NHS
Whittington Health
NHS Trust

Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board held in public on **Friday, 24 May 2024** from **9.30am to 11.00am** held at rooms A1 and A2 Whittington Education Centre Highgate Hill London N19 5NF

Item	Time	Title	Presenter	Action
		Standing agenda items		
1.	*0930*	Patient experience story	Chief Nurse	Discuss
2.	*0945*	Welcome, apologies, declarations of interest	Trust Chair	Note
3.	*0946*	26 March 2024 public Board meeting minutes, action log, matters arising	Trust Chair	Approve
4.	*0950*	Chair's report	Trust Chair	Note
5.	*0955*	Acting Chief Executive's report	Acting Chief Executive	Note
		Quality and safety		
6.	*1005*	Quality Assurance Committee report	Committee Chair	Approve
7.		Annual safeguarding children & adults declaration	Chief Nurse & Director of Allied Health Professionals	Approve
8.		Annual single gender accommodation declaration	Chief Nurse & Director of Allied Health Professionals	Approve
		Performance		
9.	*1015*	Integrated performance report	Chief Strategy Digital and Improvement Officer	Discuss
10.	*1020*	Finance, capital expenditure and cost improvement programme report	Chief Finance Officer	Discuss
		People		
11.	*1025*	Workforce Assurance Committee report (to follow)	Committee Chair	Approve

12.	*1030*	Freedom to Speak Up Guardian report	Chief People Officer	Note
13.	*1035*	2023 NHS Staff Survey Outcomes and Priorities	Chief People Officer	Discuss
14.	*1040*	Workforce Disability & Race Equality Standards Submission	Chief People Officer	Approve
		Governance		
15.	*1045*	Charitable Funds Committee report (to follow)	Committee Chair	Note
16.	*1050*	Questions to the Board from the public agenda items	Committee Chair	Note
17.	*1055*	Any other urgent business	Trust Chair	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 26 March 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
Amanda Gibbon	Non-Executive Director (via Microsoft Teams)
Chinyama Okunuga	Chief Operating Officer
Nailesh Rambhai	Non-Executive Director
Baroness Glenys Thornton	Non-Executive Director (via Microsoft Teams)
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
Ann Phillips	Colorectal Clinical Nurse Specialist (item 2)
Andrew Sharratt	Associate Director of Communications and Engagement
Swarnjit Singh	Joint Director of Inclusion and Trust Company Secretary
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 being held in public.
1.2	Apologies for absence were noted for Junaid Bajwa, Non-Executive Director. There were no new declarations of interest.
2.	**Patient story**
2.1	Sarah Wilding introduced Mr X who had who had been under the care of Whittington Health for several years and had come to share his journey and patient experience. He explained that: • In November 2018, was referred by his GP to have a scan following a bad cough, following which, he was immediately referred for a colonoscopy that confirmed a diagnosis of colorectal cancer. • He was grateful for the speed of response of Trust services and the level of communication from the colorectal services team, which was always very good.

	• Surgery took place on 20 December 2018 to remove a tumour and was successful. Without complications or further treatment required, he was discharged after four days in hospital. • He was put on the five-year surveillance protocol for colorectal cancer, which provided a personal treatment plan created between patient and staff. • One of the elements of the plan was that the patient can initiate their own follow up in advance of their next planned appointment date, should they have concerns and get treated earlier. As part of the protocol, he had had further checks in 2022 and 2023, which had identified no problems.
2.2	In discussion, Board members raised the following points: • The Chair and Matthew Shaw thanked the colorectal services team. • Rob Vincent welcomed the impressive level of contact and communication maintained with Mr X, particularly during the Covid-19 pandemic period. • Naomi Fulop supported Mr X's ability to be able to contact the colorectal team directly, which was an efficient use of patient initiated follow ups and suggested this approach be adopted in other services. • Ann Phillips explained that GPs were kept informed of further monitoring and checks carried out by the colorectal services team. **The Chair thanked Mr X for sharing his experiences with Board members.**
3.	**Minutes of the previous meeting**
3.1	The minutes of the meeting held on 26 January 2024 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 all staff, who were working incredibly hard. She also thanked the senior team, in particular Matthew Shaw, Clare Dollery and Terry Whittle, for the visible leadership they had shown across the Trust. On behalf of the Board, she expressed huge thanks to Norma French, Director of Workforce, and to Matthew Shaw, Interim Accountable Officer, both of whom were leaving the Trust at the end of March. In addition, she paid a warm welcome to Liz O'Hara, Chief People Officer, who was attending her first Whittington Health Board meeting.
4.2.	**The Trust Board received and noted the Chair's report.**
5.	**Interim Accountable Officer's report**
5.1	Clare Dollery took the report as read and drew attention to the following: • The results of the 2023 NHS Staff Survey, which took place between 27 September and 24 November 2023, showed a number of areas in which significant progress had been achieved. The priority areas for action would be related to questions in the survey on the areas of safe and healthy, flexible working and morale. • She was delighted to attend the official opening of the Wood Green Community Diagnostic Centre's lower ground floor by Professor Sir Mike Richards. As well as providing blood tests, x-rays, ultrasounds, and an eye

