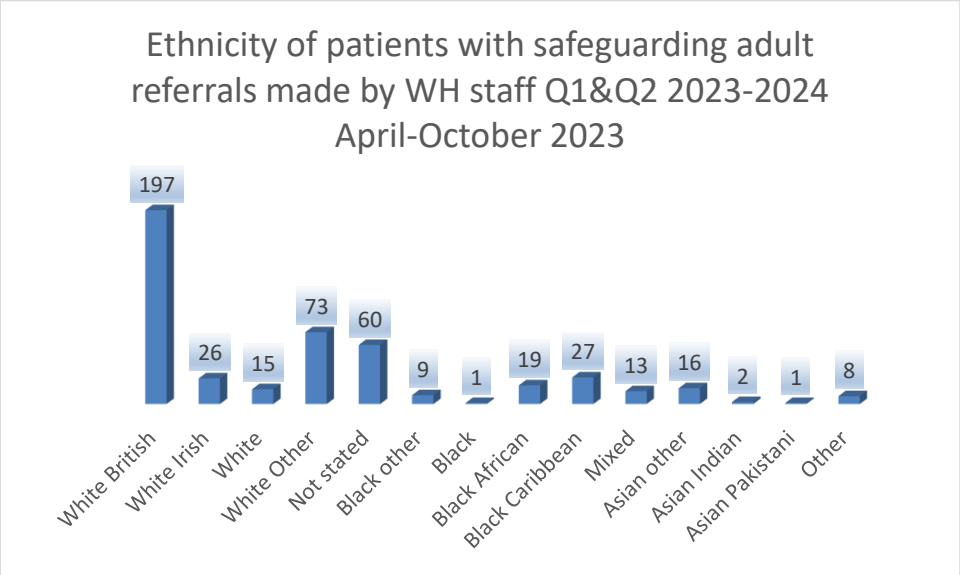
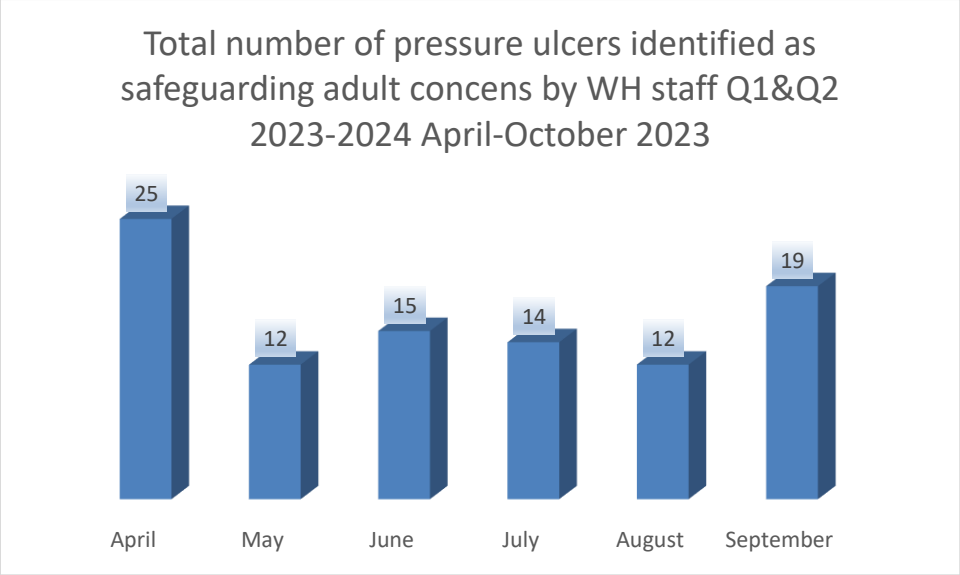


Table 8

3.9 Below is a case example of a safeguarding adult concern raised by a member of Trust staff.

CASE EXAMPLE

Phil 31 was born with a congenital condition causing significant mobility problems and being reliant on others for all activities of daily living. Phil lives at home with his parents and safeguarding concerns were raised by community services about the generally cluttered living conditions, rotting food on the floor of the kitchen and way in which Phil's parents would talk for Phil. Such was the concern that a discussion with the police led to a police officer visit and social care visit to identify how best to support Phil, and his parents in their caring role.



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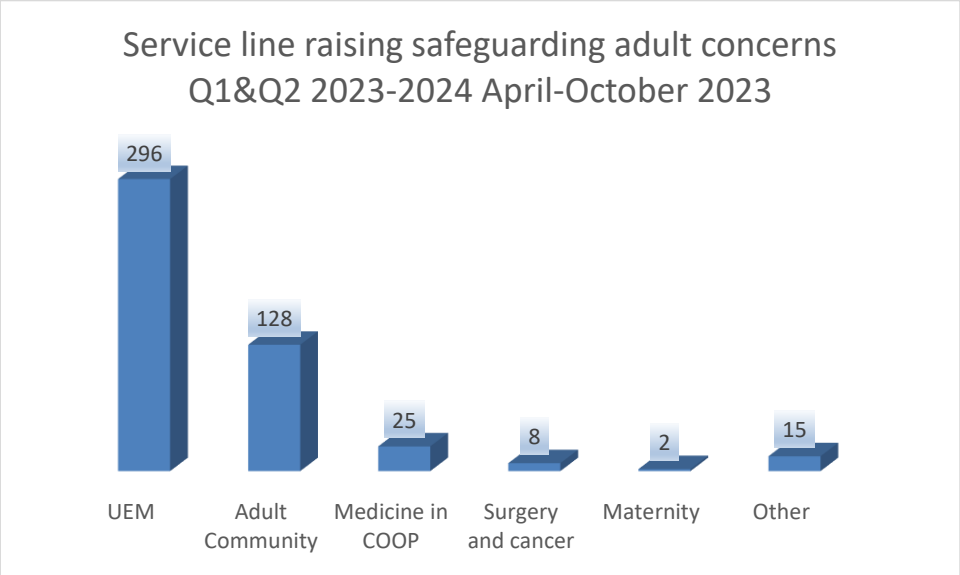

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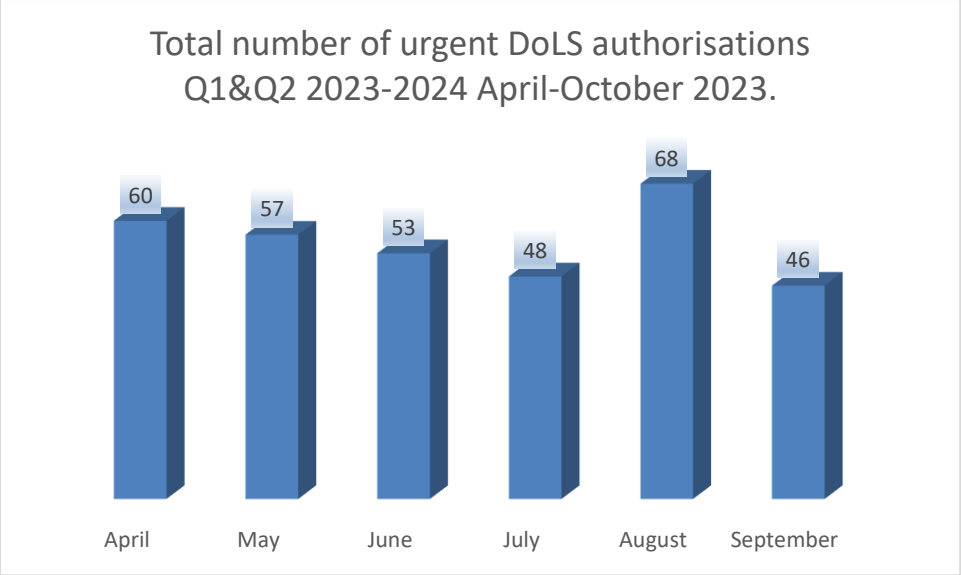

Table 11

4.0 ALLEGATIONS MADE AGAINST STAFF

4.1. In this reporting period there has been one case 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. Where there are concerns the Named Nurses for both Haringey and Islington liaise closely with the LADO leads for the respective local authorities.

4.3 The Trust is engaged in work being undertaken by both Safeguarding Adult Boards around formalising a process for allegations against Persons in Positions of Trust (PiPOT).

5.0 TRAINING

Children

5.1 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.

For the 6 month reporting period

Training compliance: Level 1 89%
Level 2 90%

Level 3 83%

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.

5.3 **For safeguarding adults**

Level 1 was at 84%
Level 2 safeguarding adults stood at 85%
Basic Awareness of Prevent (BPAT) was 91%
Level 3 PREVENT training was 91%.

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

Learning and action plans from the SCRs, Safeguarding Adult Reviews (SARs) and relevant SIs are presented to the Integrated Safeguarding Committee and through subgroups of the relevant Safeguarding Partnerships and Safeguarding Adult Board (SAB).

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.

6.2 New guidance has been issued in relation to bruises/marks observed on non-mobile babies. A multi-agency pathway for referral is now in place. This guidance allows for a multi-disciplinary approach to risk assessment and whilst this pathway may prove distressing for some families who undergo investigations for child abuse, it provides a robust approach to risk assessment.

6.3. Whittington Health has a Serious Case Review/Serious Incident (SCR/SPR/SI) Action Plan that is monitored through the quarterly Integrated Safeguarding Committee to ensure relevant learning from the SCR/SPR/SI's is implemented. Actions are also monitored through the Safeguarding Partnerships and their respective subgroups.

There are plans for Share Point to be utilised for action plan updates across the partnership. In response to some of the learning there has been a revision of the neglect toolkit and training available to all staff in Haringey.

The Threshold documents have been updated across the partnership as have the information sharing agreements. Learning from case reviews is regularly circulated across health services in various fora and at events organised across the partnership.

6.4. In October 2022 external funding from Islington NCL and Public Health to fund a dedicated MASH health worker substantively. This is recognition of the crucial role health plays in the safeguarding partnership.

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 collect data on referral sources and also quality check referrals, and those of poor quality are re-directed back to Whittington Health via the safeguarding team for support and training purposes.

Our MASH health teams in Haringey and Islington also collect data on their activity in relation to referrals through the 'front door' of social care.

Safeguarding Adults.

6.6 The Trust has been involved in four Safeguarding Adult Reviews (SARs) in this reporting period, and one Domestic Homicide Review.

6.7 Learning identified and shared in the face-to-face safeguarding adult refresher and induction training includes the importance of making referrals to the London Fire Brigade for fire safety checks, and identification of Deprivations of Liberty.

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7. PRIORITIES 2023/24 – Children and young people

- To review the pathways regarding Domestic Abuse
- Recruit a Domestic Abuse Specialist across the Trust
- To continue to develop the Trust's response to Domestic Abuse by providing bespoke training and completing an audit into the Trust's response to allegations of domestic abuse.
- To continue to support staff to access appropriate training, supervision and consultation.
- 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.

Safeguarding Adults.

- Activity within safeguarding adults continues to increase, with the complexity and time required to offer support for these evident.
- A new post has been created within the safeguarding adult structure, in recognition of increase in demand for safeguarding adult, MCA and DoLS advice and expertise. It is hoped this post will be recruited to within the next quarter.
- The increase in numbers of discussions around adult safeguarding in relation to patient discharges offers an assurance that staff understand the relevance and importance of safeguarding.
- Safeguarding adult training now includes autism awareness training in addition to learning disability training, as the Trust looks to implement the requirements of the Health and Social Care Act 2022, of providing awareness training.

8. 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	**Trust Board – public meeting**	**Date: 26.03.2024**
Report title	**Finance Report February (Month 11) 2023/24**	**Agenda item: 8**
Executive lead	Terry Whittle, Chief Finance Officer	
Report author	Finance Team	
Executive summary	The Trust is reporting a deficit of £16.4m at the end of February which is £6.9m worse than plan. The planned deficit to end of February was £9.5m. 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 • Elective recovery fund (ERF) underperformance. • Other expenditure overspends. Cash position at the end of February was £68.9m. Trust has spent £25.6m on capital to end of February.	
Purpose:	To discuss year to date performance.	
Recommendation	To note year to date financial performance, recognising the need to improve savings delivery.	
Risk Register or Board Assurance Framework	BAF risks Sustainable 1 and Sustainable 2	
Report history	Trust Management Group	
Appendices	None	

CFO Message

Finance Report M11

Trust reporting £16.4m deficit at the end of February - £6.9m worse than plan

The Trust is reporting a deficit of £16.4m at the end of February which is £6.9m worse than plan. The planned deficit to end of February was £9.5m.

Key drivers for adverse year-to-date financial performance are.

- Year to date slippage on saving delivery of £9.8m. The Trust delivered £6.0m savings year to date against a target of £15.8m. The target for the year is £18.0m.
- The year-to-date cost of escalation beds in Thorogood (£0.8m prior to initial closure on 18th August), 4th Endoscopy room (£0.7m after being partially offset by income), and unfunded enhanced care (£1.4m).
- ERF showing £2.3m underperformance year to date. £0.2m in month favourable variance is driven by £0.5m April to December backdated activity, £0.3m February underperformance
- The Trust spent £14.8m on agency staff, 5.0% of total pay costs, this is £1.6m above the year-to-date target set by NHSE. The Discretionary Spend Scrutiny panel is continuing work with the ICSUs to control and monitor agency spend.
- Included in the M11 position is additional funding of £3.1m to cover industrial action impact from December to February.

Cash of £68.1m as at end of February

The Trust's cash balance on 29th February was £68.9m, which is £15.4m favourable to Plan.

Capital spend at end of February was £25.6m

Internally funded capital plan for 2023-24 is £20.1m including a £9.0m allocation to support investment in power and fire remedial works. Capital expenditure on 29th February was £25.6m, of which £8.7m related to PDC (and other externally funded), £15.6m to internally funded projects and £0.6m to IFRS16 leases. The Trust received a further £5m capital funding towards fire remediation. Significant slippage was reported against M11 forecasts for Power, and Fire Remediation. This was offset in part by greater-than-forecast spend against various projects in month. Nationally funded projects include Community Diagnostic Centre and TIF allocation for elective recovery. The Trust is forecasting capital expenditure in-line with the available capital budget (CDEL), subject to management of the usual year-end risks.

Better Payment Practice Performance – 95.9% for non-NHS by value

The Trust is part of 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 97.8% by volume and 95.4% by value. The BPPC for non-NHS invoices is 98.0% by volume and 95.9% by value.

Forecast Outturn

Following the national H2 reforecasting exercise, the Trust submitted a surplus forecast of £1.1m. This forecast is £0.9m adverse to 2023-24 plan. The H2 submission included an assumption around release of non-recurrent benefits to offset slippage against savings target and other expenditure overspends. Any changes to the level of non-recurrent benefit available will impact on the Trust's ability to deliver its forecast. The Trust is continuing to identify both recurrent and non-recurrent mitigations to help deliver its forecast outturn.

1. Summary of Income & Expenditure Position – Month 11

	In Month			Year to Date			
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Annual Budget £'000
Income							
NHS Clinical Income	24,661	31,853	7,192	270,930	292,730	21,800	295,534
High Cost Drugs - Income	817	1,049	233	8,986	11,384	2,398	9,803
Non-NHS Clinical Income	2,027	2,167	140	20,747	22,083	1,336	24,869
Other Non-Patient Income	2,069	2,453	384	22,739	26,609	3,871	24,811
Elective Recovery Fund	4,721	4,951	230	50,607	48,271	(2,336)	55,137
	34,294	**42,473**	**8,179**	**374,009**	**401,078**	**27,069**	**410,154**
Pay							
Agency	(52)	(1,833)	(1,781)	(210)	(14,954)	(14,744)	(234)
Bank	(701)	(3,300)	(2,600)	(3,998)	(30,507)	(26,509)	(4,349)
Substantive	(22,818)	(23,752)	(934)	(266,300)	(252,069)	14,231	(284,866)
	(23,570)	**(28,885)**	**(5,315)**	**(270,508)**	**(297,530)**	**(27,022)**	**(289,450)**
Non Pay							
Non-Pay	(6,238)	(9,280)	(3,042)	(82,533)	(90,310)	(7,777)	(84,893)
High Cost Drugs - Exp	(803)	(893)	(90)	(8,807)	(9,574)	(767)	(9,610)
	(7,041)	**(10,173)**	**(3,133)**	**(91,340)**	**(99,884)**	**(8,544)**	**(94,503)**
EBITDA	**3,684**	**3,415**	**(269)**	**12,162**	**3,665**	**(8,497)**	**26,201**
Post EBITDA							
Depreciation	(1,578)	(1,793)	(215)	(17,171)	(17,266)	(95)	(18,749)
Interest Payable	(79)	(65)	15	(873)	(725)	148	(952)
Interest Receivable	104	320	216	1,146	3,240	2,094	1,250
Dividends Payable	(429)	(479)	(50)	(4,715)	(5,269)	(554)	(5,750)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(1,982)	**(2,017)**	**(35)**	**(21,613)**	**(20,020)**	**1,593**	**(24,201)**
Reported Surplus/(Deficit)	**1,702**	**1,398**	**(304)**	**(9,451)**	**(16,356)**	**(6,904)**	**2,000**
Impairments	0	0	0	0	0	0	0
IFRS & Donated	(8)	(5)	3	(84)	(55)	30	(92)
Reported Surplus/(Deficit) after Impairments and IFRIC12	**1,695**	**1,393**	**(301)**	**(9,536)**	**(16,410)**	**(6,875)**	**1,908**

- The Trust year to date financial position as at the end of February is a deficit of £16.4m (excluding donated asset depreciation and impairments) against a planned deficit of £9.5m. This is £6.9m adverse to plan.

- The main drivers for this position are the under delivery on CIP (£9.8m adverse variance), higher temporary staffing costs, which are partially offset by interest received (£1.2m).

- The reported position includes non-recurrent benefit of £3.6m. The normalised position excluding non-recurrent benefit is £19.9m deficit.

2.0 Income and Activity Performance

2.1 Income Performance – February

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	1,633	1,721	88	18,866	18,459	(407)
Elective	2,255	2,058	(197)	24,175	22,627	(1,548)
Non-Elective	4,620	4,899	280	53,294	53,013	(281)
Critical care	482	467	(16)	5,571	5,069	(502)
Outpatients	4,538	4,510	(28)	48,628	49,287	660
Ambulatory	574	478	(95)	6,627	5,521	(1,106)
Direct access	1,212	1,619	407	12,982	16,744	3,762
Community	6,499	6,499	0	71,487	71,487	0
Other clinical income NHS	3,666	10,652	6,986	38,287	61,855	23,568
NHS Clinical Income	**25,478**	**32,903**	**7,425**	**279,917**	**304,062**	**24,146**
Non NHS clinical income	2,027	2,167	140	20,747	22,083	1,336
Elective recovery fund (ERF)	4,721	4,951	230	50,607	48,271	(2,336)
Income From Patient Care Activities	**32,225**	**40,020**	**7,795**	**351,271**	**374,417**	**23,147**
Other Operating Income	**2,069**	**2,453**	**384**	**22,739**	**26,661**	**3,922**
Total	34,294	42,473	8,179	374,009	401,078	27,069

- Year to date Income is £27.1m over plan, driven mainly by £24.1m NHS clinical income and offset by £2.3m underperformance in ERF income.

- £24.1m NHS clinical income is driven by £7.3m pay awards, £5.3m funding for industrial action (£3.1m M9-M11, £2.2m M1-8), £3m winter monies and risk, £2.5m drugs overperformance, £1.9m foundation trust income (£0.6m CAMHS) and £4.1m various additional NCL ICB income streams.

- £1.3m non-NHS clinical income is driven by £1.2m local authority ADHD hub income

- £3.9m other operating income is mainly driven by £2.3m education & training income, £0.5m procurement shared services, £0.3m R&D, £0.3m COVID-19 reimbursement income and remainder across corporate.