	(ophthalmology) clinic, patients could now also access MRI and CT scans. The Centre would really help to make a difference in helping the NHS to achieve its aims of reducing waiting times for diagnostic imaging and to address health inequalities for local people. • Emergency department performance against the four hour standard continued to show improvement and was now above 70%, representing a 13% improvement since December 2023. There had also been welcome improvements in performance seen against the 28 day faster diagnosis cancer standard and in the continuing reduction in the number of patients who had waited longer than 52 weeks for treatment. • She was pleased to announce 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. • She had been delighted to present Beth Bamberger, a speech and language therapist in our Barnet children's therapy services, with her extra mile award.
5.2	Matthew Shaw acknowledged the hard work and efforts of Chinyama Okunuga and operational staff. **The Trust Board noted the Interim Accountable Officer's report.**
6.	**Impact of Industrial Action**
6.1	Clare Dollery explained that the paper was an update to the previous report considered at the January Board meeting held in public, with details included about the industrial action which took place in January. The report did not include data for the industrial action which took place in February, as that information was still being collated. Clare Dollery provided assurance that Whittington Health's approach to providing services during the periods of industrial action had been focused throughout on the prioritisation of patient safety and the maintenance of good relations between different professional staff groups. She acknowledged the impact of the strikes on patients who had to have appointments rescheduled and commended the professionalism of multi-disciplinary team members who had worked very hard to ensure safety during strikes.
6.2	Nailesh Rambhai welcomed the helpful report and asked about the impact in terms of payroll. Norma French explained that calculations to deduct pay for industrial action were carried out manually and that the Finance team could arrange for an update to be sent to Board members. Rob Vincent was grateful for the clear and objective report. He asked whether the information contained within it was available to staff. Clare Dollery confirmed that the report discussed at January's Board meeting had previously been considered by the Truist's Clinical Advisory Group and that this report could be taken to the Medical Committee. Jonathan Gardner highlighted the impact of the strikes on the improvement team's work and on administrative staff who had had to rebook appointments. In reply to a question from Amanda Gibbon, Clare Dollery re-iterated the Trust's statement of intent to treat with equal courtesy staff who chose to take industrial action and those who did not.

	The Board noted the report on the impact of industrial action and agreed that details of the impact on payroll from the industrial action be circulated by email to Board members and that the report be shared with the Medical Committee.
7.	**Quality Assurance Committee Chair's report**
7.1	Amanda Gibbon presented the report and explained that the four areas to alert Board members to included the IRMER incidents, the adverse impact of industrial action , pressure ulcers in the community and anti-ligature assessments. She explained that, although the IRMER incidents involved exposure to very low levels of radiation, the volume of cases involved met the threshold for communication to the Care Quality Commission (CQC). On ligature assessments, she confirmed that the Committee took only moderate assurance from this item, as there was a need for the estates and facilities team to confirm the works needed in some places and action them.
7.2	Amanda Gibbon highlighted other agenda items considered at the meeting. She cited the quarter three maternity report and welcomed the use of maternity incentive scheme monies to deliver areas of the CQC action plan and to recruit to a specific midwifery role to review and keep clinical policies up-to-date. Amanda Gibbon reported that the Committee also welcomed the increased training compliance for safeguarding training and the presentation on Dialectical Behaviour Therapy.
7.3	Naomi Fulop sought an update on difficulties with deliveries of equipment needed in the community by NRS Healthcare, as this was one contributory factor for pressure ulcers in the community. Sarah Wilding confirmed that discussions were continuing and that the Trust would be writing formally to raise its concerns at the delays in equipment being delivered. She added that this issue would also be raised with the NCL ICB's Safeguarding Committee.
7.4	Glenys Thornton commented that compliance with the maternity incentive scheme had become considerably harder each year and that compliance with the year five requirements would be a tough challenge. **The Trust Board noted the Chair's assurance report for the Quality Assurance Committee meeting held on 13 March.**
8.	**Finance and capital expenditure report**
8.1	Terry Whittle took the finance report as read. He reported a deficit of £16.4m at the end of February which was £6.9m off plan. He explained that the principal drivers for the deficit were underperformance in the delivery of cost improvement savings, unfunded escalation beds, the impact of industrial action leading to underperformance on the level of elective recovery fund monies achieved, and expenditure overspends. Terry Whittle also explained that investment was being sought from the NCL ICB for the escalation beds and that £3m had been received in February for the costs incurred for industrial action in December 20234 and January 2024. He confirmed that at the end of February, the Trust had spent £25.7m, on capital expenditure and provided assurance that this would increase to c. £37.8m at the end of March. Terry