2.2 Elective recovery fund (ERF) – February

- ERF showing £2.3m underperformance year to date. £0.2m in month favourable variance is driven by £0.5m April to December backdated activity, £0.3m February underperformance

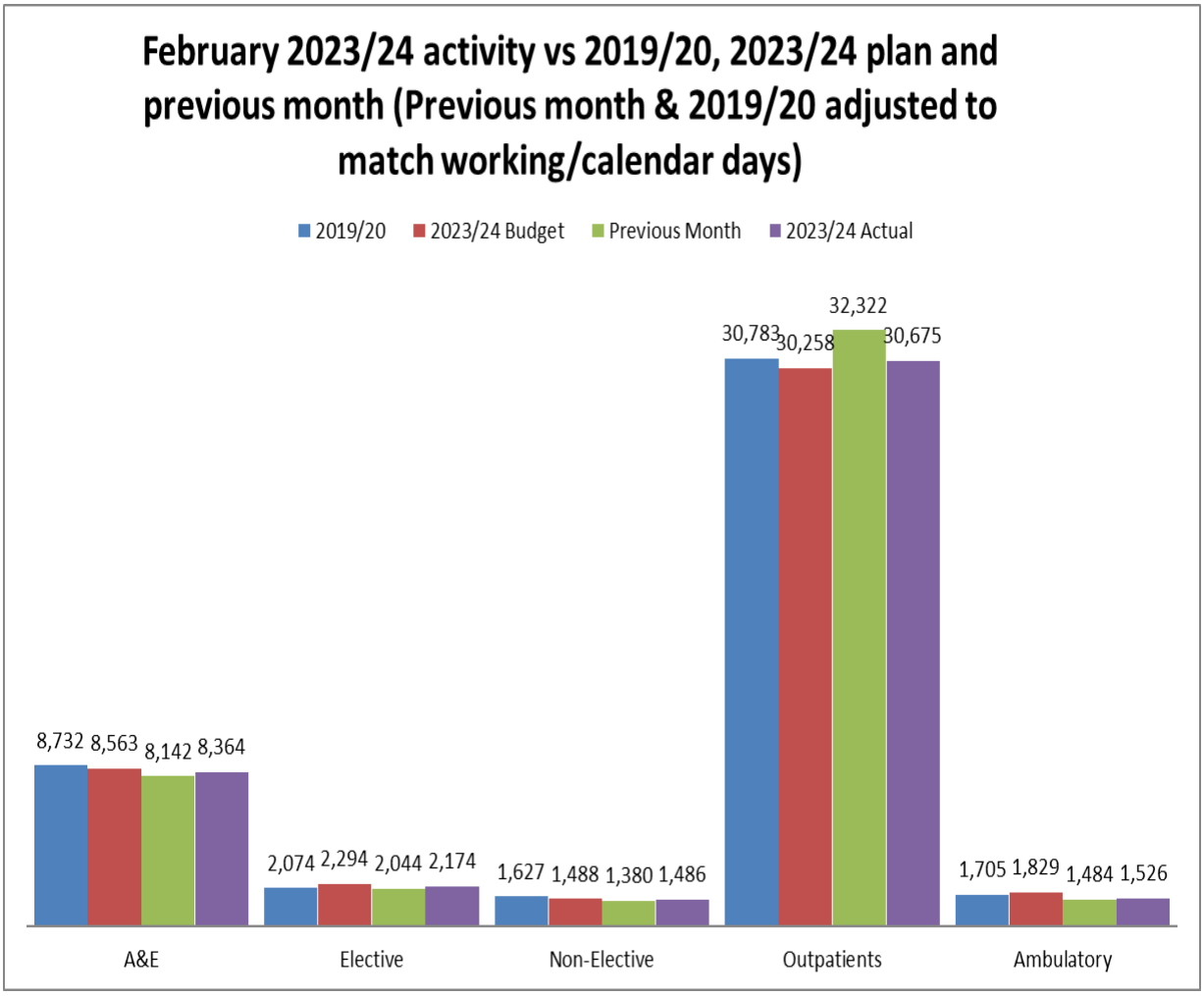
ICSU	Annual Plan £000's	In Month Income Plan £000's	In Month Income Actual £000's	In Month Income Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Income Variance £000's
Acw	6,528	560	450	(110)	5,995	4,939	(1,057)
Adult Community	0	0	0	0	0	0	0
Children & Young People	6,862	588	557	(30)	6,301	5,769	(532)
Emergency & Integrated Medicin	20,656	1,748	1,703	(45)	18,958	17,667	(1,291)
Surgery & Cancer	23,243	1,990	2,022	33	21,343	19,110	(2,234)
Corporate Central	(2,152)	(164)	219	383	(1,990)	788	2,778
Grand Total	55,137	4,721	4,951	230	50,607	48,271	(2,336)

2.3 Activity Performance – February

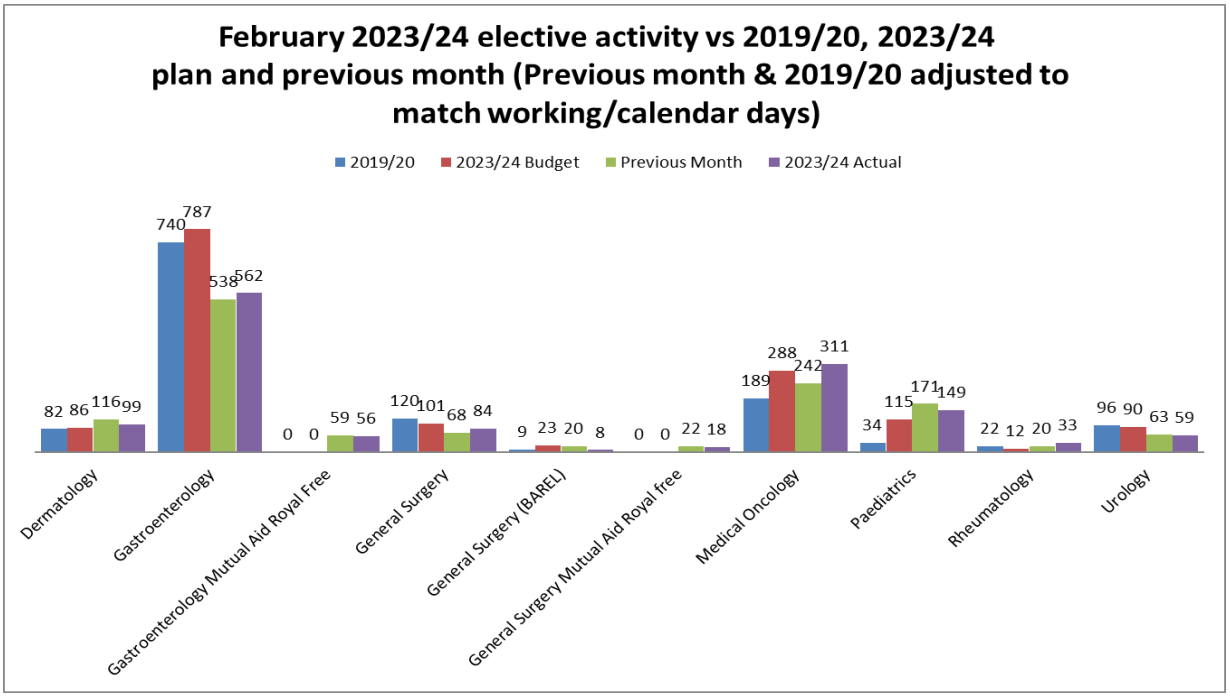
- Activity continues to be underperforming against plan in A&E, ambulatory elective and non-elective inpatients. There was overperformance in outpatients, critical care and direct access (mainly due to pathology).

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	8,563	8,364	(199)	(2%)	98,921	94,329	(4,592)	(5%)
Elective	2,295	2,190	(105)	(5%)	24,593	23,555	(1,038)	(4%)
Non-Elective	1,488	1,486	(2)	(0%)	17,175	16,302	(873)	(5%)
Critical care	293	355	62	21%	3,390	3,592	202	6%
Outpatients	30,261	30,680	419	1%	324,254	341,856	17,602	5%
Ambulatory	1,829	1,526	(303)	(17%)	21,124	17,609	(3,515)	(17%)
Direct Access	98,683	132,776	34,093	35%	1,057,304	1,373,943	316,639	30%

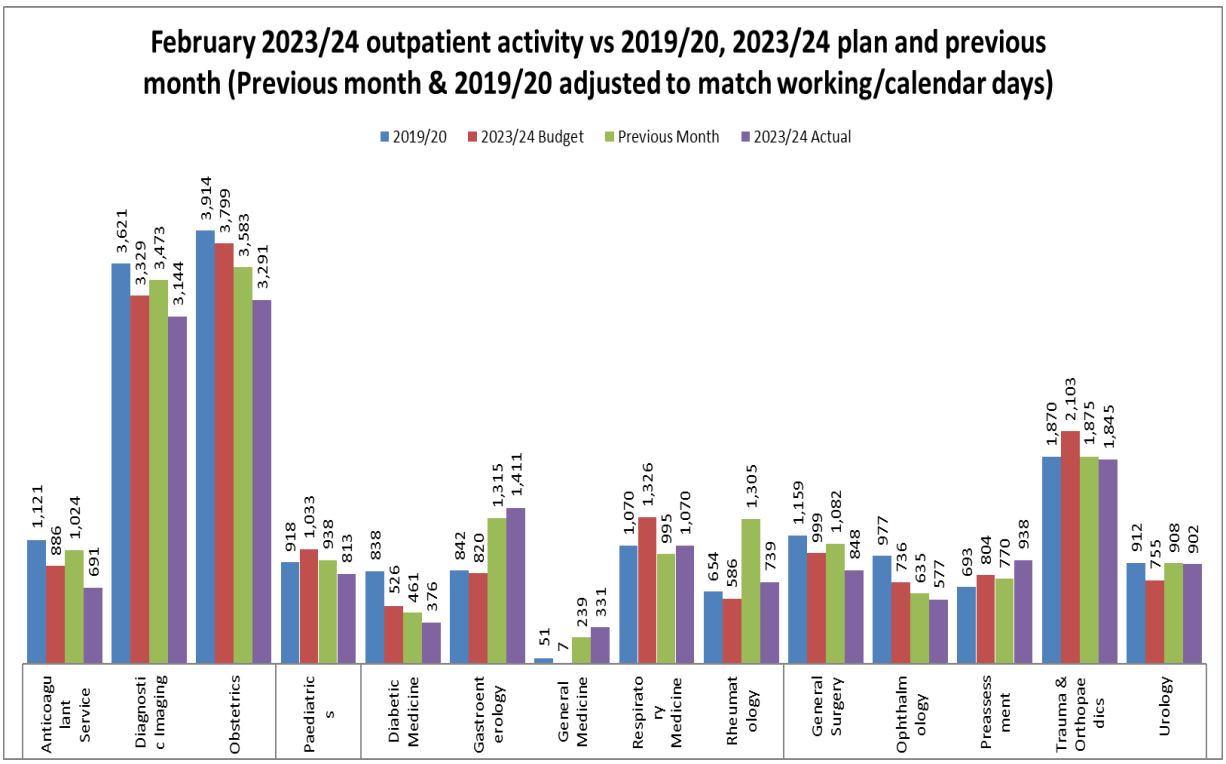
- Activity is slightly higher than January (adjusted for working/calendar days) across all points of delivery, except for outpatients.



- Elective activity is significantly under plan. The largest in month drivers were urology (34%), gastroenterology (21% including RFH) and bariatrics (65%). Offset by overperformance in medical oncology (8%), paediatrics (29%), rheumatology (167%), dermatology (16%), and general surgery (1% including RFH).



1. Outpatients over plan. The main drivers are gastroenterology (72%), rheumatology (26%), urology (19%), preassessment (17%) and general medicine. Offset by underperformance in diabetic medicine (28%), respiratory medicine (19%), anticoagulant (22%) trauma & orthopaedics (12%) obstetrics (13%), paediatrics (21%), ophthalmology (22%), diagnostic imaging (6%), and general surgery (15%)



3. Expenditure – Pay & Non-pay

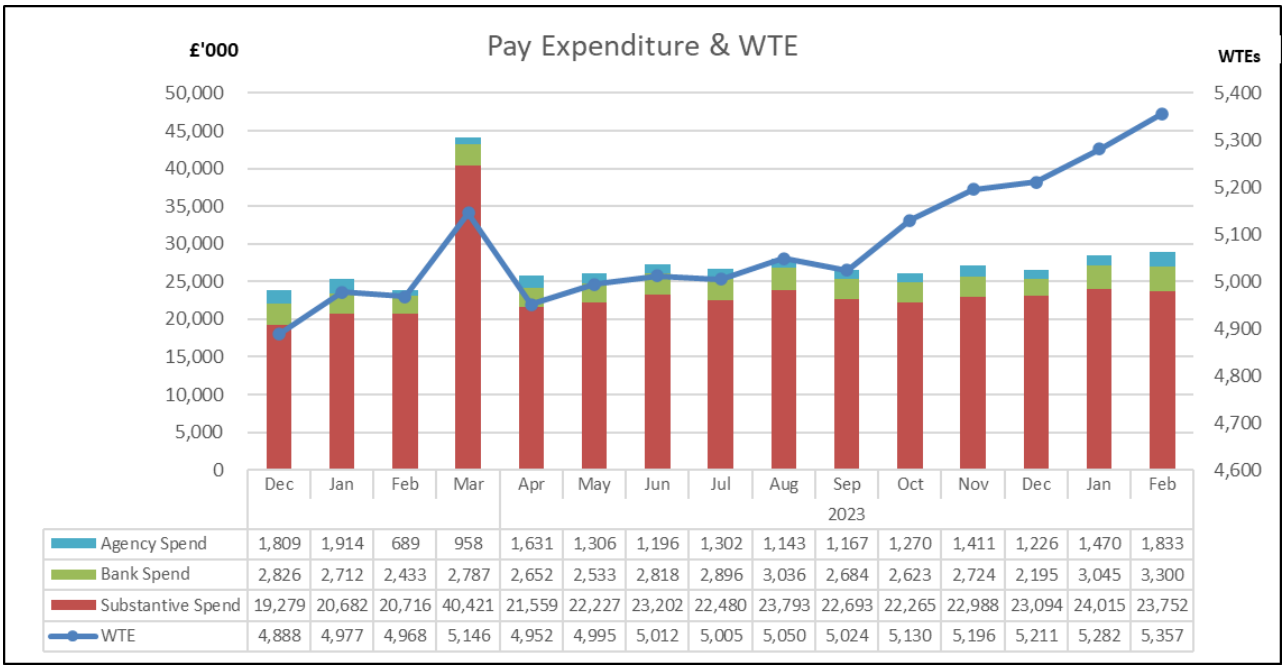
3.1 Pay Expenditure

Pay expenditure for February was £28.8m, an increase of £0.3m from the January position. The increase is due to

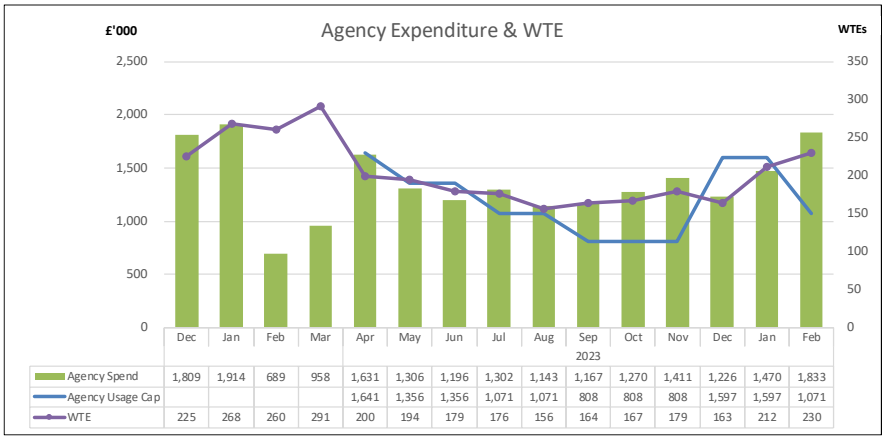
- Additional cost of CEA above assumed run rate (£0.3m)
- Additional cost of industrial action in M11 (£0.3m higher in February)
- Increase in winter pressure costs (£0.2m higher)
- Non-recurrent benefits in non-operational pay of £0.6m

Other operational movements are from unachieved CIPs across all ICSUs which is partly being offset by vacancies and slippages in some of the planned investments.

	2023-24											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mov^t
Agency	1,631	1,234	1,223	1,302	1,143	1,167	1,270	1,411	1,226	1,470	1,833	363
Bank	2,651	2,533	2,817	2,894	3,034	2,684	2,634	2,728	3,031	3,079	3,308	229
Substantive	20,561	20,960	24,015	21,847	22,448	23,751	22,566	22,868	22,974	23,906	23,844	(62)
Total Operational Pay	**24,842**	**24,726**	**28,055**	**26,043**	**26,624**	**27,602**	**26,470**	**27,006**	**27,231**	**28,456**	**28,985**	**529**
Non Operational Pay Costs	999	1,340	(839)	635	1,348	(1,057)	(312)	117	(716)	74	(100)	(174)
												0
Total Pay Costs	**25,841**	**26,066**	**27,216**	**26,678**	**27,973**	**26,544**	**26,158**	**27,123**	**26,515**	**28,530**	**28,885**	**355**



March 2023 substantive pay costs included £11m additional pension contribution from Department of Health and cost of 2022/23 non-consolidated pay award £8.5m.



*2023-24 agency usage cap figures issued by NHSE. Lower spend in Feb & March is due to release of non-recurrent provisions.

3.2 Non-pay Expenditure

Non-pay spend for February was £9.3m, a £1.3m increase from January spend. The increase is mainly due to

- Prior month transfer of expenditure to capital that was charged to revenue (£0.9m)
- Cost of IT project funded via additional income (£0.3m)
- Increase in CDC non-pay cost (£0.1m) offset by reduction in depreciation cost.

	2023-24											
Non-Pay Costs	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mov^t**
Supplies & Servs - Clin	3,112	3,161	3,514	3,523	3,087	3,182	3,214	3,262	3,455	3,230	3,295	65
Supplies & Servs - Gen	333	376	442	310	440	341	391	332	456	585	294	(291)
Establishment	263	240	284	237	273	324	320	334	293	517	278	(239)
Healthcare From Non Nhs	95	79	85	76	80	75	75	56	75	78	45	(33)
Premises & Fixed Plant	2,286	1,924	2,431	2,628	2,030	2,507	2,037	2,287	2,709	1,447	3,447	2,000
Ext Cont Staffing & Cons	193	388	265	13	169	218	127	16	152	114	146	32
Miscellaneous	1,821	1,836	1,295	1,942	669	1,255	1,868	1,732	1,997	1,968	1,765	(204)
Chairman & Non-Executives	9	9	9	9	9	9	9	11	11	11	11	0
Non-Pay Reserve	42	388	(251)	(178)	(5)	5	0	0	0	0	0	0
Total Non-Pay Costs	**8,155**	**8,400**	**8,075**	**8,559**	**6,753**	**7,917**	**8,041**	**8,031**	**9,147**	**7,951**	**9,280**	**1,330**

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

Miscellaneous Expenditure Breakdown

	2023-24											
Miscellaneous Breakdown	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mov^t**
Ambulance Contract	175	206	185	172	199	139	207	137	174	186	178	(8)
Other Expenditure	155	85	166	100	(483)	66	92	60	120	288	146	(142)
Audit Fees	15	12	(17)	11	13	11	11	11	11	11	11	0
Provision For Bad Debts	65	94	(238)	250	(596)	(212)	57	(34)	34	(55)	(115)	(59)
Cnst Premium	821	821	821	821	821	577	780	778	765	761	741	(20)
Fire Security Equip & Maint	5	5	6	10	7	13	4	47	2	7	4	(3)
Interpretation/Translation	27	8	31	21	14	21	10	102	36	20	(5)	(24)
Membership Subscriptions	125	159	117	161	135	146	146	149	61	127	154	28
Professional Services	355	354	115	288	495	399	387	389	374	450	518	69
Research & Development Exp	(1)	(1)	(1)	4	12	(1)	8	6	286	(13)	3	17
Security Internal Recharge	10	11	14	13	(0)	12	10	7	10	10	9	(1)
Teaching/Training Expenditure	66	77	92	89	49	84	152	73	124	173	116	(58)
Travel & Subs-Patients	2	4	4	1	4	0	5	7	0	3	3	(0)
Work Permits	0	0	0	0	0	0	0	0	0	0	0	0
Write Down Of Inventories	0	0	0	0	0	0	0	0	0	0	0	0
Total Non-Pay Costs	**1,821**	**1,836**	**1,295**	**1,942**	**669**	**1,255**	**1,868**	**1,732**	**1,997**	**1,968**	**1,765**	**(204)**

3.3 Cost Improvement Programmes (CIP)

The CIP target for 2023-24 is £18.0m. The targets have been allocated to ICSU and corporate divisions as part of 2023-24 budgets.

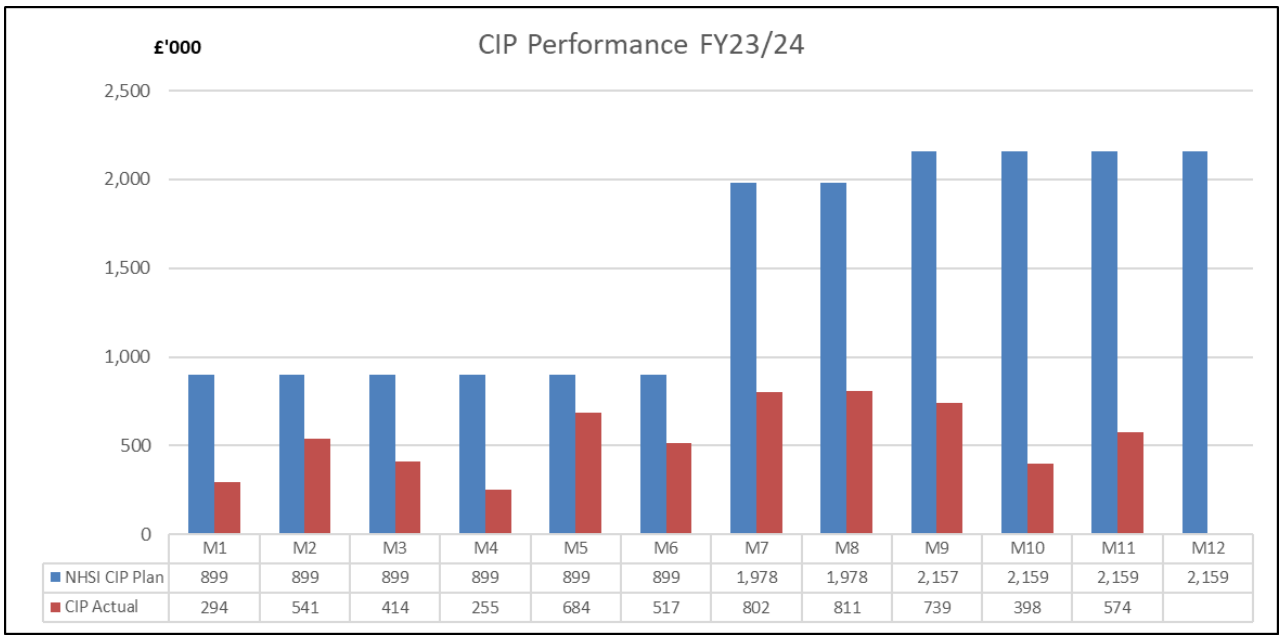
ICSU	23/24 CIP Target Allocated £'000
ADULT COMMUNITY	1,683
CHILDREN & YOUNG PEOPLE	2,525
EMERGENCY & INTEGRATED MEDICINE	3,171
SURGERY & CANCER	3,054
ACW	3,424
ICSU TOTAL	**13,857**
CORPORATE SERVICES TOTAL	4,127
CIP GRAND TOTAL	**17,984**

CORPORATE DIRECTORATES	23/24 CIP Target Allocated £'000
CHIEF OPERATION OFFICER	131
ESTASTES & FACILITIES	2,130
FINANCE	355
ICT	511
MEDICAL DIRECTOR	130
NURSING & PATIENT EXPERIENCE	352
TRUST SECRETARIAT	139
WORKFORCE	325
PROCUREMENT	54
CORPORATE TOTAL	**4,127**

Year to Date Actuals

At the end of February, the Trust is reporting actual delivery of £6.0m year to date of CIP against a target of £15.8m (38% of the YTD plan).