	Whittle thanked the Finance team for managing the cash position by accessing funds due early and through using the cash balance to enable the Trust to benefit from higher interest rates. The Chair thanked Terry Whittle for the report and agreed that a message be sent congratulating the Finance team for their work on cash balances.
9.	**Integrated Performance Report**
9.1	Jonathan Gardner presented the report and outlined the following key points: • The Community performance dashboard showed all the indicators for February as green-rated. • For adult community services, there were good improvements on waiting times for podiatry services and there had a been a significant reduction in the MSK backlog by c. 2,000 patients, reflecting the positive impact of the Super Saturday initiatives. • There had been 18 pressure ulcers recorded in February, with 3 in the hospital and 13 in the community. • There continued to be a general upward trend in performance against cancer standards and on long waiters. • In the emergency department, while performance against the four hour access standard was at 73%, there remained an issue with the high number 12-hour trolley waits. • Elective activity remained positive at 107% of 2019/20 levels. • In terms of the well led indicators on the scorecard, there was good progress on compliance with statutory and mandatory training. However average sickness absence levels were at 4.2%, above the 3.5% target.
9.2	In discussion, Board members raised the following points: • Matthew Shaw reported that the impact of the pilot regarding London Ambulance Service's post code changes was being closely monitored for its impact on patients and our performance. • Amanda Gibbon thanked the MSK team for the performance in reducing the number of patients who had been waiting for treatment. She asked whether there would be no patients at 31 March who had waited longer than 78 weeks for treatment. Jonathan Gardner replied to confirm that there would between 9-15 patients who were in this category at the end of the financial year, with the majority being vascular patients. • In reply to a question from Amanda Gibbon on the decrease in theatre utilisation rates, Chinyama Okunuga clarified that there had been an increase in the number of complex cases seen and that there had also been some cancellations. Jonathan Gardner added that theatre productivity was an area of focus for the work of the Improvement team. Clare Dollery commented that Chetan Parmar, the new Clinical Director for the Surgery and Cancer clinical division was keen to increase theatre utilisation. **Board members noted the integrated performance report**
10.	**University College London Hospitals and Whittington Health Case for collaboration**