ICSU	23/24 CIP Target Allocated £'000	YTD Plan £'000	YTD Actuals £'000	YTD Variance £'000	YTD Actuals vs YTD Plan %
ADULT COMMUNITY	1,683	1,481	789	(692)	53.3%
CHILDREN & YOUNG PEOPLE	2,525	2,222	1,150	(1,072)	51.7%
EMERGENCY & INTEGRATED MEDI	3,171	2,790	199	(2,592)	7.1%
SURGERY & CANCER	3,054	2,688	926	(1,761)	34.5%
ACW	3,424	3,013	1,005	(2,008)	33.4%
ICSU TOTAL	**13,857**	12,194	**4,068**	**(8,126)**	**33.4%**
CORPORATE SERVICES	1,943	1,710	1,633	(77)	95.5%
ESTATES & FACILITIES	2,130	1,874	328	(1,547)	17.5%
PROCUREMENT	54	48	-	(48)	0.0%
CIP GRAND TOTAL	**17,984**	**15,826**	**6,029**	**(9,797)**	**38.1%**



4.0 Statement of Financial Position (SoFP)

The net balance on the Statement of Final Position as of 29th February 2024 is £241.7m, £8.5m higher than January 2024, as shown in the table below.

Statement of Financial Position as at 29th February 2024	2022/23 M12 Balance	2023/24 M10 Balance	2023/24 M11 Balance	Movement in Month
	£000	£000	£000	£000
NON-CURRENT ASSETS:				
Property, Plant And Equipment	230,044	229,448	240,073	10,624
Intangible Assets	7,051	6,059	5,911	(148)
Right of Use Assets	36,444	40,449	43,338	2,889
Assets Under Construction	31,917	40,807	35,064	(5,742)
Trade & Other Rec -Non-Current	584	523	555	31
TOTAL NON-CURRENT ASSETS	**306,040**	**317,286**	**324,941**	**7,655**
CURRENT ASSETS:				
Inventories	942	1,052	1,186	134
Trade And Other Receivables	25,881	18,182	20,473	2,291
Cash And Cash Equivalents	72,991	62,094	68,903	6,810
TOTAL CURRENT ASSETS	**99,813**	**81,328**	**90,562**	**9,234**
CURRENT LIABILITIES				
Trade And Other Payables	(80,777)	(80,088)	(88,111)	(8,023)
Borrowings: Finance Leases	(808)	61	148	87
Borrowings: Right of Use Assets	(4,370)	(4,370)	(4,370)	0
Borrowings: Dh Revenue and Capital Loan - Current	(116)	(116)	(116)	0
Provisions for Liabilities and Charges	(1,774)	(1,716)	(585)	1,131
Other Liabilities	(2,701)	(6,320)	(3,927)	2,393
TOTAL CURRENT LIABILITIES	**(90,545)**	**(92,549)**	**(96,961)**	**(4,412)**
NET CURRENT ASSETS / (LIABILITIES)	**9,268**	**(11,221)**	**(6,399)**	**4,822**
TOTAL ASSETS LESS CURRENT LIABILITIES	**315,309**	**306,065**	**318,541**	**12,477**
NON-CURRENT LIABILITIES				
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,624)	(1,566)	(1,566)	0
Borrowings: Finance Leases	(3,011)	(3,011)	(3,011)	0
Borrowings: Right of Use Assets	(32,250)	(36,403)	(39,284)	(2,881)
Provisions for Liabilities & Charges	(31,963)	(31,842)	(32,958)	(1,116)
TOTAL NON-CURRENT LIABILITIES	**(68,848)**	**(72,822)**	**(76,818)**	**(3,996)**
TOTAL ASSETS EMPLOYED	**246,460**	**233,243**	**241,723**	**8,480**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	120,707	125,293	132,380	7,087
Retained Earnings	25,454	7,650	9,043	1,393
Revaluation Reserve	100,300	100,300	100,300	0
TOTAL TAXPAYERS EQUITY	**246,460**	**233,243**	**241,723**	**8,480**

The most significant movements in the month to 29th February 2024 were as follows:

NON-CURRENT ASSETS

Asset Under Construction closed at £35.1m in February, a net decrease of £5.7m from previous month due Wood Green Community Diagnostics Centre Phase 2 transfer from AUC to completed Asset £12.0m and in month capital expenditure spend £5.9m.
A remeasurement or Right use of Asset also account in M11 for seven building which resulted an increase the total asset value by £3.4m

CURRENT LIABILITIES

Trade and Other Payables closed at £88.1m in February 2024, an increase of £8.0m. This is aged creditors NHS £6.00m & Temp staff accrual £1.1m

Other Liabilities closing at £3.93m in February 2024, a reduction of £2.4m. This is mainly deferred income from winter pressure funding & Industrial action.

TAXPAYERS EQUITY- a total of £7.1m of Public Dividend Capital (PDC) was drawn down in February in respect of the Fire (£5.0m), CDC Phase 2 (£0.5m) and Digital Diagnostics (£0.1m) programmes.

CASH
The Trust's cash balance at 29th February was £68.9m, which is £15.4m favourable to Plan.

The Trust continues to monitor its actual and forecast cash position against Plan. The current favourable variance is predominantly due to the arrival of PDC in advance of the cash payment of capital creditor invoices.

Interest Received
Year-to-date interest received is £3.2m which is favourable to Plan by £2.0m. The Plan was set with an anticipated peak to interest rates around Month 6-7 of the 2023-24 financial year and expected reduction in cash balances during the year. Work with the PMO team determined that the amount of £0.4m can be identified as CIP with minimal risk, whilst having regard to interest rate and cash balance reductions as the year progresses.

5.0 Capital Expenditure

Capital expenditure on 29th February was £25.6m, of which £8.7m related to PDC (and other external) -funded, £15.6m to internally funded projects and £0.6m to IFRS16 leases.

The table below details progress against internally funded capital, including performance against M11 forecast. Significant slippage was reported against M11 forecasts for Power, and Fire Remediation. This was offset in part by better-than-forecast spend against various projects in month. The risk around slippage against forecast is managed through regular meetings with the project leads and the Capital Monitoring Group chaired by the Chief Finance Officer. For Month 12, the most significant projects at risk of slippage are subject to separate, dedicated reviews to minimize the likelihood of late notified capital scheme underspends.

	YTD Actuals	Annual Plan	Project lead Forecast outturn	YTD spend as % of Annual plan	M11 Actuals	Forecast for M11	Variance from M11 forecast
	£(000)	£(000)	£(000)		£(000)	£(000)	£(000)
Internally Funded:							
Estate							
Estates 2324	1,452	2,292	2,749	63.4%	283	164	119
Estates PY 2223	2,363	1,208	2,205	195.6%	265	0	265
Strategic Projects							
M & N	1,551	1,000	2,000	155.1%	623	700	(78)
Power	2,807	7,240	5,790	38.8%	1,076	2,359	(1,283)
Fire Safety A and L Blocks	4,080	5,000	5,000	81.6%	915	1,511	(596)
Salary recharge capital	269	250	350	107.7%	19	38	(19)
New Block C LV Switch Room	93	0	350				
Salix	21	0	48		0	0	0
ICT	1,015	512	2,540	198.2%	617	83	534
Equipment	730	500	2,018	145.9%	187	0	187
Contingency	77	260	204	29.4%	15	0	15
MES Enabling work	814	860	860	94.6%	145	58	88
Pathology	126	600	126	21.0%	69	0	69
ICSUs	188	355	317	52.8%	47	0	47
VAT			0				
Total Internally Funded	**15,585**	**20,077**	**24,557**	**77.6%**	**4,261**	**4,912**	**(651)**

The Trust accepted a £5.0m increase to CDEL for fire remediation towards the end of December 2023, and PDC has been requested for draw down in March.

The TIF project underspent its Month in-month forecast by £0.3m. The project has total purchase order (PO) commitment of £1.6m of which £1.1m Estate work and £0.5m for medical equipment purchase and PO's will be receipted on delivering the goods/work completed prior to the 31st of March 2004.

Within the above figures, purchase orders have been raised for the MES Enabling project, which carries a £0.8m accrual to budget, and is expected to complete for 31st March 2024.

	YTD Actuals	Plan	Additional Approval	Annual Plan	Project lead Forecast outturn
	£(000)	£(000)	£(000)	£(000)	£(000)
Externally funded (PDC):					
Wood Green CDC	**7,659**	8,350		8,350	7,869
LIMS & Interoperability	**36**	44		44	44
DDC: Image Sharing	**1**	72		72	72
TIF: Relocation of Recovery	**1,029**	3,595		3,595	3,595
Fire Safety A and L Blocks	9	0	5,000	5,000	3,225
Cyber Improvement Programme £93k					93
Digital Pathology	0	87		0	0
Total Externally Funded	**8,734**	**12,148**	**5,000**	**17,061**	**14,898**
ROU funded (Leases):					
MES finance lease untrasound	0	0		0	0
Wood Green CDC 2 RoU	579	579		579	579
Total ROU	**579**	**579**	**0**	**579**	**579**

Restatement of leases:

The Trust has evidenced rental increases for seven of its 25 leased properties in 2023/24, and in accordance with IFRS16 these must be restated. NCL ICB has been alerted of the projected additional impact of £3.4m against CDEL for remeasurement of these leases. This figure is not included above. Management of the CDEL pressure is being discussed with NCL ICB.

Meeting Title	**Trust Board – public meeting**	**Date:**	**26 March 2024**
Report Title	**Integrated Performance Report**	**Agenda Item:**	**9**
Executive lead	Jonathan Gardner, Chief Strategy, Digital and Improvement Officer		
Report Owner	Paul Attwal, Head of Performance, Jennifer Marlow, Performance Manager		
Executive Summary	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. This report should be read in the context of considerable pressures of high demand in our urgent care and elective care pathways as a result of industrial action. The organisation has put considerable effort at every level to mitigate these issues where possible. **Emergency Care Flow** During February 2024, performance against the 4-hour access standard was 70.8%, which is improving and higher than the NCL average of 68.81%, but lower than the London average of 73.15% and the national average of 70.92%. There were 221 12-hour trolley breaches in February 2024. **12-hour trolley breaches show the numbers of patients who waited longer than 12 hours to be admitted to the ward following a decision to admit (DTA)* **Cancer** 28 Day Faster Diagnosis was at 70% in January 2024 against the standard of 75%. This is a worsening of 9.5% compared to 79.5% in December 2023. 62-day referral to treatment performance was at 54.4% for January 2024 against a target of 85%. This is a worsening of 7.4% compared to 61.8% in December 2023 At the end of February 2024, the Trusts position against the 62-day backlog was ahead of trajectory with 48 patients against a target of 60. **Referral to Treatment: 52+ Week Waits** Performance against 18-week standard for February 2024 was 66.5%, this is a worsening of 0.1% from January's performance of 66.6%. The Trust position against the 52-week performance has improved from 607 patients waiting more than 52-weeks for treatment in January 2024 to 500 in February 2024. The Trust had 17 patients over 78-weeks at the end of January 2024 against a target of 0. All providers are expected to have zero 78-week breach patients by 31st March 2024. **Workforce** Appraisal rates for February 2024 were at 81.4%, this is an improvement of 1.2% from January's performance of 80.2%. Work continues to support service areas to improve overall compliance. December's performance for Mandatory was not available at time of publication.		

	Complaints Complaints Responded to Within 25 or 40 Working Days has improved from 61.5% in January 2024 to 62.5% in February 2024, but remains below the required standard of 80%. The Complaints Team continue to work closely with the ICSUs to support with the completion of these and all complaint investigations.
Purpose:	Review and assurance of Trust performance compliance
Recommendation	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan
Risk Register or Board Assurance Framework	The following BAF entries are linked: Quality 1; Quality 2; People 1; and People 2.
Report history	Trust Management Group

Whittington Health NHS Trust

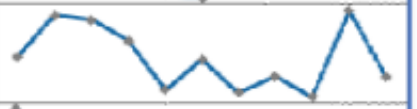
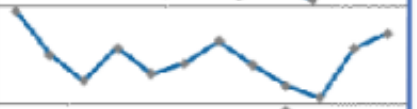
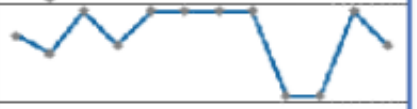
Performance Report

March 2024

Month 11 (2023-2024)

Community - Performance Dashboard

NHS Whittington Health NHS Trust

Indicator	Target	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	2023-2024	Activity
IAPT Moving to Recovery	50.0%	52.5%	48.7%	50.0%	49.9%	44.5%	43.8%	46.8%	45.5%	45.2%	52.5%	48.1%		47.4%	
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	93.3%	96.2%	95.9%	94.4%	90.9%	93.1%	90.7%	91.9%	90.4%	96.6%	91.9%		93.1%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	91.5%	81.7%	75.8%	83.3%	77.5%	79.8%	84.7%	79.5%	74.8%	72.0%	83.1%	86.5%	79.9%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	87.5%	83.3%	75.0%	61.8%	78.3%	81.8%	66.7%	81.8%	93.8%	83.3%	69.6%	88.2%	76.4%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	75.3%	77.4%	70.4%	74.3%	70.9%	71.6%	72.0%	71.2%	73.9%	70.4%	70.3%	71.3%	71.9%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	95.5%	87.7%	94.7%	89.1%	91.1%	89.7%	91.7%	91.7%	95.3%	88.9%	91.5%	90.3%	91.3%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	85.7%	75.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	50.0%	50.0%	100.0%	80.0%	86.0%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 weeks	>45%	54.3%			51.9%			54.1%			55.6%			53.8%	

ICARE EQUITY

Adult Community - Waiting Times

Whittington Health NHS Trust

Indicator (Urgent Appointments)	Target	Target Weeks	Dec-23	Jan-24	Feb-24	Average Wait (Latest Month)	No. of Patients Seen
Community Matron	>95%	6	100.0%	93.8%	100.0%	1.8	21
Adult Wheelchair Service	>95%	8	100.0%	98.0%	98.3%	1.4	60
Community Rehabilitation (CRT)	>95%	12	78.7%	78.0%	71.8%	11.5	39
ICTT - Other	>95%	12	100.0%	99.4%	99.3%	4.1	140
ICTT - Stroke and Neuro	>95%	12	77.8%	40.9%	14.3%	12.9	14
Home-based Intermediate Care Service	>95%	-	90.8%	92.8%	88.8%	3.5	80
Paediatric Wheelchair Service	>95%	8	100.0%	100.0%	60.0%	6.9	5
Bladder and Bowel - Adult	>95%	12	46.2%	48.4%	44.1%	13.3	136
Musculoskeletal Service - CATS	>95%	6	24.7%	30.2%	32.0%	13.3	488
Musculoskeletal Service - Routine	>95%	6	34.4%	34.3%	28.8%	19.0	1410
Nutrition and Dietetics	>95%	6	97.7%	94.2%	96.7%	2.9	151
Podiatry (Foot Health)	>95%	6	29.5%	31.1%	41.9%	10.4	449
Lymphodema Care	>95%	6	15.4%	36.8%	58.3%	6.3	12
Tissue Viability	>95%	6	97.9%	100.0%	100.0%	2.1	49
Cardiology Service	>95%	6	98.2%	90.3%	94.5%	2.6	73
Diabetes Service	>95%	6	100.0%	90.1%	79.8%	3.9	124
Respiratory Service	>95%	6	33.7%	69.8%	56.7%	6.2	67
Spirometry Service	>95%	6	100.0%	100.0%	100.0%	3.5	71
Integrated MDT	>95%	6	91.6%	83.2%	93.9%	1.8	163
Self-Management	>95%	6		59.5%	57.1%	6.5	14
Covid	>95%	6	71.4%	88.9%	93.8%	1.8	16
Indicator (Urgent Appointments)							
Community Rehabilitation (CRT)	>95%	2	42.9%	45.0%	38.5%	9.7	13
ICTT - Other	>95%	2	0.0%	21.4%	14.3%	6.7	7
ICTT - Stroke and Neuro	>95%	2	55.6%	20.0%	66.7%	1.3	3
Home-based Intermediate Care Service	>95%	-	89.7%	92.9%	89.2%	1.0	83
Musculoskeletal Service - CATS	>95%	2	25.0%	11.1%	50.0%	2.4	4
Musculoskeletal Service - Routine	>95%	2	57.8%	60.1%	59.2%	2.3	103
Nutrition and Dietetics	>95%	2	100.0%	100.0%			0

Adult Community Waiting Times

Podiatry

The service continues to see an improvement in overall waiting list size and is now below 30 weeks and there has been some recovery with referrals in January 1870, February 1700, and March 1607. PIFU continues to support overall reduction in the number of follow-ups needed as patients will not return for a follow up if they are improving and self-managing.

Islington Community Neuro-Rehabilitation (ICRT)

Workforce issues affecting the waiting times which are a combination of sickness, annual leave and vacancies coupled with post covid recovery. Ongoing work on recruitment and skill mix to see if this will help staff recruitment and retention. This continues to be an area of concern and this service is also included on the risk register

Bladder and Bowel Service

Due to being a fragile service recovery plans are underway; however recruitment has been unsuccessful, and the service is now looking at other options to ensure sustainability within the service.

MSK

MSK backlog figures for January 2024 were at 12046 and has reduced in February to 10685. Reduction in waiting list continues as a result of utilising Super Saturdays, GetUBetter app, and Community Appointment Day. The service is now fully recruited, and this will support a further reduction in waiting times over the coming months.

The MSK service piloted a MSK Community Assessment Day in Haringey, which saw over 300 patients of which 45% no longer required follow-up. Feedback from staff and patients was positive, evaluation to be carried out to support delivery within Islington.

ICARE EQUITY

Children's Community – Waiting Times

Whittington Health NHS Trust

Indicator (Routine Appointments)	Target	Target Weeks	Dec-23	Jan-24	Feb-24	Average Wait (Latest Month)	No. of Patients Seen
CAMHS	>95%	8	59.8%	57.5%	52.1%	17.7	234
Community Children's Nursing	>95%	6	98.2%	59.0%	62.8%	3.8	61
Community Paediatrics - Haringey	>95%	18	94.3%	97.7%	91.9%	5.7	37
Community Paediatrics - Islington	>95%	18	100.0%	100.0%	92.3%	6.3	13
Haringey - SCT	>95%	20	0.0%	0.0%	0.0%	53.0	27
Islington SCT (0-5s)	>95%	20	0.0%	32.0%	3.8%	48.4	26
CLA Initial Assessments - Haringey	>95%	4	83.3%	62.5%	66.7%	5.6	9
CLA Initial Assessments - Islington	>95%	4	66.7%	92.3%	83.3%	3.3	6
Occupational Therapy - Barnet	>95%	18	70.6%	92.0%	97.5%	11.5	40
Occupational Therapy - Haringey	>95%	18	94.1%	100.0%	100.0%	8.0	19
Occupational Therapy - Islington	>95%	18	66.7%	5.0%	18.2%	28.4	33
Paediatrics Nutrition & Dietetics - Haringey	>95%	12	100.0%	100.0%	93.3%	5.9	15
Paediatrics Nutrition & Dietetics - Islington	>95%	12	100.0%	100.0%	100.0%	4.5	13
Physiotherapy - Barnet	>95%	18	97.0%	96.6%	97.5%	7.8	40
Physiotherapy - Haringey	>95%	18	100.0%	98.9%	98.2%	5.9	56
Physiotherapy - Islington	>95%	18	100.0%	97.2%	98.3%	5.2	59
PIPS	>95%	12	100.0%	100.0%	100.0%	2.9	6
SALT - Barnet	>95%	18	32.8%	33.3%	40.0%	26.8	45
SALT - Camden	>95%	6	75.0%	47.2%	46.8%	8.4	47
SALT - Haringey	>95%	13	34.4%	24.5%	27.5%	17.7	80
SALT - Islington	>95%	13	76.9%	68.4%	88.0%	7.3	25
SALT - MPC	>95%	18	94.4%	79.3%	100.0%	4.2	37
School Nursing - Haringey	>95%	12	97.2%	92.5%	95.3%	3.3	64
School Nursing - Islington	>95%	12	96.9%	100.0%	87.7%	3.7	57
Indicator (Urgent Appointments)							
CAMHS	>95%	2	88.2%	80.0%	90.9%	1.4	11
Community Children's Nursing	>95%	1	100.0%	100.0%	100.0%	0.1	6

Indicator	Target	Current Month		Previous Month	2023-2024
Haringey New Birth Visits - % Seen Within 2 Weeks	>95%	Jan	95.9%	89.2%	92.4%
Islington New Birth Visits - % Seen Within 2 Weeks	>95%	Jan	92.8%	92.7%	94.7%

Children's Community Waits

Community Children's Nursing: The waits relate to Primary Care Nursing cases and have all been triaged. A shortage of administrative support has caused a delay in updating notes and ensuring appointments are outcomed. Support is now in place and an improvement is expected in March.