10.1	Matthew Shaw took the report as read. He highlighted the 2017 memorandum of understanding between both organisations and the provisions within the Health and Social Care Act as a context for increased collaboration between both organisations for the benefit of patient pathways and for staff development and opportunities. Matthew Shaw gave strong support to the case for collaboration and said that next steps would involve establishing a joint committee to take work forward. Clare Dollery stated that it was an exciting and pivotal time for this partnership and reported that an update had been taken to the Medical Committee and a briefing shared with local stakeholders.
10.2	Both Rob Vincent and Nailesh Rambhai voiced support for the collaboration and Jonathan Gardner confirmed that the joint committee would have delegated powers to act. The Chair welcomed the good opportunities to achieve economies of scale and better value for money through increased collaboration. Amanda Gibbon was also supportive of the collaboration and suggested a need to be clear that the Trust did not suffer a financial detriment for either party, particularly through changes in case mix. In response to a question from Glenys Thornton, Jonathan Gardner explained that the collaboration would enable more resilient services, particularly in chemotherapy. Clare Dollery said that joint meetings would be held between the collaboration partners and local authority chief executives and would be more fruitful. She added thanks to the UCLH and Whittington Health urology teams who had established a five-day urology model which was more sustainable. In reply to a question from Naomi Fulop on the reporting arrangements for the joint committee, the Chair confirmed that its meetings would be reported to the Boards of both organisations. Rob Vincent asked that the new Programme Director be invited to a future Board seminar. **The Board approved the case for collaboration between UCLH and Whittington Health and the recommended next steps and agreed that the Programme Director be invited to a future Board seminar.**
11.	**Audit and Risk Committee**
11.1	Amanda Gibbon drew Board members' attention to the agreed 2024/25 plans for internal audit and counter fraud and the reasonable assurance the Committee took from the two internal audit reviews of controlled drugs and payroll services. She reported that KPMG LLP had started their three month audit of the 2023/24 annual accounts. Amanda Gibbon confirmed that the Committee had welcomed the increase in declarations of interest by consultants but said that the current level of disclosures was unsatisfactory. She noted work that was underway to continue to increase that level, including confirmation where there were nil returns.
11.2	In addition, Amanda Gibbon said that the Committee had received a helpful presentation on the impact of the new Procurement Act and welcomed the opportunity for that to be included in the 2024/25 Board seminar programme. She also highlighted the Risk Management Framework and sought endorsement for the Trust's risk appetite statement.

	The Board noted the Chair's assurance report for the Audit and Risk Committee meeting held on 21 March and approved the Risk Management Framework and the 2024/25 risk appetite statement.
12.	**Charitable Funds Committee**
12.1	Amanda Gibbon reported that a positive meeting took place on 24 February. She outlined that Committee members had welcomed the successful expression of interest submission to the NHS Charities Together Greener Communities Fund to create a garden at Tynemouth Road and that the Committee had considered a proposal to implement a door drop mailing exercise and agreed that its proposed date of late May be reconsidered. **The Board noted the Chair's assurance report for the Charitable Funds Committee meeting held on 24 February 2024**
13.	**Questions from the public**
13.1	No questions had been received in time to be asked at the meeting.
14.	**Any other business**
14.1	On behalf of the Board, the Chair gave a huge thanks to Matthew Shaw for bring the Interim Accountable Officer since December 2023.

Trust Board action log

Actions carried forward

Agenda item	Action	Lead(s)	Progress
Patient story, January 2024 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.

Actions from 26 March 2024 meeting

Agenda item	Action	Lead(s)	Progress
Impact of industrial action	Circulate by email to Board members the impact on payroll deductions from industrial action	Terry Whittle	Completed
	Take the paper to a Medical Committee meeting	Clarissa Murdoch	This is on the forward agenda for the Medical Committee
Finance report	On behalf of the Board, send thanks to the Finance team for the year-end cash position	Terry Whittle	Completed
Case for collaboration	Invite the Programme Manager to a future Board seminar	Jonathan Gardner	Included in 2024/25 Board seminar programme
Audit and Risk Committee	Include a briefing/training on the new Procurement Act provisions	Terry Whittle	Included in 2024/25 Board seminar programme

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2024**
Report title	**Chair's report**	**Agenda item: 4**
Non-Executive Director lead	Julia Neuberger, Trust Chair	
Report authors	Swarnjit Singh, Trust Company 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 March 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 start by commending all our staff and volunteers for their hard work in ensuring there are safe services in place and for delivering a good experience for our patients. I fully appreciate that staff have been working under significant pressure with high demand for services and I and all Board members are very grateful to them for their significant efforts.

April Board seminar and private Board meeting

The Board of Whittington Health held a seminar on Friday, 26 April. The issues discussed covered a briefing on fire remediation works for blocks A and L and discussions taking place with the London Fire Brigade on a misting solution. In addition, the Board also reviewed and approved Whittington Health's 2024/25 plan submission on finances, activity and workforce to the North Central London Integrated Care Board and discussed the outcomes from the 2023 NHS staff survey and the priority areas for action.

At the private Board meeting held on the same date, the agenda items discussed included a report from the Acting Chief Executive, an update on Simmons House, the monthly reports on operational performance and finances. The Board also considered Chair's assurance reports from the Improvement, Performance and Digital Committee and the Finance and Business Development Committee. Finally, the Board reviewed delivery in quarter four of 2023/24 the Trust's corporate objectives and approved the 2024/25 annual corporate objectives.