Children Looked After: Timeframes for completion of initial health assessments are monitored closely. The small numbers mean that a few delays have a significant impact on reported performance. Providers across NCL are discussing the challenge of completing initial reviews within timeframe, aiming to agree actions with local authority partners to improve performance.

Autism Assessments: Sustained increased demand for assessments continues to have an impact on waiting times in Haringey and Islington.

Providers across NCL are working to improve and ensure consistency of the assessment model. Providers are also working with commissioners to secure additional investments in assessment services to support a reduction in waiting times.

Therapy services: Occupational Therapy waiting times in Islington have risen due to increases in demand for the service. Work with the local authority is progressing to roll out the universal training offer to schools to help reduce referrals and are also exploring options to increase the capacity of the service.

In Barnet the SLT service is working to capacity with staffing available for assessment. The Universal offer may lead to a decrease in referral rates over time, in the meantime non-recurrent funding will be used in 2024/2025 to provide additional assessment capacity.

In Camden vacancies in the mainstream school SLT service have impacted on performance. Recruitment to posts is underway

Islington CAMHS: The majority of CAMHS teams continue to offer first contacts within the 8-week waiting time target. Long waiting times continue to be seen in the CAMHS Therapies team and the NDT. For the former, waiting times have improved faster than predicted following recurrent ICB investment in 2023/2024 and a revised model.

ICARE EQUITY

Safe

Indicator	Target	Current Month		Previous Month	2023-2024	Variation	Assurance
Admissions to Adult Facilities of Patient <16 Years	0	Feb	0	0	0		
HCAI C Difficile	<13	Feb	5	1	18		
Actual Falls	400	Feb	30	39	317		
Category 3 or 4 Pressure Ulcers	64	Feb	18	9	120		
Medication Errors Causing Serious Harm	0	Feb	0	0	1		
MRSA Bacteraemia Incidences	0	Feb	0	0	1		
Never Events	0	Feb	0	0	2		
Serious Incidents	N/A	Feb	2	0	10		
VTE Risk Assessment %	>95%	Feb	95.9%	94.4%	95.2%		
Mixed Sex Accomodation Breaches	0	Feb	8	12	92		
Summary Hospital Level Mortality Indicator (SHMI)	1.14	July 2022 - June 2023	0.94		0.93		

Category 3 or 4 Pressure Ulcers - *Target 0*

February Performance – 18 pressure ulcers on 17 patients

Category 3 = 12 (2 in hospital, 10 in the community)

Category 4 = 6 (1 in hospital, 5 in the community)

Issues: Five category 4 (community acquired) pressure ulcers were reported as unstageable in a previous month but have since debrided; frailty, visit allocations, equipment utilisation and concordance with care planning were contributory factors in all community pressure damage. The hospital acquired category 4 occurred on a critically unwell septic patient with multi-co-morbidities, with learning identified. The two hospital category 3 pressure ulcers developed on high risk, multi co-morbidity patients, with learning identified around effective repositioning and escalation.

Actions:

- Ongoing fortnightly Pressure Ulcer Oversight Group for senior leadership in ACS to review pressure ulcers issues and removing barriers to implementing actions
- After action reviews being undertaken on hospital acquired category 3 & 4 pressure ulcers.
- Ongoing implementation of Trust Pressure Ulcer Improvement action plan and multi-format education programmes including service users/carers.
- Senior Nursing Team have been out shadowing community teams to look at pressure area care being planned, delivered and engage with staff to understand the issues. ACS Nursing Lead visiting other NCL community Trust with exemplar pressure ulcer incidence data to liaise and compare practices

HCAI C. Difficile - *Target <13 in Year*

February Performance – 5

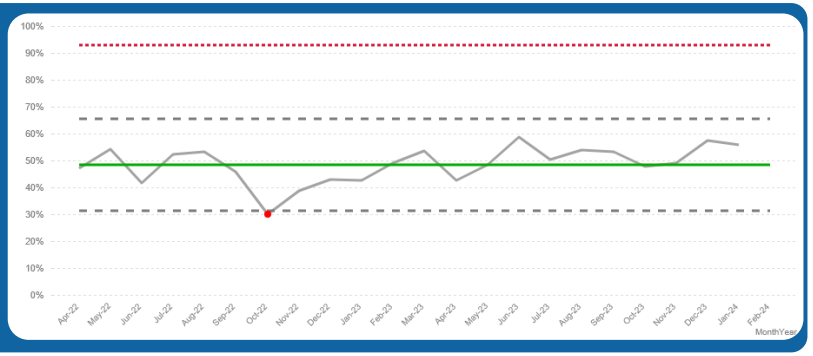
This is a worsening of 4 compared to 1 in January 2024.

- February's CDI cases were reviewed by the Multi-disciplinary team and were deemed unavoidable healthcare acquired infections. On review there was no inappropriate antibiotic stewardship and each case had unavoidable clinical risk(s) of CDI associated with their care from admission.

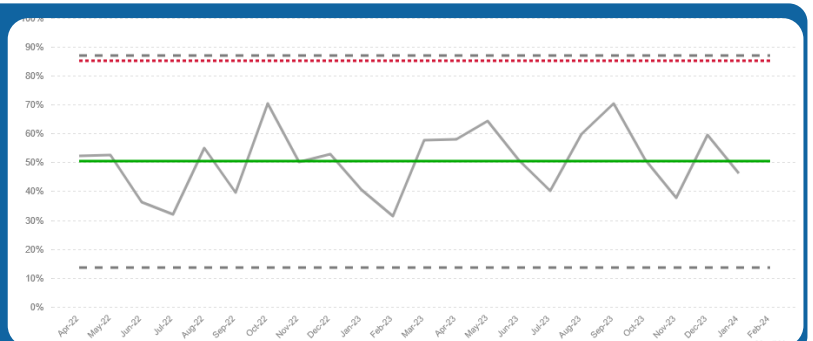
Responsive - Access

Indicator	Target	Current Month		Previous Month	2023-2024	Variation	Assurance
Cancer - 14 Days to First Seen	>93%	Jan	55.7%	57.5%	51.8%		F
Cancer - 14 Days to First Seen - Breast Symptomatic	>93%	Jan	24.1%	25.9%	12.1%		F
Cancer - 62 Days From Referral to Treatment	>85%	Jan	46.2%	59.4%	53.3%	L	F
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%	Jan	47.1%	60.3%	51.2%	L	F
Cancer ITT - % Of Pathways Sent Before 38 Days	>85%	Jan	25.0%	50.0%	23.4%	L	F
Cancer - % Pathways Received a Diagnosis Within 28 Days of Referral	>75%	Jan	70.0%	79.5%	66.7%	L	?
Cancer - 31 Days to First Treatment	>96%	Jan	81.8%	92.5%	93.4%	L	F
Cancer - 62 Day Screening	>90%	Jan	54.4%	61.8%		L	F
DM01 - Diagnostic Waits (<6 Weeks)	>99%	Feb	94.6%	91.8%	86.2%		F
RTT - Incomplete % Waiting <18 Weeks	>92%	Feb	66.5%	66.6%	66.3%		F
Referral to Treatment 18 Weeks - 52 Week Waits	0	Feb	500	607	7507		F
% Seen <=48 Hours of Referral to District Nursing Service	>95%	Feb	96.4%	93.9%	91.5%		F
% Of Rapid Response Urgent Referrals Seen Within 2 Hours of Referral		Feb	55.9%	65.8%	71.2%	L	

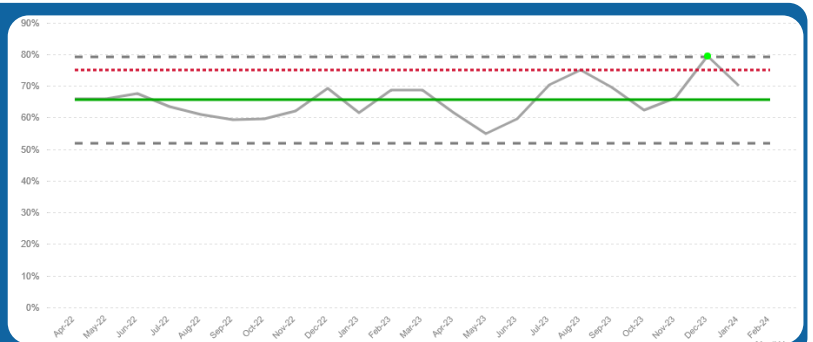
Cancer - 14 Days to First Seen



Cancer - 62 Day Performance



Cancer - 28 Day FDS



Responsive - Access

Whittington Health NHS Trust

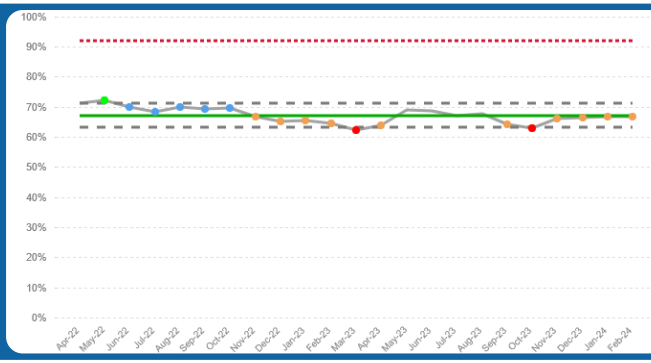
What the Data Tells Us	Issues	Actions
Cancer: 14-Days to First Seen - *Target >93%* *No. of pts first seen by a specialist within two weeks of referral.* **January Performance – 55.7%** This is a worsening of 1.8% compared to 57.5% in December 2023	• Breast 1st Outpatient appointment average wait time in January was 20 days. • Dermatology average wait time for 1st Outpatient appointment was 22 days. • Industrial action (IA) from December and in January also impacted all services with reduced clinic capacity.	• Continuation of additional capacity for Rapid Access Clinics for Gynaecology funded by NCL Cancer Alliance till March 2024 – Business case to support demands of Gynaecology in progress. • Dermatology and Breast continuing with additional weekend activity to meet referral demands and reduce wait times for 1st Outpatient appointment. • Referral patterns continued to be monitored throughout all tumour groups to plan and provide appropriate capacity where possible.
Cancer: 28-Day Faster Diagnosis Standard (FDS) - *Target >75%* *% Pathways Received a Diagnosis within 28 Days of Referral.* **January Performance – 70%** This is a worsening of 9.5% compared to 79.5%. in December 2023	• Except for the lung pathway, all tumour groups 28-day FDS performances decreased from December's performance, with the trust not meeting the target of 75% for January. • Urology performance of 20.3% impacted by the industrial action and workforce constraints. • Christmas period, annual leave and industrial action impacted all services.	• Urology performance continues to be challenging due to capacity constraints within the workforce compounded further by Industrial action. • Industrial action in December 2023 and January 2024 impacted performance for all tumour groups due to cancellation of clinical activity. • Additional capacity in colorectal and urology provided where possible. • Gynaecology progressing business case to address workforce resilience including sonography/admin/CNS/consultant staffing. Annual leave and IA impacted December's performance.
Cancer: 62-Day Performance - *Target >85%* *No. of pts receiving their first treatment for cancer within 62 days of GP referral.* **January Performance – 54.4%** This is a worsening of 7.4% compared to 61.8% in December 2023	Trust overall combined performance decreased in January predominantly as a result of: • Breast performance at 20%. • Urology performance at 20%. • Industrial action and Christmas holiday had an impact on performance.	• Urology surgical and prostate oncology pathway progressing well for a joint pathway with UCLH. Delayed start date for January 2024 with proposal of start date now April 2024. Urology PTL reviewed twice weekly with service management review to ensure patients progress along pathways as smoothly as possible. • Breast additional weekend activity continued throughout January. This will progressively improve 62-day performance forecast from February .

ICARE EQUITY

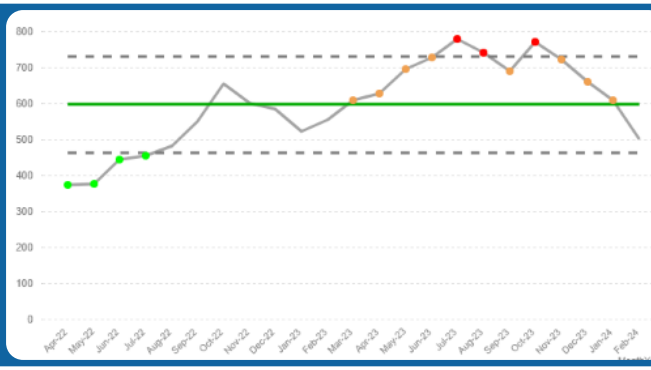
Responsive - Access

What the Data Tells Us	Issues	Actions and Mitigations
Referral to Treatment Incomplete % Waiting <18 Week – ***Target 92%*** **February Performance – 66.5%** This is a worsening of 0.1% from January's performance of 66.6%	• The Trust was 17 patients away from hitting the 78-week target of 0. This is an improvement of 17 from January's performance of 34. • Vascular Surgery remains at risk of being non-compliant against meeting the national target of having no 78 weeks waiters, this is as a result of capacity constraints. • The overall 52-week position has seen a significant reduction of over 21% in February.	• Additional sessions to mitigate backlog increase took place throughout January 2024. • Ongoing review to check the Trust is compliant against the new national requirement of having no over 78-week waiters by the end of March 2024. • Vascular service is working with 18- weeks support to reduce and minimise non-compliance. • From 1st of April 2024 the Trust will monitor patients against the national target of 65-weeks by the end of September 2024.
Referral to Treatment 18 Weeks - 52 Week Waits – ***Target 0*** **February Performance – 500** This is an improvement of 107 from January's performance of 607 At the end of February there were 17 patients waiting over 78 weeks.		
DM01: Diagnostic Waits <6 Weeks – Target 99% *Percentage of patients waiting less than 6 weeks for 15 key diagnostic tests and procedures.* **February Performance – 94.62%** This is an improvement of 2.8% from January's performance of 91.8%	• Overall improvement in the backlog continues, with a noticeable improvement in audiology assessments which achieved 93% in February 2024. • Concerns remain around the neurophysiology test service (50.3%) which relate to capacity constraints.	• Audiology continue to implement extra clinics to support recovery plan. • Service reviewing capacity for neurophysiology and sleep studies as part of business planning for 2024/25 • Neurophysiology recovery plan in place which will provide additional capacity via Bank Staff. The service is recruiting for a Lead Physiologist due to start in July 2024.

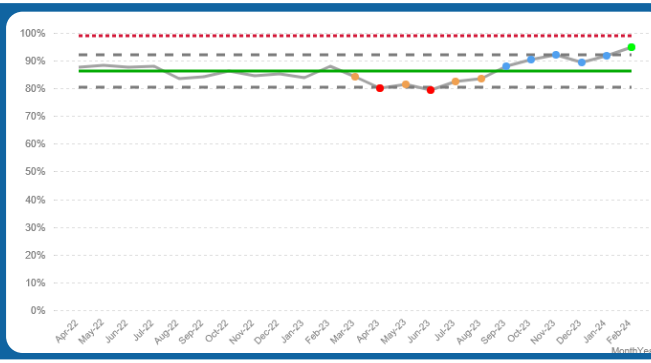
18 Weeks RTT



52-Week Waiters



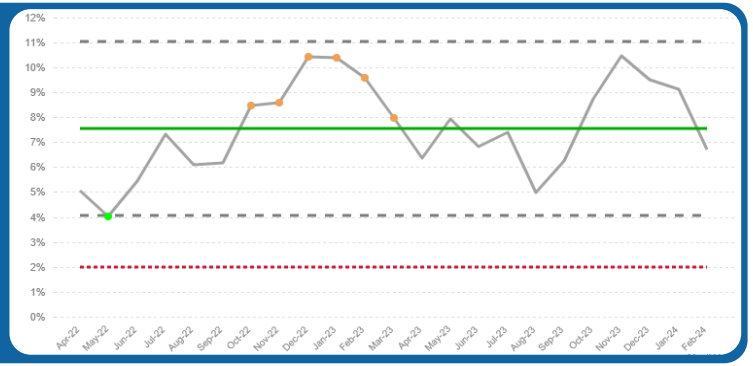
DM01



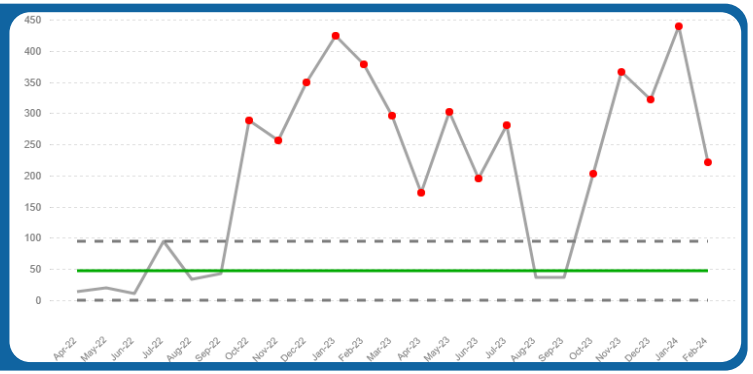
Responsive - Emergency Care

Indicator	Target	Current Month		Previous Month	2023-2024	Variation	Assurance
Las Patient Handover Times - 30 Mins	0	Feb	77	100	810		F
Las Patient Handover Times - 60 Mins	0	Feb	4	10	186	L	F
% Streamed to an Onsite Service	>7.5%	Feb	2.7%	1.5%	2.0%		F
Median Wait for Treatment (Minutes)	< 60 min	Feb	88 Mins	107 Mins	104 Mins	L	F
% Of ED Attendance Seen by Clinician Within 60 Mins of Arrival		Feb	37.5%	30.1%	35.5%		
Median Time From Arrival to Decision to Admit		Feb	04:11	05:04	04:50		
12 Hour Trolley Waits in ED	0	Feb	221	440	2576	L	F
Total ED Attendances in Dept for More Than 12 Hours (Arrival to Dept)		Feb	560	848	7257		
% Of ED Attendances Over 12 Hours From Arrival to Departure	<2%	Feb	6.7%	9.1%	7.7%		F
ED Waits (4 Hrs Wait)	>95%	Feb	70.8%	63.2%	64.5%	H	F
% Left ED Before Being Seen		Feb	7.1%	9.0%	11.2%	L	
% ED Re-Attendance Within 7 Days		Feb	9.0%	9.1%	10.0%		

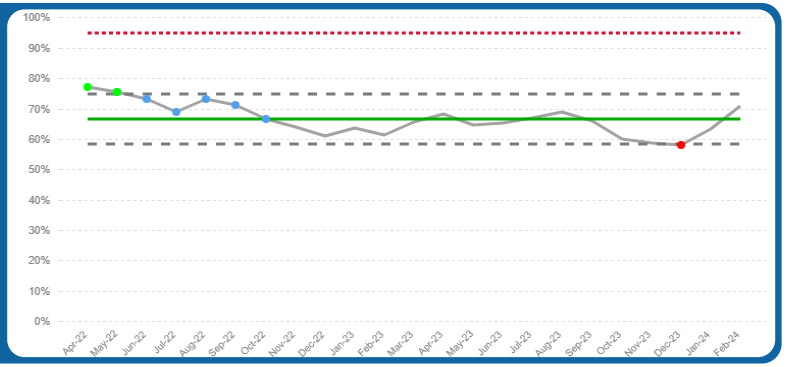
ED Attendances Over 12 Hours



12-Hour Trolley Waits in ED



ED 4-hour Waits



Responsive - Emergency Care

Whittington Health NHS Trust

What the Data Tells Us	Issues	Actions and Mitigations
% of ED Attendances Over 12 Hours - *Target <2%* *Percentage of patients in ED for more than 12 hour.* **February Performance – 6.7%** This is an improvement of 2.4% from January's performance of 9.1% **12-Hour Trolley Waits in ED - *Target 0*** *No. of patients who waited longer than 12 hours to be admitted to the ward following decision to admit.* **February Performance – 221 (Average 7.6 per day)** This is an improvement of 219 from January's performance of 440 **Emergency Department Waits (4 hrs wait) - *Target >95%*** *No. of patients treated within 4 hours of arrival in ED.* **February Performance – 70.8%** This is an improvement of 7.6% from January's performance of 63.2% **LAS Handovers - *Target 0*** *Number of Ambulance Handover delays of greater than 30 minutes and 60 minutes.* **February Performance (30 mins) – 77** This is an improvement of 23 from January's performance of 100 **February Performance (60 mins) – 4** This is an improvement of 6 from January's performance of 10 ***Median Wait for Treatment - Target <60*** *Time from arrival to seeing a doctor or nurse practitioner.* **February Performance – 88 minutes** This is an improvement of 19 minutes from January's performance of 107 minutes	• Regular NCL Sector pressures with North Middlesex University Hospital requesting regular diverts. • High number of out of borough conveyancing. • Discharge bottlenecks into the community which impact on wider hospital flow. • Industrial action 24th, 25th, 26th, 27th and 28th of February. **Whittington position and impact** • Attendances reduced from 8,704 in January to 8,364 in February which is a 3.9% reduction. However daily average attendance in February increased from 281 per day in January to 288 per day in February. • Workforce challenges with sickness and vacancies. • Increase in out of borough LAS conveyances impacting on ability to discharge from hospital.	**UEC improvement plan developed which focusses on Inflow, ED assessment and Outflow** ED improvement working group being established Focus on streaming: • Improving streaming pathways to Urgent Treatment Centre (UTC) and Primary Care and working with GP liaison to engage with Primary Care partners • Increased collaboration with Ambulatory Emergency Care (AEC) to improve pathways and increase streaming • Embedding senior decision makers in Rapid Assessment Triage (RAT) ED assessment and Management: • Implemented huddles in majors to focus on breach prevention, resource redirection and escalations • GP tendering underway to provide increased GP provision in the UTC Specialty review, discharge, flow and admission: • Focus on UTC performance with daily huddles to review wait times, breach preventions and resource allocation • Pilot in UTC successful to ensure appropriate patients streamed to UTC • Embedding senior decision maker presence in UTC • Improve specialty response times and escalations • Embedding criteria led discharge • Early system escalation for discharges working with community partners, social care, mental health providers and councils • Focus on criteria not met to reside and reducing long LOS • Increased virtual ward capacity • Focus on reducing LLOS • Explore locations for a discharge lounge

ICARE EQUITY

Activity

Indicator	Target	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Activity
ED Attendances		8762	7988	8823	9098	8609	8042	8426	8772	8592	8911	8704	8364	
ED Admission Rate %		10.4%	10.6%	9.6%	9.3%	9.7%	10.0%	10.3%	10.2%	10.8%	11.4%	10.6%	10.2%	
Elective and Daycase		2152	1876	2221	2418	1910	2167	2160	2307	2407	1908	2178	2243	
Emergency Inpatients		1619	1395	1551	1588	1576	1589	1622	1638	1674	1777	1598	1560	
GP Referrals to an Acute Service		8492	6670	10039	8081	7126	7905	7781	8689	8263	6438	8272	8935	
% Of GP Referrals Completed via eRS		69.5%	61.9%	58.6%	52.7%	43.9%	44.7%	50.0%	52.8%	66.1%	69.5%	73.0%	76.5%	
% e-Referral Service Slot Issues	<4%	38.5%	48.0%	48.2%	56.5%	69.6%	65.8%	60.3%	61.2%	69.6%	71.9%	68.9%	69.4%	
Maternity Births	320	227	192	226	228	237	263	245	266	256	237	229	206	
Maternity Bookings	377	356	313	263	291	302	274	271	300	271	245	310	288	
Outpatient DNA Rate % - New	<10%	11.7%	11.8%	11.5%	11.8%	11.7%	11.3%	12.4%	13.1%	13.0%	11.7%	12.1%	13.3%	
Outpatient DNA Rate % - FUp	<10%	10.2%	9.9%	10.3%	10.6%	9.9%	10.3%	10.2%	11.0%	10.5%	10.9%	9.7%	10.9%	
Outpatient New Attendances		12269	10657	12192	13238	12571	12750	11907	12636	11329	8936	10257	9797	
Outpatient FUp Attendances		17878	14797	17722	18610	16999	17975	17286	17465	18694	15713	18814	17231	
Outpatient Procedures		6561	5416	5734	6420	6313	5979	6172	6344	6409	5531	6428	5834	

GP Referrals

February Performance – 8,935

This is an increase of 663 compared to January's performance of 8,272.

It is an increase of 1,524 compared to 7,411 in February 2023.

% e-Referrals Appointment Slot Issues (ASI) - *Target <4%*

February Performance – 69.4%

This is a worsening of 0.5% from January's performance of 68.9%

Due to an ongoing increase in 2WW referrals for Dermatology, General Dermatology capacity has been moved to accommodate this demand, this has subsequently contributed to an increase in ASIs within the Dermatology service.

Activity - Highlights

Whittington Health NHS Trust

Activity Highlights

Maternity Births February Performance – 206

This is a worsening of 23 from January's performance of 229, and a worsening of 15 from 221 in February 2023.

ED Attendances February Performance - 8,364 (Daily average attendance 288)

This is a decrease of 340 from January's performance of 8,704 (Daily average attendance 281) and an increase of 473 from 7,891 in February 2023.

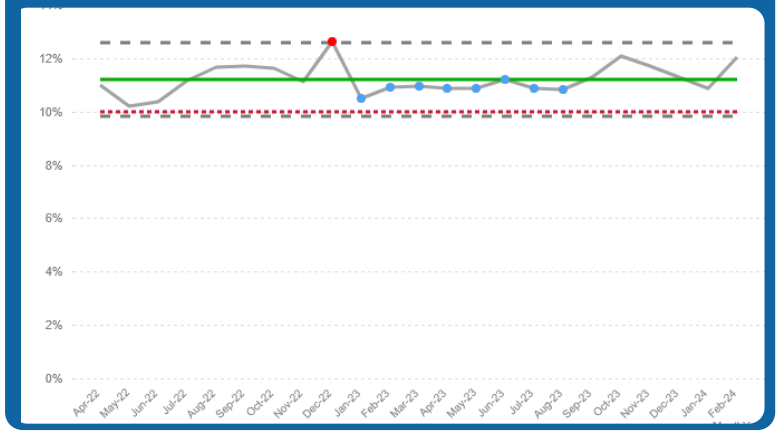
DNA Rates February 2024:

Acute DNA rate for February was 12%, this is a worsening of 1.2% from January's performance of 10.8%.

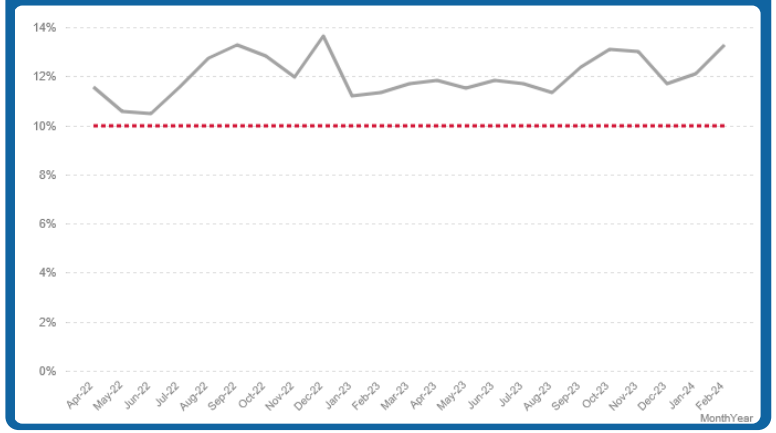
Outpatient DNA rate for new appointments was 13.3% for February, this is a worsening of 1.2% from January's performance of 12.1%.

Outpatient DNA rates for follow-up appointments was 10.9% for February, this is a worsening of 1.2% from January's performance of 9.7%.

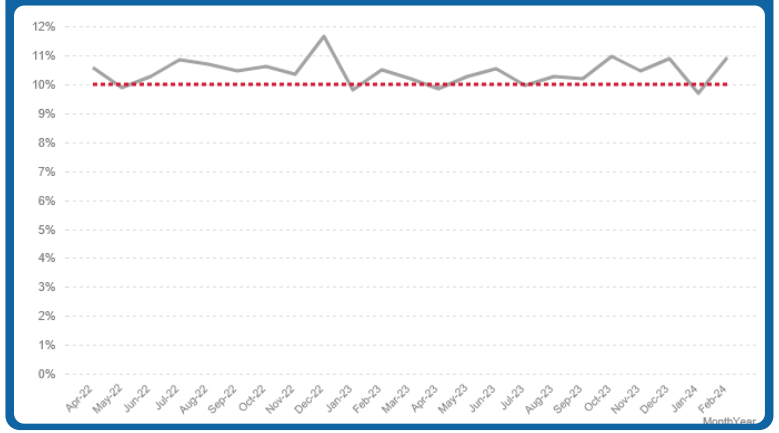
Acute DNA % Rate



Outpatient DNA % Rate - New



Outpatient DNA % Rate – Follow-Up



ICARE EQUITY

Activity – Activity and Forecasts

NHS Whittington Health NHS Trust

Activity Highlights

Outpatient First Appointments:

There were 13,713 first appointments in the last 4 weeks of February, this is 106% of 19/20 levels.

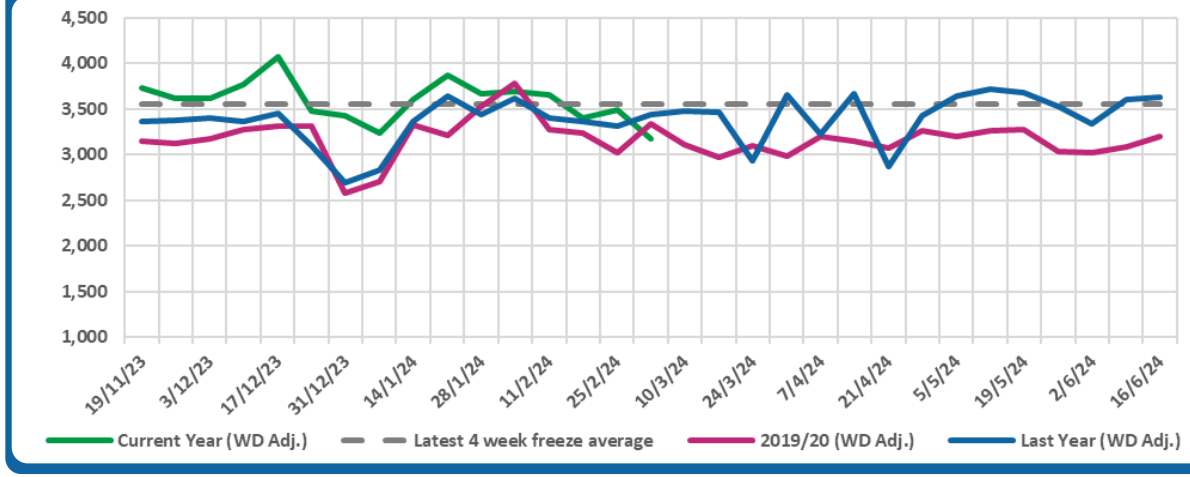
Outpatient Follow-up Appointments:

There were 12,107 follow-up appointments in the last 4 weeks of February, this is 90% of 19/20 levels. Follow-up activity is in line with productivity improvements.

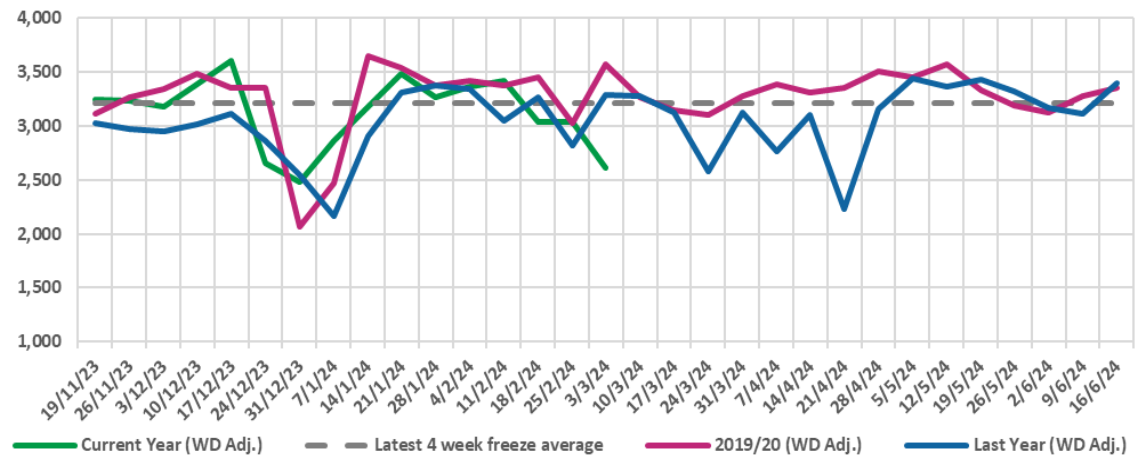
Elective Activity:

There were 2,108 cases in the last 4 weeks of February, this is 107% of 19/20 levels. However, there is a variation in case mix where we have seen less inpatient activity and increased day cases.

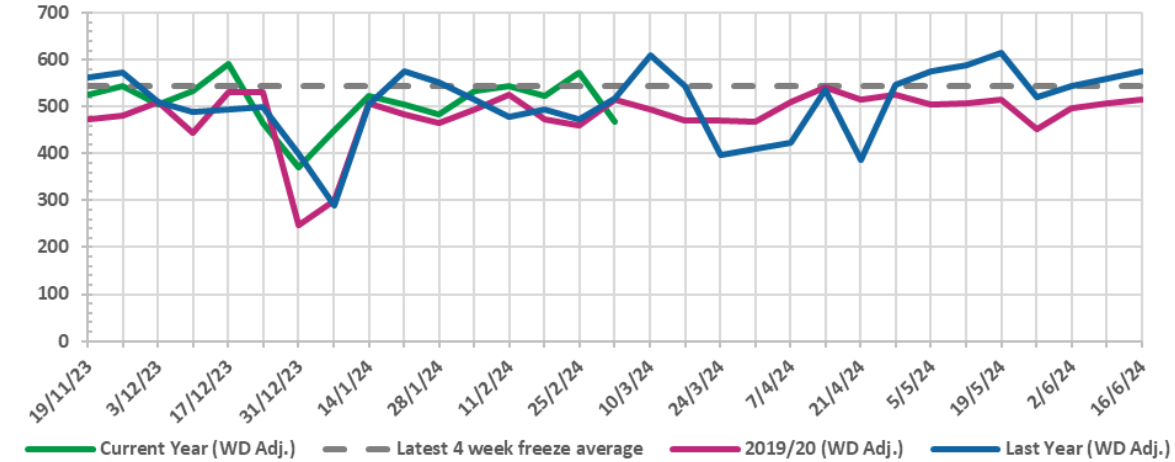
Weekly Outpatient First Attendances



Weekly Outpatient Follow-up Attendances



Weekly Elective Activity



ICARE EQUITY

Effective

Indicator	Target	Current Month		Previous Month	2023-2024	Variation	Assurance
Cancelled Ops Not Rebooked <28 Days	0	Jan	4	8	27		F
Hospital Cancelled Operations	0	Jan	11	13	71		F
Theatre Utilisation	>85%	Feb	71.9%	75.0%	74.5%		F
Community DNA % Rate	<10%	Feb	8.0%	7.4%	7.5%		P
Acute DNA % Rate	<10%	Feb	12.0%	10.8%	11.3%		F
Outpatients New:Follow Up Ratio	2.3	Feb	1.76	1.83	1.52		P
Non Elective Re-Admissions Within 30 Days	<5.5%	Feb	3.5%	3.9%	3.8%		P
Rapid Response - % Of Referrals With an Improvement in Care		Feb	68.2%	72.2%	71.4%		

Theatre Utilisation - Target 85%

Percentage of available Theatre time used for elective procedure.

February Performance – 71.9%

This is a worsening of 3.1% from January's performance of 75%.

Issues:

- Average utilisation concerns continue within paediatric dental and Urology.
- Challenge of driving utilisation and efficiency for paediatric dental lists with patient cohort with learning difficulties requiring pre-med before anaesthesia.

Actions:

- Amend recording of time stamps to include administration of all medication in anaesthetic start time.
- Reiterate booking rules to ensure case mix and booking numbers to maximise utilisation.

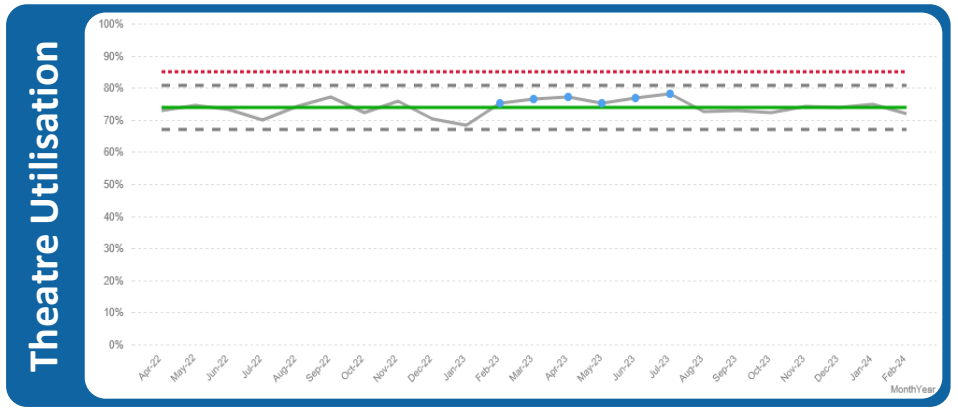
Hospital Cancelled Operations - Target 0

January Performance – 11

This is an improvement of 2 from 13 in December 2023

Issues:

- 4 out of the 11 cancellations are related to bed pressures and availability for inpatient stay.
- 3 cases cancelled on a single list as a result of a complicated caseload with extended operating times.
- Continued pressures with anaesthetic staffing limits resilience to short notice sickness.



Caring

Indicator	Target	Current Month		Previous Month	2023-2024	Variation	Assurance
ED - FFT % Positive	>90%	Feb	83.1%	77.5%	78.1%		
ED - FFT Response Rate	>15%	Feb	9.5%	9.2%	11.0%		
Inpatients - FFT % Positive	>90%	Feb	93.3%	88.6%	93.2%		
Inpatients - FFT Response Rate	>25%	Feb	17.4%	16.3%	15.9%		
Maternity - FFT % Positive	>90%	Feb	99.0%	97.1%	97.5%		
Maternity - FFT Response Rate	>15%	Feb	12.8%	11.7%	9.4%		
Outpatients - FFT % Positive	>90%	Feb	89.6%	87.6%	90.8%		
Outpatients - FFT Response Rate	400	Feb	337	428	3630		
Community - FFT % Positive	>90%	Feb	95.2%	95.3%	95.8%		
Community - FFT Response Rate	1500	Feb	685	851	8591		
Complaints Responded to Within 25 or 40 Working Days	>80%	Feb	62.5%	61.5%	53.2%		
Complaints (including Complaints Against Corporate Division)		Feb	32	26	282		

Friends and Family Test (FFT)

February Performance – Trust wide the FFT for positive sits at 91% and increase on January of 2%. Negative FFT response rate was 6% a decrease of 1% on January.

An additional iPad has been sourced for Maternity and volunteers are supporting the collection of FFT, alongside outpatient areas.

The Day Treatment Centre have included a QR code on their discharge letters.

Three areas of focus for future delivery: Maternity 99% positive, ED 83% positive and outpatients 90%.

Complaints Responded to Within 25 or 40 Working Days - *Target >80%*

February Performance - 62.5%

This is an improvement of 1% from January's performance of 61.5%.

The 32 complaints due a response in February 2024 were allocated to ACW 31% (10), E&IM 28% (9), S&C 16% (5), CYPS 16 (5), E&F 6% (2) & ACS 3% (1)

Severity of Complaints: 56% (18) were designated 'low' risk & 44% (14) were designated as 'moderate' risk

Themes: A review of the complaints due a response in February 2024 shows that 'Medical Care' 25% (8), 'Communication' 22% (7) & 'Attitude' 16% (5) were the main issues for complainants.

Of the 21 complaints that have closed, 4 (19%) were 'upheld', 16 (76%) were 'partially upheld', and 1 (12%) was 'not upheld', meaning that 95% of the closed complaints in February 2024 were upheld in one form or another.

Well Led

Indicator	Target	Current Month		Previous Month	2023-2024	Variation	Assurance
Appraisals % Rate	>85%	Feb	81.4%	80.2%	78.0%		F
Mandatory Training % Rate	>85%	Feb	88.1%	88.5%	87.5%		P
Permanent Staffing WTEs Utilised	>90%	Feb	90.2%	90.0%	89.6%		P
Staff Sickness Abscence %	<3.5%	Jan	4.2%	4.5%	3.8%		F
Staff Turnover %	<13%	Feb	11.4%	11.4%	12.6%		P
Vacancy % Rate Against Establishment	<10%	Feb	9.8%	10.0%	10.4%		P
Average Time to Hire	<=63	Feb	65	68	61		
Safe Staffing Alerts - Number of Red Shifts		Feb	3	1	37	L	
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		Feb	9.9	9.9	9.7		

Appraisals % Rate - *Target >85%*

February Performance – 81.4%

This is an improvement of 1.2% from January's performance of 80.2%

Issue: Appraisal compliance improved marginally during the month and is now reaching pre-pandemic levels.

Actions: Messages around appraisal benefits and importance are being kept up.

Staff Turnover % - *Target <13%*

February Performance – 11.4%

This is the same as January's performance of 11.4%.

The Trust continues to identify the reasons for staff leaving the Trust in order to positively respond and reduce the turnover rate further. Implementation of the Workforce Strategy to further reduce staff leaving the organisation.

Vacancy % Rate - *Target <10%*

February Performance – 9.8%

This is a worsening of 0.2% from January's performance of 10%.

The Trust continues to review roles and skill mixes and look at alternatives that are open to a wider pool of people. Targeted recruitment on hard to recruit posts. Targeted recruitment within the local community. Implementation of the Workforce Strategy to further attract talent into the organisation.

Meeting title	**Trust Board – public meeting**	**Date: 26 March 2024**
Report title	**University College London Hospitals/Whittington Health Case for Collaboration**	**Agenda item: 10**
Report authors	Matthew Shaw, Interim Accountable Officer, and David Probert, Chief Executive, University College London Hospitals NHSFT	
Executive summary	**Executive summary** The collaboration between University College London Hospitals NHS Foundation Trust (UCLH) and Whittington Health NHS Trust (WH) was originally formalised in 2017 through a Memorandum of Understanding (MOU). The MOU described the complementary strengths of both organisations and the opportunity to leverage them to better deliver services and support a population approach to healthcare. Substantial partnerships have emerged between the two providers in areas including community services, paediatric dentistry, pathology, cancer, orthopaedics, and general surgery. In addition, there are long-standing collaborations in other areas including medical training, red cell haematology, and tuberculosis screening. The pandemic provided further opportunities for the Trusts to work more closely together. Although the collaboration has achieved significant success, there is recognition that there is more that could be done to join up additional care pathways and work more closely to better improve health and access for the shared population. The 2022 Health and Social Care Act formalised the requirement for an integrated approach to health and care, with provider collaboratives established to promote partnership working for the benefit of patients. The UCLH and WH collaboration is part of a broader set of partnership arrangements within the North Central London Integrated Care System which aim to improve population health. Given UCLH and WH's close proximity, collaborating at the service level creates further opportunities to deliver services together for the local population, as well as addressing	

	points of vulnerability and sustainability in services, and maximising combined resources to deliver more care. A Partnership Development Committee was established in May 2023 with the primary purpose of creating a long-term vision for the partnership, developing a plan to achieve this vision and overseeing the successful delivery of priorities. To help take this forward, the Trusts worked with the Carnall Farrar consultancy, as an advisory support partner, to develop a 'Case for Collaboration' which proposed a way forward for strengthening the partnership. This work engaged clinical teams, senior leaders, partners and stakeholders to seek the widest range of views about the potential benefits and opportunities of collaboration, the conditions needed for success and the risks and barriers to change. A summary of the case for change is shown at appendix 1. The recommendations made are being proposed as a way to crystallise the plans for collaboration and to set out a path for the partnership to move forward at pace.
Purpose	Approval
Recommendation	The Board is asked to approve the Case for Collaboration between UCLH and WH and the recommended next steps, which are summarised below and can also be found in full at Appendix 1: • Formation of a Joint Committee, with delegated responsibility for allocating resources and overseeing the delivery of the collaboration programme • A joint appointment for a programme leader • Implementation of good governance principles and ways of working with effective conflict resolution, decision making and clear accountability arrangements • Agreeing new mission and vision statements • Creating an organisational development programme in support of the increased collaboration • Clarifying the priority level of collaboration initiatives • Maximising the existing collaborations on orthopaedics and cancer collaborations • Further developing the surgical collaboration • Building the business case to demonstrate how collaboration can generate savings to invest in appropriate resourcing to support delivery and for the necessary organisational development work
Risk and compliance	Failure to engage in new ways of working and collaboration

impact	with partners makes it more challenging to improve clinical and financial resilience of services and presents a risk to clinical outcomes, patient safety and the patient experience.
Equality impact	There is no adverse equality impact on any particular group of individuals.
Report history	Report to each Board meeting held in public
Appendices	1: Case for collaboration

University College Hospitals London and Whittington Health Case for Collaboration

March 2024

A vision and mission statement were developed to support the purpose and objectives agreed in the MOU following input from executives and clinical leaders

Engagement throughout the project identified the need for a vision and mission to which both Trusts are aligned. After seeking input in the Partnership Development Board, it was agreed that a vision needed to be established to help align teams at both Trusts behind the partnership and support momentum. Through further discussions with leadership at both Trusts, the following draft vision and mission statements were developed:

Purpose
As set out by the MOU

- The collaboration aims to improve the quality, safety and experience across a common local population in Haringey, Islington, and Camden by improving services across the two trusts and supporting a population approach to health care. It also aims to reduce costs to the health system by collaborating on the delivery of clinical services, changing pathways, rationalising support services where mutually agreed and providing mutual aid.

Vision
The future UCLH and Whittington Health are trying to create

- To use our collective strengths to improve the health of our community and deliver excellent patient care for our combined local population.

Mission
Formal statement of aims and values

- We will use our collective strengths in acute care, community services, education and research to improve access and quality for our patients, lower costs, and provide a compelling offer to our staff to connect with our local communities.

Objectives for the Collaboration
As set out by the MOU

- To improve quality, safety and patient experience: specifically we will work together to create and support standard approaches; creating effective joined up pathways through sharing of data and implementation of any changes in a timely fashion.
- To secure efficiencies and higher quality through minimising duplication of deployment, and related activity, sharing best practice, expertise and experience, and maximising resource allocation across the two trusts.
- To create a flexible workforce where we support each other to improve resilience of services, reduce duplication, and improve training of staff and quality of care.
- To use common data and information securely to support clinical improvements.
- To strengthen clinical services and improve our resilience to external pressures.
- To strengthen and maintain local access to services.
- To consider the benefits of joint approaches to capacity and workforce issues.

 Source: October 2017 WH UCLH Memorandum of Understanding

Eight areas of focus for potential further collaboration have been identified

Engagement has highlighted the clear opportunities to strengthen existing collaborative initiatives and realise the full value and benefits of these. A further eight opportunities with high collaborative potential have been identified, which we have outlined on the subsequent slides.

- **Proactively collaborate across Trusts and with place-based partners to reduce inequalities and better meet the needs of the local population**
- **Leverage WH's strength in community services to optimise acute hospital care including non-elective care pathways, discharge processes and frailty care across both Trusts to reduce hospital-based care**
- **Enable provision of the right care at the right place and right time by strengthening long-term condition pathways, enabling patients to self-manage, and reduce acute exacerbations**
- **Improve resilience and clinical and financial sustainability of services offered by both Trusts**
- **Maximise use of joint capacity by concentrating high-volume elective activity in WH and more specialist activity at UCLH**
- **Plan, implement and share learning on workforce to better support recruitment and retention of staff and address high staff turnover rates**
- **Expand UCLH research and trials to the population served predominantly by Whittington Health enabling access**
- **Collaborate on non-clinical services to support efficiency and cost reduction**

For each opportunity, there are some distinct enablers that are required for them to be successfully realised

Opportunity	Enablers
Proactively collaborate across Trusts and with place-based partners to reduce inequalities and better meet the needs of the local population	• Joint data collection and review of population health metrics • Regular engagement with external partners e.g. local authority leads and VCSEs
Leverage WH's strength in community services to optimise acute hospital care including non-elective care pathways, discharge processes and frailty care across both Trusts to reduce hospital-based care	• WH community services to be 'provider of choice' • Interoperability of IT and sharing of data between acute and community services • Workforce modelling to assess where staff can move from acute to community
Enable provision of the right care at the right place and right time by strengthening long-term condition pathways, enabling patients to self-manage, and reduce acute exacerbations	• Interoperability of IT and sharing of data between acute and community services • Workforce modelling to assess where staff can move from acute to community • Upskilling of community care staff to provide anticipatory care
Improve resilience and clinical and financial sustainability of services offered by both Trusts	• Contract arrangements for workforce to support ease of movement between sites • Organisational development to improve ways of working across clinical teams
Maximise use of joint capacity by concentrating high volume elective activity in WH and more specialist activity at UCLH	• Contract arrangements for workforce to support ease of movement between sites • Aligned procurement of consumables • Sharing of patient lists or establishment of joint lists
Plan, implement and share learning on workforce to better support recruitment and retention of staff and address high staff turnover rates	• Data collection and sharing on workforce and temporary staff usage • Shared learning on staff wellbeing initiatives
Expand UCLH research and trials to the population served predominantly by Whittington Health enabling access	• Interoperability of IT and sharing of data between acute and community services • Equipment availability at WH
Collaborate on non-clinical services to support efficiency and cost reduction	• Align on shared systems as contracts expire and procurement begins • Establish ways of working between teams to address culture differences

There is a need to establish good governance principles and ways of working within the future structure, even if the form of the collaboration does not change

Components	Good Governance Framework	Proposed Changes to Strengthen Governance
Vision & scope	• Programme develops and articulates a clear vision which it seeks to achieve	• Communicate new joint mission and vision statement to all staffed involved in the partnership in both organisations
Programme leadership	• Programme leadership implements, evaluates and improves governance and decision-making authority is clear	• Clarify decision-making authority of PDC and Collaboration Board and ensure decisions that are made by these bodies are quickly communicated back down the governance structure
Meeting structure	• Governance meetings have clear roles, responsibilities, escalation pathways, and accountabilities	• Reconsider membership in Collaboration Board to support operational focus and limit overlap with Partnership Development Committee • Develop reporting to escalate issues and decisions needing sign-off; have standing agenda items to address risks and decision points
Reporting & information flow	• A dedicated PMO resource that facilitates the flow of information between key meetings	• Develop standard reporting inputs and highlight reports for each meeting group, with someone accountable for development of the reporting
Programme organisation	• Consistent documentation and a comprehensive organisational structure with clear sign-off points	• Sequence meetings to enable flow of information and reporting between them
Workstreams	• Workstreams support strategic objectives of the programme and have clear milestones and timelines for all activities	• Ensure PIDs, TORs, and workplans of each workstream board are aligned to the strategic objectives of the PDC
Communication	• There is centralised communications planning and support	• Have regular, programme-wide communications to ensure all staff are aligned to one message and prevent “rumour mill”
Stakeholder engagement	• Stakeholders are equally engaged across organisations and are held accountable for delivery	• Governance structure has accountability for progress, ensuring stakeholders engaged give collaboration equal priority

Conclusion

In conclusion, this report sets out the near-term and longer-term priorities that UCLH and Whittington Health can undertake to further their collaboration and better serve the common population. Foundational to the success of the existing collaboration is addressing the programme governance and initiating an organisational development programme in order to improve the ways of working across the Trusts.

Specifically, we would recommend implementing the following to set up the collaboration for success:

- The formation of a Joint Committee who is responsible for allocating resources and overseeing the delivery of the collaboration programme
- A joint appointment for a programme leader who oversees the collaboration and governance, and holds responsibility for the progress of the programme
- Implement the good governance principles to ensure clear pathways for conflict resolution, timely and effective decision-making, and clarity of accountability
- Creating an organisational development programme to build trusted relationships across those involved in the collaboration and improve ways of working to develop high-performing, effective teams
- Clarify the priority level of collaboration initiatives, ensure they have appropriate resources to deliver to agreed timelines with clear accountability and oversight

To further the partnership, the first priority should be maximising the existing collaborations on orthopaedics and cancer by:

- Resolving challenges in orthopaedic partnership that have prevented high volume surgery from being transferred to Whittington Health to the degree expected due to challenges with list sharing and staffing
- Continuing the development of the model for cancer services, potentially through a UCLH@ model
- Capturing lessons learned from these collaborations to build “proof of concept” and apply learning to new partnership opportunities

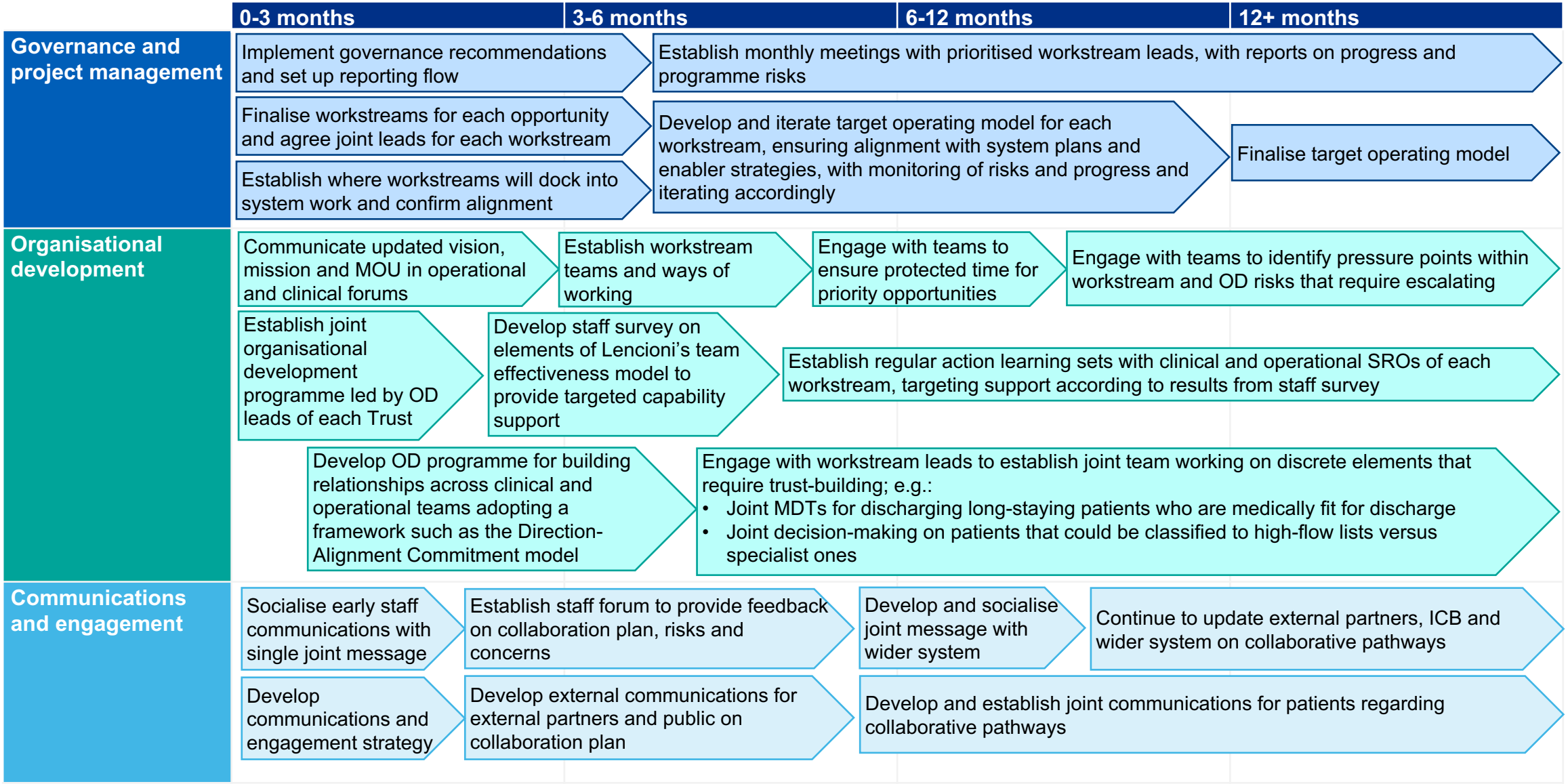
In terms of the new collaboration opportunities that have been identified, we recommend prioritising the following:

- Better manage the health of the shared population in the community to reduce admissions and improve discharge to reduce length of stay and relieve pressure in non-elective care pathways of both Trusts
- Strengthen fragile services through collaboration to improve clinical outcomes and ensure financial sustainability
- Further develop the surgical collaboration by concentrating additional high volume surgery at WH and complex specialist surgery at UCLH; specialties to consider include general surgery, urology, and gynaecology

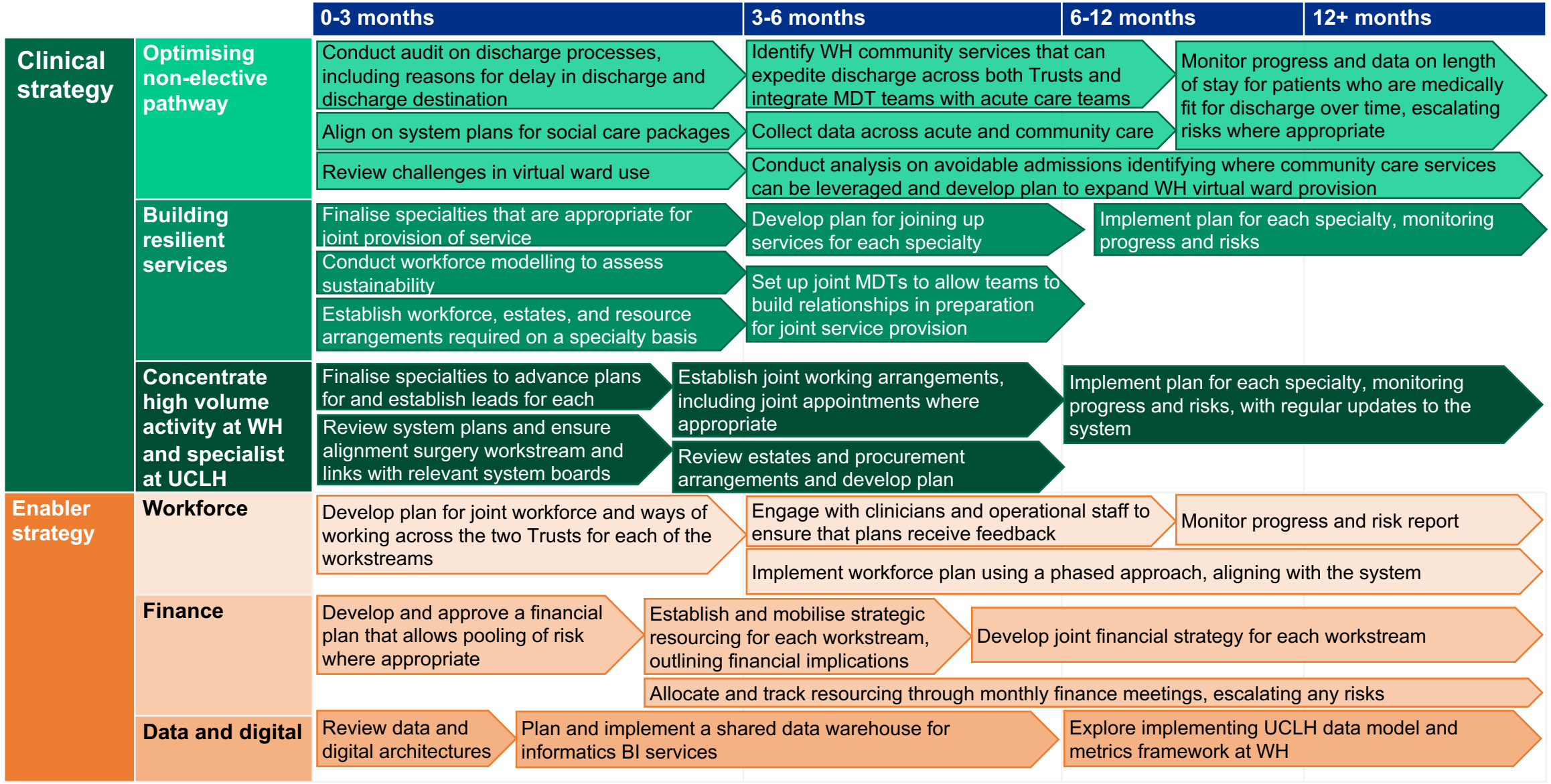
We recommend the organisations prioritise the following next steps to first address the governance and alignment of the organisations to the collaboration:

- Agree new mission and vision statements and cascade through organisations to create alignment among the divisional leadership, explaining how these connect to the organisations’ own visions and missions
- Engage the OD leads at both organisations to initiate an organisational development programme to improve the culture of the collaboration and strengthen the ways of working across Trusts
- Build the business case to show how collaboration can generate sufficient savings to justify investment in appropriate resourcing, including programme leadership, to support programme delivery and organisational development

High-level roadmap of programme-wide activities



High-level roadmap of prioritised opportunities and key enablers



Meeting title	**Trust Board – public meeting**	**Date: 26 March 2024**
Report title	**Audit & Risk Committee Chair's Assurance report**	**Agenda item: 11**
Committee Chair	Amanda Gibbon, Non-Executive Director	
Executive director lead	Terry Whittle, Chief Finance Officer	
Report author	Swarnjit Singh, Trust Company Secretary	
Executive summary	This report reports on the items considered at the Audit and Risk Committee meeting held on 21 March 2024. **Committee members were able to take good assurance from the following reports:** • Internal audit reviews – controlled drugs and payroll • 2024/25 internal audit plan • Draft Annual Governance Statement • Draft Head of Internal Audit Opinion • Draft 2024/25 Counter Fraud plan • External audit progress report • Trust Risk Management Framework and risk management policy and procedure • Board Assurance Framework • Year-end accounts update **Areas of moderate assurance:** • Trust Risk Register • Medical declarations of interest • Losses and special payments • Debtors report • Tender waivers and breaches report The Committee also noted the Chair's assurance report from the Quality Assurance Commitete meeting which will be considered at the Board meeting on 26 March. The key issues which Committee members wish to draw to the Board's attention are: 1. The good outcomes from the internal audit reviews of controlled drugs and payroll arrangements; 2. Progress in delivery of audited 2023/24 year-end accounts; 3. Declarations of interests for consultant staff; and 4. An update on the provisions of the Procurement Act (2023).	
Purpose	Noting	

Recommendations	Board members are invited to note the Chair's assurance report for the Audit and Risk Committee meeting held on 21 March and to note the attached risk appetite statement from the risk management framework.
BAF reference	All entries
Appendices	1: Risk Management Framework and Risk Appetite Statement

Committee Chair's Assurance report

Committee name	Audit and Risk Committee
Date of meetings	21 March 2024
Summary of assurance:	

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

Internal audit reviews – controlled drugs and payroll
The Committee reviewed the successful outcomes from the two reviews into controlled drugs and payroll respectively. They welcomed the positive assessments of reasonable assurance given for both reviews. The controlled drugs review identified that a good process was in place and could be enhanced further when it came to embedding incident reporting within day to day work. The actions recommended by the review had been accepted and included work to align processes to the new Patient Safety Incident Response Framework. The payroll review also identified positive processes being in place. Whittington Health benchmarked well against other organisations on overpayments to staff who had left and a number of actions were suggested in the review to further minimise this risk going forward. The Committee Chair commented that it would welcome an outcome where there were no overpayments made to people who had left the Trust's employment.

2023/24 internal audit plan
The Committee reviewed the draft internal audit plan for the next financial year. John Elbake confirmed that the plan had been developed through extensive engagement with executive team members and with non-executive directors and a review of our Board Assurance Framework and Trust Risk Register. Committee members approved the internal audit plan and also agreed that additional resource investment for the Data Security and Protection toolkit review later this year was not needed. The Committee also noted that a financial efficiency report in the March part II Board meeting would include cost improvement programme schemes which covered more than one year.

Draft Annual Governance Statement
The Committee Chair welcomed early sight of the draft Annual Governance Statement (AGS). Committee members noted that there would be further opportunities to provide drafting comments on the AGS once the final Head of Internal Audit Opinion was received in May or June.

Draft Head of Internal Audit Opinion
The Committee noted the draft Head of Internal Opinion report which gave a provisional assessment of amber/green opinion. This was a good outcome and consistent with the assessment achieved in 2022/23. The Opinion would be updated once the internal audit review of discharges was finalised. However, it was unlikely to change considerably.

Draft 2024/25 Counter Fraud plan and progress report
The Committee approved the 2024/25 counter fraud plan. They were informed that an organisation-wide assessment of fraud and bribery risks would be undertaken and the plan would be updated to reflect any identified high risk areas. The Committee received assurance that the annual submission to the NHS Counter Fraud Authority in May would be undertaken by BDO LLP, the previous local counter fraud specialist for Whittington Health. The Committee noted the progress report which highlighted a prosecution case undertaken by the NHS Counter Fraud Authority of a locum consultant who submitted fraudulent time sheets up the value of £50k.

External audit progress report
The Committee took assurance from the update from KPMG on the audit of the annual accounts. They noted that a productive interim audit visit had taken place and the draft value for money assessment would be circulated by email to Committee members next week for comments. Dean Gibbs also informed the Committee that there had been helpful engagement on the risk areas identified in the audit plan and work would progress over the next few weeks to provide as much assurance as possible before the preparation of year end statements. Dean Gibbs highlighted one new requirement for NHS trusts – governance and risk management processes for emissions data on green sustainability. The Committee agreed that a short interim meeting should took place prior to the 20 June next scheduled Committee meeting to review and discuss issues highlighted by the audit of the annual accounts.

Trust Risk Management Framework and risk management policy and procedure
The Committee received the risk management framework along with the risk management policy and procedure for any drafting suggestions outside of the meeting. Committee members noted that the annual review of risk management arrangements was underway and that both the framework (strategy) and policy would be updated in the light of the RSM review which was due to conclude in June 2024. It was agreed that the current risk appetite statement would be appended to the Committee Chair's report for Board members to agree.

Board Assurance Framework
The Quarter four Board Assurance Framework agreed at the February part II Board meeting was agreed. Assurance was provided that the Quality Assurance Committee had reviewed the two Quality entries and the Integration 2 entry at its meeting on 13 March and that the Workforce Assurance Committee had reviewed both People entries at its last meeting on 24 January.

Procurement Act 2023
The Committee welcomed a helpful update from the Partners Procurement Service on the provisions of the 2023 Procurement Act which will come into force on 1 October 2024. They were informed that the aim of the legislation was to increase flexibility and transparency and to open up public procurement to new entrants, particularly small businesses. Key changes involved in compliance with the new regulations would include the publication of contracts

	awarded (with redactions for commercially confidential issues), the publication of any contract variations and also post-contract award notices. The Committee was assured that work was taking place with NHS England and with technology partners to minimise the administrative impact of the new requirements. In addition, the Committee noted that healthcare contracts were specifically excluded from the Procurement Act provisions and would go through the new provider selection regime. **Year-end accounts update** Committee members noted the publication of the year end timetable with draft accounts being submitted on 24 April and the final audited accounts needing to be submitted on 28 June.
2.	**The Committee can report partial assurance to the Trust Board in the following areas:** **Trust Risk Register** The Committee reviewed the risk register and the Committee Chair reported that discussion was held with quality governance colleagues on making the register, which is derived from the Datix system, much more user-friendly for the Board and its Committees, and to also show older risks at the start of the report with the date they were included on the register. The Committee noted that at the end of February, there were 33 entries scored at 15 or above. Of these, 24 had been approved and 9 were being assigned to an executive lead, following review by the executive team. The Committee discussed whether the individual in-year operational risk for the surgery and cancer clinical division not meeting its cost improvement programme target fed adequately into the residual risk, Sustainable 1 (control total delivery and underlying deficit). It was agreed that the Chief Finance Officer and Company Secretary would discuss this entry outside the meeting. The following points were highlighted in discussion: • The Committee welcomed the review of risk entries being led by the Chief Nurse and Director of Allied Health Professionals and sought an update at the next meeting in June when greater progress should have been achieved. It was felt that having c. 240 risk entries was too many. • Assurance was provided by the Chief Finance Officer that the risk entries scored at 20 were being actively reviewed and that a report on the overcrowding risks in the emergency department would soon be made available and would be circulated to Committee members. • The Chief Finance Officer provided an update in respect of the risk entry relating to high temperatures and drug storage to explain that the mitigating actions for three rooms were to be concluded imminently. • Risk entry 1475, which related to the inability of the referrals system used by the screening laboratory to effectively interface with cancer records, would be reviewed and an information technology solution sought to improve the current mitigation which involved manual input.

	Medical declarations of interest The Committee considered a report which demonstrated the good progress achieved in securing a declaration of interest from consultants during job planning. It welcomed the increase in declarations achieved in the 2023/24 job planning round to 35% of consultants and noted the strengthened controls in place for the 2024/25 job planning round which would seek declarations, including nil returns from all consultant colleagues. **Losses and special payments** The Committee approved the write-off for two salary overpayments totalling £667 and noted that the year-to-date salary overpayments stood at £155k as of 29 February. The Committee also noted the update on legal claims recently received through court enforcement orders and sought a report outside of the meeting providing details of the claims involved. **Debtors report** The Committee reviewed an analysis of aged debtors by NHS and non-NHS organisations. Committee members noted the £2.1m of debt that sat with the Royal Free London and that discussions were taking place to achieve a resolution by 31 March. The Committee also discussed the significant £1.737m debt with the London Borough of Haringey and discussed the adverse financial outlook for some local authorities. Committee members received assurance that the Haringey local authority debt was likely to be paid. **Tender waivers and breaches report** The Procurement Business Partner presented the report which covered the period January and February 2024 and reported tender waiver applications approved agreed for a total expenditure figure of £1.8m. The Committee acknowledged the increased pressures in quarter four to spend the further capital allocation received from NHS England.
3.	**Meeting attendance** **Present:** Amanda Gibbon, Non-Executive Director (Committee Chair) Glenys Thornton, Non-Executive Director Robert Vincent, Non-Executive Director **In attendance:** Richard Ayres, Partner, Gerald Eve LLP Vivien Bucke, Business Support Manager, Finance Kirst Clarke, Local Counter Fraud Specialist, RSM Mick Corti, Director, Partners Procurement Service Clare Dollery, Acting Chief Executive and Medical Director John Elbake, RSM LLP Michael Evans, Counter Fraud Manager, BDO LLP Jerry Francine, Operational Director of Finance Jonathan Gardner, Chief Strategy, Digital and Improvement Officer Dean Gibbs, Manager, KPMG LLP Matthew Goddard, Head of Estates and Facilities

	Mohini Katoch, KMP LLP Martin Linton, Assistant Director of Financial Services Phill Montgomery, Procurement Business Partner Chinyama Okunuga, Chief Operating Officer Swarnjit Singh, Trust Company Secretary Terry Whittle, Chief Finance Officer **Apologies:** Clive Makombera, Partner, RSM Sarah Wilding, Chief Nurse and Director of Allied Health Professionals Anne O'Connor, Associate Director of Quality

2023/26 Risk Management Framework

Version control

Version	Date	Author/Lead	Changes made
1.0	01.11.2021	Swarnjit Singh, Trust Secretary	Updated Strategy for review and feedback by Quality Assurance Committee
1.1	20.01.2022	Swarnjit Singh, Joint Director of Inclusion Trust Secretary	Changes incorporated following consideration by the Audit and Risk Committee
1.2	10.07.2023	Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary	Changes included following review of risk arrangements by RSM, internal auditors
1.3	06.10.2023	Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary	Changes incorporated from Associate Director, Quality Governance
1.4	17.10.2023	Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary	Amendments from Chief Executive incorporated

Contents

Executive summary

Effective risk management processes are essential to the delivery of high quality and safe healthcare services. The Trust believes that due attention to risk management both reduces harm to patients and staff as well as create safer environments of care and is essential for the achievement of the organisation's strategic goals and annual corporate objectives.

This Risk Management Framework provides the overarching structure Framework within which risk is managed by the organisation and is fully endorsed by the Trust Board as reflecting currently available information, guidance and legislation governing the NHS.

The Board Assurance Framework (BAF) provides the Board with a comprehensive method for the effective and focused management of the strategic risks that could affect the delivery of its strategic goals and principal objectives.

The Trust uses the risk register as a means of describing risks, scoring and ranking them, identifying who owns them, identifying controls and assurances that are in place, identifying whether the risk needs to be reduced further and, if so, recording what steps need to be taken to reduce the risk to an acceptable level (reducing either likelihood of the risk materialising and / or reducing the level of harm arising). need to be put in place.

The Trust Risk Register is comprised of all risk entries from Integrated Care Service Units (ICSUs) and / or departmental risk entries. All Trust risks rated above 15 have an identified director lead, who is ultimately accountable for ensuring the risk is managed appropriately, a risk owner, who is the senior manager accountable for ensuring suitable plans are in place to mitigate the risk and risk lead who is the person with direct responsibility and oversight of the activities to manage the risk.

Every risk scored at 15 or above must first be considered and agreed at executive team meetings for inclusion at that level on the Trust Risk Register. Conversely, the reduction of risks with an entry of at 15 or above must also be considered at executive level.

Risk registers are maintained by each division and Trust department and are mainly populated by risks that affect the achievement of objectives and/or the particular local service operation.

All risk registers are viewed as 'live documents' and are populated, updated and reviewed on an ongoing basis.

All Trust staff are responsible for reporting risks and incidents, following Trust risk management policies and procedures, attending appropriate training and following health and safety procedures.

Details of and specific risk management responsibilities for individuals and Board members are set out in this Risk Management Framework and the supporting Risk Management Policy and Procedure and its appendices. The Audit and Risk

Committee is accountable to the Board for ensuring that the risk management process is implemented across the Trust in line with the overall risk management framework.

Introduction

An understanding of the risks that face NHS Trusts is crucial to the delivery of safe and effective healthcare services. The business of healthcare is by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing Whittington Health's Board with assurance on the arrangements for clinical quality and Trust governance.

The stated vision for Whittington Health is to help local people live longer, healthier lives. To ensure that the care we provide is safe, effective, caring and responsive for patients, the Board must supported by a strong governance structure.

Whittington Health is committed to developing and implementing a Risk Management Framework that will identify, analyse, evaluate and control the risks that threaten the delivery of its operational and strategic objectives. Together the BAF and the Trust Risk Register ensure that key risks are identified and controlled and that robust mechanisms are in place to provide assurance to the Board that risk is being appropriately controlled.

The management of risk underpins the achievement of the Trust's strategic objectives. Whittington Health believes that effective risk management is imperative to not only provide a safe environment and improved quality of care for service users and staff. It is also significant in the financial and business planning process recognising the Board's accountability for the delivery of cost-effective care that meets the needs of the population and the priorities and objectives set out by the Department of Health and Social Care and NHS England. **Risk management is the responsibility of all staff.**

The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. The Risk Management Framework represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective performance management and accountability for organisational learning to continuously improve the quality of services.

The Board recognises that complete risk control and/or avoidance is impossible, but that risks can be controlled by making sound judgments from a range of fully identified options and having a common understanding at Board level on risk appetite.

The Whittington Health Risk Management Framework and associated policies formalise risk management responsibilities and processes and set out how all stakeholders may be assured that risks are identified and managed effectively.

The Trust considers risk management to be an essential and integral element of the entire management process and not a separate entity.

The Trust recognises that it is impossible to deliver its services and achieve positive outcomes for its stakeholders without taking risks. Indeed, only by taking risks can the Trust realise its aims. It must, however, take risks in a controlled manner, thus reducing its exposure to a level deemed acceptable by the Board and, by extension, external inspectors/regulators, and relevant legislation. The Trust will have a low threshold for risks that impact on safety and a greater appetite to take considered risks in terms of their impact on operational, commercial, and reputational issues. The Trust has the greatest appetite to pursue quality improvement and innovation and will take opportunities where positive results can be anticipated.

The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. As part of this, the Trust undertakes to ensure that adequate provision of resources, including financial, personnel, training and information technology is as far as reasonably practicable, made available.

The Framework has been developed to ensure that the latest guidance, best practice and recommendations from independent reviews and assessments are taken into account in the systems and processes that are in place to manage risk and strengthen assurance arrangements. It reflects NHS Improvement's Well Led Framework, Code of Governance and Department of Health and Social Care requirements and guidance.

Purpose

This document and associated supporting processes set out the systems and arrangements to enable all staff to manage risk and includes the Trust's risk appetite statement to articulate the levels and types of risk the Trust is prepared to accept in pursuance of its objectives. This informs planning and objective setting, as well as underpinning the threshold used when determining the tolerability of individual risks, supporting the organisation and its staff's pursuance of its goals and opportunities, as well as the process of managing its risks.

The purpose of the Risk Management Framework is to detail the Trust's approach to risk management and its risk appetite within which the Trust leads, directs and manages risk. The internal arrangements for implementing the Framework are detailed within the Risk Management policy and procedure and cover the following areas:

- Ensure compliance with relevant statutory, mandatory and professional requirements and maintenance of the Trust's registration with the Care Quality Commission
- Define and set out what drives risk management within Whittington Health
- Embed consistent and effective risk management processes at all organisational levels
- Promote an open culture where people feel encouraged to take responsibility for reporting and managing risks

- Integration of risk management into business processes, for example ensuring service developments do not adversely impact on safety
- Set out the Trust Board's appetite for risk
- Set out the relationship between the Board Assurance Framework and the Trust Risk Register and how the Framework relates to the Trust's wider strategic aims and annual Trust objectives

Scope of the risk management framework

The Risk Management Framework applies to all employees of the Trust and requires an active lead from managers at all levels and from all staff. The Risk Management Framework and associated risk management processes include risk assessments, the Trust risk register, incident management, complaints, claims and safety alerts. The Framework encompasses both clinical and non-clinical risk management.

This Risk Management Framework is supported by a range of processes including

- The Trust's Quality Governance processes, supported by the Trust's Quality Account which is published on an annual basis.
- Financial, operational and clinical policies and procedures.
- Health and safety policy and procedures for complying with NHS England, Care Quality Commission and other regulatory requirements.

In addition to this Framework there are a range of policies that support the identification and management of risk within the Trust. These include:

- Risk management policy and procedure
- Patient Safety Incident Response Framework Policy and plan
- Incident Reporting & Investigation policy
- Health & Safety policy
- Claims handling policy and procedure
- Being open and the duty of candour policy
- Freedom to Speak Up / whistleblowing

Aims and background

The aim of the Risk Management Framework is to further strengthen our effective risk management across the organisation. which operates from ward to Board. The Framework includes clear risk escalation arrangements and provides clarity regarding roles and responsibilities for risk management at each level of the Trust's governance structures.

The key objectives of this Risk Management Framework are to:

- embed the principles of risk management at all levels of the organisation
- create a culture which supports effective risk management
- provide the tools and training for staff to support effective risk management
- establish an effective means of managing strategic risk
- ensure that lessons are learnt from adverse incidents.

The Framework applies to all ICSUs, corporate departments, Trust staff, contractors and other third parties, including those with honorary contracts, working in all areas of the Trust, with the underlying principle that:

- Risk management is the responsibility of all members of staff.
- All services, divisions and Trust level managers are expected to take an active role in ensuring that risk management is a fundamental part of their approach to clinical, non-clinical and Trust governance.

Risk is an inherent part of the delivery of healthcare. All activities associated with healthcare, such as the treatment and care of patients, the employment of staff, maintenance of premises, and financial management attract risk. Risk management is the process of identifying, quantifying, and managing the risks that the organisation faces in order to ensure achievement of its objectives. Effective risk management supports a safe, caring, effective and responsive service for patients, families and staff and contributes to the Trust being a well-led organisation.

Our approach to risk management

Our Trust Board acknowledges that:

- The services it provides, and the way it provides these services, carries with it unavoidable and inherent risk.
- The identification and recognition of these risks - together with the proactive management, mitigation, acceptance and (where possible) elimination of these risks - is essential for the efficient and effective delivery of safe and high-quality services.
- Effective risk management is not an end in itself, but an integral part of the Trust's quality, governance and performance management processes.
- All staff have a role in considering risk and helping to ensure it does not prevent the delivery of safe and high quality service
- Our Trust Board, with the support of its committees, has a key role in:

- Ensuring a robust risk management system is maintained and effectively resourced,
- A culture whereby risk management is embedded across the Trust is encouraged.
- Through its plans, it sets out its risk appetite and priorities in respect of the mitigation of risk when delivering a safe and high-quality service.

A prerequisite for good risk management is to ensure a positive risk management culture, providing a supportive, positive environment which allows risks to be identified and ensuring that actions taken in response to risks are not seen as punitive to individuals or teams.

The Trust uses the Datix risk management system to record and track risks. The risk register is a central repository for all risks, identified from ward to board, that have been identified throughout the organisation. The register is a management tool for recording risks that threaten the achievement of the Trust's objectives, regulatory compliance, financial stability or ability to deliver a safe and effective service.

Risk definitions and types

The following key definitions are used:

Term	Definition
ISO 31000	is the main set of guidelines on managing risk faced by organisations. The application of these guidelines can be customised to any organisation and are widely used in the NHS. ISO 31000 defines Risk as "The effect of uncertainty on objectives".
Risk management	is the process whereby the Trust identifies, evaluates, manages and monitors the risks related to its activities, with the aim of achieving sustained benefits and improvements, as a result of actions taken to mitigate and remove risk.
Risk evaluation	has two main components: consequence and likelihood. Consequence is a reflection of the damage or loss which may occur should a risk materialise. Likelihood is an indication of how often the event might occur. Taken together, they provide a means of consistently rating the severity of risks across any aspect of the business.
Control	is the mitigating action put in place to reduce the risk; further actions may be required to reduce the risk to an acceptable level.

A risk is not an **incident** nor an **issue**. These are managed through the Management of Incidents Policy. An incident is an event that has occurred and which has had an effect on the achievement of objectives. An issue is a certain, or on-going circumstance, which will have, or is already having, an effect upon the achievement

of objectives.

Categories of risk

The Trust is exposed to range of risks which have the potential to damage or threaten the achievement of the Trust objectives. The categories of risk faced by the Trust include:

Risk category	Description
Strategic	is associated with the Trust's ability to deliver national and local priorities and maintain ongoing clinical and financial viability
Performance	the ability of the Trust to deliver high quality care for patients in accordance with the Trust's business plan and the standards set by NHS England, the Care Quality Commission, and the North Central London Integrated Care System
Financial	is a potential weakness in financial control which could result in a failure to safeguard assets, impacting adversely on the Trust's financial viability and capability for providing services
Reputation	may occur if the organisation receives negative publicity, which impacts on public and stakeholder confidence in the organisation.
Operational	threaten the day-to-day delivery of clinical care and services
Clinical	are risks whose causes or effects are primarily related to the health and wellbeing of service users or the provision of care to them.
Health and safety	are risks which potentially affect the health or safety of any person as a result of environmental or Trust factors.
Organisational	are defined as those risks which relate to the way in which the Trust is organised, managed and governed.
Information security	any breach of confidentiality/deliberate or inadvertent disclosure of person identifiable /sensitive information to those outside the ''need to know'' requirements. Loss of data – loss, theft or destruction of records held by the Trust in whatever form (paper/electronic) including cyber-crime / security
Event	relate to happenings outside of the control of the Trust for example environmental disasters such as floods, acts of terrorism and major epidemics.

Risk management definitions

Risk management is a process of:

the systematic and consistent identification, analysis, assessment and control of risks to the delivery of the organisation's objectives, evaluating their potential likelihood and consequences and implementing the most effective way of controlling, mitigating or tolerating risks.

Risk term	Definition
Risk	"the chance of something happening, or a hazard being realised, that will have an impact upon objectives''. It is measured in terms of consequence and likelihood.
Risk appetite statement	can be defined as 'the amount and type of risk that an organisation is willing to take in order to meet their strategic objectives. Organisations will have different risk appetites depending on their sector, culture and objectives. A range of appetites exist for different risk types and these may change over time.
Mitigating actions	are individual actions which reduce the likelihood of a risk materialising or reduce the potential impact of a risk
Controls	are committees, systems, policies or people which act to minimise or reduce either the impact (consequence) or likelihood (or both) of risks. Controls may be comprised of a number of individual actions, which need to be taken together to become effective. The Trust must ensure that there are controls in place to manage identified risks. The controls in place must be documented in the Risk Register. Controls must be mapped to each of the risks identified. Controls are assessed regularly to determine whether there are any gaps. Mitigating actions should be identified to address gaps in control if the level of risk is deemed as unacceptable.
Assurance	is an integral part of the Trust's governance and risk management arrangements. Assurance provides the Board with the confidence that the controls (systems, policies and people in place) are operating effectively. Assurance can be identified from a number of sources;

Risk term	Definition
	internal, external or independent sources or a combination. All sources of assurance used to evidence that the controls in place are effective should be documented within the Trust's risk register. Assurances listed should be specific and clearly mapped to controls. Actions should be identified to address gaps in assurance if the level of risk is deemed as unacceptable. Assurance on the effectiveness of the controls detailed in the Trust Risk Register will be obtained through a range of internal and external sources including e.g. internal and external audit, regulatory visits and peer reviews.
Risk Registers	are a tool for documenting risks, controls and actions to manage each risk.

Risk appetite

Risk appetite is the level of risk, the Trust Board deems acceptable or unacceptable based on the specific risk category and circumstances/situation facing the Trust. This allows the Trust to measure, monitor and adjust via mitigations and investments, as necessary, the actual risk positions against the agreed risk appetite.

The Trust Board has adopted a risk appetite statement which is the amount of risk it is willing to accept in seeking to achieve its agreed strategic objectives. As well as the overall risk appetite statement, separate statements are provided for each, in the table overleaf.

The following risk appetite levels, adapted from the Good Governance Institute, along with this statement, will be used to assess the effective mitigation of risks in the Board Assurance Framework and the in-year, operational risk register (Trust Risk Register).

Appetite level	Description	Comments
None	Avoid	A requirement to avoid risk and uncertainty to deliver an agreed organisational objective
Low	Minimal	A preference for very safe delivery options that have a low degree of inherent risk
Moderate	Cautious	A preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for improvement or value for money gains

Appetite level	Description	Comments
High	Open	A willingness to consider all potential delivery options and select those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement or value for money gains
Significant	Seek	There is a preference to be innovative and to choose options potentially seeking higher rewards despite greater inherent risk. This would partly be because there was confidence of assurance that controls, forward scanning and responsive systems are robust,

Risk Appetite Statement

The Trust recognises that its long-term sustainability depends upon the delivery of its strategic and Trust objectives and its relationships with its service users, carers, staff, public and partners. It will not tolerate risks that materially provide a negative impact on quality or safety of patient care. It does, however, have a greater appetite to take considered risks in terms of their impact on organisational issues. It also has the greatest appetite to pursue commercial gain, partnerships, clinical innovation, financial/value for money and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Whittington Health NHS Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its service users, carers, staff, public and partners. The Board of Directors has developed and agreed the principles of risk that the Trust is prepared to accept, deal and tolerate whilst in pursuit of its objectives.

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

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

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

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

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

Board Assurance Framework

The Board Assurance Framework (BAF) provides a structure and process that enables the Trust to focus on risks to the delivery of its 2019/24 Framework and its annual Trust objectives and be assured that adequate controls are operating to reduce these risks to tolerable levels (Good Governance Institute 2009).

The Board and its Committees review the progress in controlling risks to these important objectives, the levels of assurance, and plans to mitigate the impact of the actual or potential risk on the Trust. It importantly determines the accountability structure for the risk.

Good practice associated with the BAF is, as follows:

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

The relationship between the risk register and BAF is set out in the table below (**note this is an example, not based on actual DATIX references**). The fundamental difference between the Risk Register and the BAF is that the Risk Register is focused on the day-to-day operational management of risk for the organisation and the BAF details more longer term risks to the delivery of our strategic objectives.

Example

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

The Associate Director for Quality Governance is responsible for presenting the key changes to the ≥15 Risk Register to the Trust Management Group (TMG). The TMG, along with other Board Committees referenced in section 6. are responsible for recommending changes to the BAF that must be approved by the Trust Board.

In partnership with respective risk leads, the Chief Strategy, Digital and Improvement Officer and Trust Company Secretary are responsible for maintaining and reporting on the BAF, including updating the Framework as required, including providing reports to the Trust Board, highlighting changes to the BAF.

Trust Risk Register

The Trust has set a threshold of a 15 or above score for a risk entry for review by Board Committees. This is to ensure that there is Non-Executive Director and Executive Director oversight of these risks and a clear escalation and assurance process through the Trust's committee governance structure to Board.

All ICSUs/Directorates are responsible for ensuring there are clear risk management structures and processes in their areas, including the regular review of all their risks from a specialty to ICSU/Directorate level.

All risks ≥15 and are automatically escalated to the relevant sub- committees and collated from the central database on DATIX.

The Associate Director of Quality Governance is responsible, with the help of ICSU Quality and Risk Managers, for managing the Trust Risk Register and for reporting to the executive team, Trust Management Group, Board Committees and Board on the ≥15 Risk Register.

There will be a monthly review of the above 15 scored Risk Register entries by the Executive Team and each quarter by the Trust Management Group. New risk entries scored 15 or above will be reviewed at the next available Executive Team meeting before being formally accepted onto the Trust's Trust risk register. If the risk rating is agreed a nominated executive director lead will be agreed who will take responsibility for ensuring the risk entry clearly documents controls and assurances and agreeing an action plan to further mitigate the risk.

Conversely any ≥15 that is reduced will be reviewed at the next available Executive Team meeting before being formally reduced on the Trust's Trust risk register

Governance arrangements for ≥15 risk register and the BAF

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

Governance forum	Board Assurance Framework	Risk Register
Trust Board	Quarterly	Quarterly - ≥ 15 risk register

Governance forum	Board Assurance Framework	Risk Register
Audit & Risk Committee	Quarterly	Each meeting - ≥ 15 risk register
Finance & Business Development Committee	Finance risks at each meeting	Each meeting - Finance, Information Management & Technology and Information Governance risks ≥15
Quality Assurance Committee	Quality risks at each meeting	All ≥ 15 risks
Workforce Assurance Committee	People risks at each meeting	All workforce risks ≥15
Innovation Performance Digital Committee	Digital and performance risks at each meeting	All risks ≥15
Trust Management Group	Quarterly	Quarterly ≥ 15 risk register
ICSU Performance review	Monthly	All risks ≥15
Executive team	Weekly	New Trust Risk Register entries scored at ≥15

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

Risk management process

The risk review process is detailed within the risk management policy and procedure. It includes the following steps:

- Risks are included on the risk register using the Datix system.
- Risk entries scored at 15 or above risks must first be approved by the executive team before being included. A reduction in these risks' scores must also be approved by the executive team.
- Risks relevant to each ICSU / department on the risk register are reviewed at the ICSU Board Governance meetings.
- Approved risks are reported to the Board and sub committees

Escalation and de-escalation of risks

Risks will be escalated or de-escalated within the defined risk levels (≥15 as Trust risks) and authority to act for each level. The risk owner should discuss and seek approval from their manager, who in turn should consult the risk register owner before risk escalation or de-escalation to the next level, when necessary.

A risk will then be reviewed and either accepted at the next level and agreed at the relevant risk forum or rejected and returned to the management team to review and rescore, or for further action. It is important that risks are reviewed regularly to ensure appropriate action, including closing risks or action plans where necessary.

Risk registers at ICSU and corporate department level are reviewed to ensure that any common risks across areas are identified and aggregated to ensure that the full risk profile of the Trust is considered. This will aid in identifying lower risk issues which may be common across many areas.

Training

At the heart of the Risk Management Framework is the desire to learn from events and situations in order to continuously improve management processes. All members of staff have an important role to play in identifying, assessing, reviewing and managing risk. The Trust will develop all staff to ensure they have the knowledge and skills in risk management appropriate to their role and provide information, training and support to achieve this.

Further details of training requirements for staff are contained in the risk management policy and procedure – please contact the Quality governance team. As general principles, the Trust will:

- ensure all staff have access to a copy of this Risk Management Framework via the Trust's Intranet
- communicate with staff actions to be taken with respect to assurance, quality and risk issues as appropriate e.g. via the Trust weekly e-noticeboard
- develop policies, procedures and guidelines based on the results of assessments, investigations and all identified risks
- ensure that training programmes raise and sustain awareness of the importance of identifying and managing risk
- ensure that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies, procedures and guidelines associated with this Framework
- facilitate specific risk management training for Board Members, Executives and Senior Managers, as specified

Monitoring the effectiveness of the Risk Management Framework

The Trust Board and Audit and Risk Committee will review this Framework annually following the recommendations made by internal auditors.

The Trust will seek assurance that risk management activities and systems are being appropriately identified and managed through the following:

- The Annual Governance Statement, the Board Assurance Framework and the management of entries on the Trust Risk Register
- Achievement of the Trust's strategic goals and annual Trust objectives
- Achievement of the ICSU business plans
- Compliance with National Standards e.g. Care Quality Commission
- Monitoring of key performance indicators via the Trust, Quality Account and ICSU performance dashboards
- Receiving assurance from internal and external audit reports that the Trust's risk management and governance processes are being implemented
- External reporting is undertaken in accordance with reporting requirements and timescales
- Risk register reports to the Trust Management Group, Board Committees and Board

Appendix 1: Governance forums - risk management roles and responsibilities

This section outlines roles, responsibilities and accountability for risk management for Trust governance forums, as follows:

Area/Forum	Risk management responsibility
Trust Board	is corporately responsible for ratifying and adhering to the Risk Management Framework and for providing leadership of the organisation within prudent and effective controls that provide assurance that risks are effectively identified and managed. is responsible for ensuring that the Trust follows the principles of sound governance. The Board is required to produce statements of assurance that it is doing its "reasonable best" to ensure the Trust meets its objectives and protect against risks of all kinds. In relation to this Framework the Trust Board will: • have a structured risk identification system covering all possible risks to its objectives, with robust controls in place for the management of identified risks including action and contingency plans • develop appropriate monitoring and review mechanisms that provide independent assurance to the Board that the system of risk management across the trust is effective • pay particular note to bribery risks within the Trust and note the requirements of s7 of the Bribery Act 2010 (Failure of commercial organisations to prevent bribery). The Trust will have a defence to the above section as long as procedures are put in place to prevent bribery as informed by the six principles set out in the Ministry of Justice Bribery Act Guidance).
Audit and Risk Committee	provides an independent objective opinion to the Board on whether the Trust has adequate and effective internal financial control systems in place. It receives reports and where any issues or concerns are raised, the committee reviews action plans in place to address the issues in a timely manner. is the lead forum for risk management, including oversight of the Board Assurance Framework, supported by other Board Committees. This is achieved by receiving reports and presentations from lead directors, and receiving reports from the Trust's internal auditors, on the effectiveness of the Board Assurance Framework and the systems in place to

Area/Forum	Risk management responsibility
	enable the Chief Executive to sign off the Annual Governance Statement. oversees risk management and providing assurance for the Trust Board that all significant risks are adequately managed. appoints independent internal auditors who will develop and deliver an annual audit programme for the Trust. This includes verifying that the Trust has suitable and effective systems of internal controls with respect to risk management are in place and effective. An annual Head of Internal Audit Opinion will be presented to the Audit Committee. provides overview and scrutiny of risk management. The terms of reference have been devised in line with the Audit Committee Handbook to reflect its role as the senior Board committee taking a wider responsibility for scrutinising the risks and controls which affect all aspects of the organisation's business including oversight and scrutiny of the Trust's systems of internal control and risk management. is responsible for compliance with the NHS Counter Fraud Authority's Standards for NHS providers which include the requirement for fraud risk assessment to be conducted and accounted for in the Trust's annual self-review return.
Finance and Business Development Committee	Will review and oversee the mitigation of risks to the delivery of the Sustainable 1 and 2 entries on the BAF
Quality Assurance Committee	focuses on reviewing, monitoring and scrutiny of all aspects of the Trust's quality governance risks, across the Trust's activities, which threaten the achievement of the Trust's Quality objectives. It also had leads responsibility for overseeing the effective delivery of our integration 2 BAF entry which covered population health and health inequalities.
Innovation Performance Digital Committee	Will review and provide assurance on the effective mitigation of risks to delivery of our digital strategy and also on performance areas covered in the integrated performance report
Workforce Assurance Committee	Will review and provide assurance on the effective mitigation of People entries on the BAF and risks to the delivery of the People strategy and Inclusion Improvement Plan

Area/Forum	Risk management responsibility
Executive Directors	Each Executive Director has delegated authority for the delivery of specific objectives and therefore for assessing the risks associated with the delivery of those objectives. This includes a Quality Impact Assessment on all CIP schemes. It is the responsibility of each Director and their management team to implement local arrangements which accord with the principles and the objectives set out in this Framework. Each Director has overall responsibility for ensuring that information held on the risk register and Board Assurance Framework is up to date and accurately reflects the current status. Executive Directors also have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge and oversight of risk.
Non-Executive Directors	are expected to hold the Executive to account and to use their skills and experience to make sure that the interests of patients, staff and Trust as a whole, remain paramount. They have a significant responsibility for scrutinising the business of the Trust particularly in relation to risk and assurance.
Executive team	will review and consider new proposed entries scored at 15 and above for the trust risk register and ensure they are sighted on Trust risks and assured that there is appropriate mitigation and actions in place
Trust Management Group	is the key executive and director-led forum for the review and management of risks included on both the Board Assurance Framework and the Trust Risk Register
ICSU Boards and corporate departments	as a minimum at each ICSU Board meeting, provides leadership, driving the local governance agenda that includes reviewing and monitoring: • local arrangements for risk management • aggregated risk data • ICSU local risk registers They are also responsible for undertaking regular 'horizon scanning' to identify risks by looking forward to as part of the development of the ICSU and Trust Risk Registers, and to ensure effective escalation of serious risk to the relevant Executive lead
Quality Governance Committee	is responsible to the Quality Assurance Committee for developing and monitoring an effective and integrated process of clinical governance and risk management.

Area/Forum	Risk management responsibility
Health and Safety Committee	is responsible to the Quality Assurance Committee for developing and co- ordinating the implementation of risk control plans in relation to the health and safety and welfare of staff, patients and members of the public in accordance with legislation. It is responsible for ensuring that health and safety decisions are adequately consulted upon with accredited representatives
Safeguarding Committee	is responsible to the Quality Assurance Committee for providing strategic direction for the Trust in relation to its statutory obligations for safeguarding adults and children and promoting their welfare and to provide the Trust Board with assurance that adequate controls are in place to identify and manage risk and to integrate activities relating to safeguarding
Medicines Safety Group	is responsible for reviewing and monitoring medication incidents and ensuring appropriate actions have been taken.
Infection Prevention and Control Committee	is responsible for developing implementing and monitoring the Trust's strategy for infection prevention and control including the development of the annual programme for infection control in line with Trust Framework for infection prevention and control.
Serious Incident Executive Assurance Group	is responsible for providing assurance to the Quality Committee and Trust Board for the management and investigation and learning following Serious Incidents

Appendix 2: BAF review process by Board Committees

Board Assurance Framework Reporting and Process

BAF reviews/assurance ratings

In order for committees to provide the Board with assurance and evaluate the BAF risks, the Board requested that the committees should review the BAF entries it has responsibility for and assign an assurance rating to each.

Board and executive-led committees should ask the following questions when reviewing risk registers:

a) Are the issues set out in the Committee's allocated BAF risks planned through the committee's workplan/cycle of business?

b) What information have we considered as part of our agenda that provides us with assurance related to this risk? (If none or insufficient, then what do we expect/need to receive on future agendas to provide us with assurance?)

c) On the basis of the information received as a committee, how assured are we that this risk is being managed appropriately? (Are we communicating significant, partial or limited assurance to the Board and on what basis?)

A guide for assigning an assurance rating is provided in the table below:

High/significant	High – Positive / Reasonable Assurance is where there is sufficient evidence that the subject matter agrees to certain criteria.
Medium/partial	Medium – Negative / Limited assurance e.g A weakness in control which, although not fundamental, relates to shortcomings which expose individual business systems to a immediate level of threatening risk or poor value for money. Such a risk could impact on operational objectives and should be of concern to senior management and requires prompt specific action.
Low/limited	Low – Negative / no assurance provided. A control showing weakness where there is substantial risk of loss, fraud, impropriety, poor value for money, or failure to achieve organisational objectives. Such risk could lead to an adverse impact on the business. Remedial action must be taken urgently.

Meeting title	**Trust Board – public meeting**	**Date: 26 March 2024**
Report title	**Charitable Funds Committee Chair's Assurance report**	**Agenda item: 12**
Committee Chair	Amanda Gibbon, Non-Executive Director	
Executive lead	Jonathan Gardener, Chief Strategy, Improvement and Digital Officer	
Report author	Swarnjit Singh, Trust Company Secretary	
Executive summary	In line with governance arrangements, this Committee Chair's report reports on areas of assurance on the items considered at the 26 February 2024 Charitable Funds Committee meeting which included: • Month 9 Finance report including fund balances. • Charity report – door drop mailing proposal • Applications for funding There were no items covered at this meeting for which the Committee is reporting limited assurance to the Trust Board. The key areas that the Committee wishes to draw to the Board's attention are: 1. The Committee welcomed the successful expression of interest submission to the NHS Charities Together Greener Communities Fund to create a garden at Tynemouth Road and the subsequent application submitted on 28 January. The Committee also welcomed the matched funding contribution which had been secured for this £150k application. 2. The Committee considered a proposal to implement a door drop mailing exercise and agreed that its proposed date of late May be reconsidered. 3. The success of the Charity in the last quarter both in securing cash donations and 'in kind' support.	
Purpose	Noting	
Recommendation(s)	Board members are invited to note the Chair's assurance report for the Charitable Funds Committee meeting held on 24 February 2024	
Appendices	None	

Committee Chair's Assurance report:	Charitable Funds Committee
Date of meeting	24 February 2024

Summary of assurance:

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

Month 9 Finance report

- The Committee reviewed the Finance report and noted these points:
- Reported income to December 2023 was £359k.
- Expenditure to July was £531k.
- Investments decreased by £21k on the value which was now around £1m
- There was a net consumption of Charitable funds in the amount of £172k before movements in the investment portfolio were taken into consideration.
- The investment portfolio's performance is reported quarterly and showed a gain of £38k for the period 1 April 2023 to 31 December 2023.
- As of 31 December 2023, the total fund balance was £1.95m.
- Donations and grants contributed £308k (85.7%) of total income. A significant proportion (£98k) related to donations received from the Stuttering Foundation.
- The statement of financial position outlined that the Charity had settled a number of its liabilities with the Trust and that had had an impact on cash balances, which reduced from £1.67m to £1.19m at the end of December.
- All the individual funds ended in a positive balance as at 31st December.

The Committee agreed that charity expenditure should be monitored and managed, including for the urgent assistance fund. Committee members also agreed that reporting on the use of the urgent assistance fund should come to future meetings to demonstrate its effectiveness along with individual stories in the Impact report.

Assurance was sought on the mismatch between income and expenditure and whether it was expected that income would catch up in the last quarter. The Charity Accountant explained that all liabilities would be cleared by 31 January 2024 and there would be a very up-to-date set of accounts with no outstanding items brought forward.

In answer to a question from Nailesh Rambhai, the Head of the Charity confirmed that, in addition to the Charity Accountant, there were 2.9 wte staff in the team. It was agreed that the Head of the Charity would send Nailesh Rambhai the report with recommendations from the More Partnership.

Charity Report

The Committee reviewed a report setting out all significant charity activity during the period 10 November 2023 to 14 February 2024. In particular, they noted the following issues:

- The Charity was successful in an expression of interest to the NHS Charities Together Greener Communities Fund to create a garden at Tynemouth Road. A matched funding contribution, subject to the application's success, was also secured.
- Following consultation with NHS Charities Together, the Charity had submitted an application for £150,000 with the full support of community partners including Tottenham Hotspur Community Foundation and SEND

Power in Haringey. The Charity was very proud of the quality of the application and an outcome was expected by Easter.

- As part of the maternity and neonatal project, three rooms are being refurbished with the help of an interior designer and with good engagement from the staff and patient voices reflected. The shortfall would be fundraised for.
- The Stuttering Foundation of America had pledged another year of support amounting to $250,000.
- The Michael Palin Centre had at least £20,000 not showing but expected. The lack of resource in the estates and facilities department had now been resolved so the Courtyard project, intensive treatment unit, and Dementia garden projects were in a better place.
- Events at Simmons House had necessitated the pausing of fundraising activity for the garden, and discussions were taking place with Dr Kerry Robinson on Ifor ward regarding fundraising for paediatric mental health so as not to lose previous work.
- The Christmas appeal was disappointing but this was in line with performance across the sector and it was felt that this was further evidence of the need to focus on the major fundraising donations.

The Committee welcomed the very good application to create a garden at Tynemouth Road. The Committee also received assurance that monitoring took place of gifts in kind and that confirmation was being sought from auditors that substantial gifts should be referenced with a note in annual accounts. The Committee also discussed and agreed that, as the maternity and neonatal transformation project progressed, there would be discussions with the Whittington Babies charity regarding use of the Whittington name and whether they would wish to be part of the Charity.

Door drop mailing proposal

The Committee was informed that the Charity team were considering this proposal and hoped to start work next month. The aim was to raise awareness and to recruit supporters and regular donors from the local area. The Letterbox Consultancy had confirmed the number of potential high wealth donors within the local community. The proposal was for a one-mile radius which entailed approximately 33,000 households, with an appeal focusing on paediatrics and other refurbishment projects. The cost would be £10.7k with estimated immediate income of £7.4k to breakeven around 18 months-3 years, with good stewardship principles applied. The intention was for the Door drop to take place in late May. It was noted that the Royal Free Hospital had recently had a successful mailing initiative.

The Committee discussed the proposal and received confirmation that a more personalised approach could not be undertaken because of requirements laid out in the general data protection regulation. Committee members expressed concern at the need to carry out a door drop exercise twice a year in view of the costs. Committee members also discussed delaying the door drop until September and it was agreed that the date for its go ahead would be confirmed outside the meeting.

Applications for Funding

The Committee reviewed and approved the following bids for charitable funding:

- Mosaic Benches at River Place Health Centre (£6,600)
- Increased supplier costs for the installation of interactive play equipment in the atrium space for children's paediatric imaging (£12k-£14k)
- Annual staff awards (£36k with the proviso that sponsorship be sought along with a cheaper proposed venue)

	The Committee also provided feedback on successful bids, some of which would be brought back to its next meeting.
2.	**Attendance:** Amanda Gibbon, Non-Executive Director (Committee Chair) Clare Dollery, Acting Deputy Chief Executive and Medical Director Jonathon Gardner, Chief Strategy, Digital and Improvement Officer Julia Neuberger, Non-Executive Director Nailesh Rambhai, Non-Executive Director Terry Whittle, Chief Finance Officer Sarah Wilding, Chief Nurse and Director of Allied Health Professionals **Fundraising** Vivien Bucke, Business Support Manager Ellen Kyriacou, Charity Accountant Martin Linton, Assistant Director Financial Services Sam Lister, Head of Charity Katherine Mobey, Fundraising Manager Ilana Pizer-Mason, Consultant Midwife for Public Health and Education (Interim) Swarnjit Singh, Trust Company Secretary **Apologies:** Tony Rice, Independent Director