Senior staff changes

I am delighted to welcome Liz O'Hara to the Board. On 27 March she was appointed as the Chief People Officer for both Whittington Health and University College London Hospitals NHS Foundation Trust. 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 organisations.

Visible leadership

I carried out several lengthy walkabouts, talking to staff, patients and volunteers. I was also a regular passenger in the lifts, to hear what people were saying about them. There was noticeable pleasure and relief expressed at the greater cleanliness around the main Whittington Health site, and a real accolade from volunteers for Clare Dollery, Terry Whittle and Chin Okunyuga for their frequent walkabouts and watchful presence. It was a pleasure to hear!

Corporate induction

On 8 April, I took part in corporate induction training and had the opportunity to welcome new starters to Whittington Health.

I have also participated in the following meetings and events:

- University College London Health Alliance
- Whittington Health Medical Committee

- NCL Strategy and Development Committee
- Breast Cancer Expert Advisory Group
- Quarterly meeting with Islington Council
- International Day for Nurses and Midwives

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2024**
Report title	**Acting Chief Executive report**	**Agenda item: 5**
Executive lead	Dr Clare Dollery, Acting Chief Executive	
Report authors	Swarnjit Singh, Trust Company Secretary, and Clare Dollery	
Executive summary	This report provides Board members with an update on key developments nationally, regionally and locally since the last Board meeting held in public on 26 March 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	

Acting Chief Executive report

This is my first report to a Board meeting held in public as Acting Chief Executive and I am delighted to have been given the opportunity to lead Whittington Health as its Accountable Officer. I would like to start by thanking all of my colleagues, who have continued to work extremely hard through the winter months with ongoing industrial action. While the priority has been to maintain patient safety and access to urgent and emergency care, the teams have also continued to offer elective activity through outpatients, diagnostics and surgery as we believe that all patients should have timely access to care.

2024/25 Priorities and operational planning guidance

On 10 April, NHS England published the annual priorities and planning guidance[1] which focuses on the recovery of core services through continuous improvement in access, quality, and productivity, while transforming the way in which care is delivered to help create stronger foundations for delivery in the future. The key national priorities are:

- Maintaining the collective focus on the quality and safety of services – with specific reference to maternity and neonatal services.
- An improvement in ambulance response and accident and emergency waiting times.
- A reduction in waits of over 65 weeks for elective care and an improvement in core cancer and diagnostic standards.
- Improving access to community and primary care services, including dentistry.
- Improving access to mental health services for patients across all age groups.
- Improving staff experience, retention and attendance.
- Integrated Care Boards, trusts and primary care providers working together to plan and deliver a balanced net system financial position.

Internally, staff have been reviewing and refining our submission to the North Central London Integrated Care Board (NCL ICB). The deadline for final submissions was 2 May and the draft plan was considered at the Board's April seminar.

Consultants' pay ballot and junior doctors' industrial action

In early April, the outcome of the revised pay offer that trade unions representing medical staff who are on consultant contracts in England put to their members was accepted. The pay increase is effective from 1 March 2024 and is expected to be implemented in May salaries, including backpay. This positively impacts on the risk of industrial action from this staff group. At the time of writing this report on 16 May there were two developments to include. First, it was announced that junior doctors in England had agreed to meet the government for talks, with independent mediation, for their pay dispute. This is a positive development and it is hoped that it may provide a way forward to end the junior doctors' industrial action. Furthermore, the British Medical Association's GP Committee voted to launch a ballot on potential collective action following a dispute with NHS England over the 2024/25 contract.

[1] 2024/25 priorities and operational planning guidance (england.nhs.uk)

NCL Cancer Alliance Board
On 10 April, I attended the North Central London (NCL) Cancer Alliance Board meeting and am really pleased to report that during a review of achievements in 2023/24, there are a number of successes of which NCL should be proud. These include:

- NCL recording the highest one year and five year survival rates in England.
- Significant year-on-year reductions in the 62-day backlogs– as at 10 March, this stood at 472 which was the lowest position recorded since June 2021
- A significant increase in uptake for targeted lung health checks
- The launch of the NCL Lynch hub – a trailblazer nationally
- The launch of the Innovation Programme with 10 provider-led innovations and a Memorandum of Understanding agreed with University College London Partners

I also informed the meeting that I would be standing down as Chair of the NCL Cancer Alliance program board due to my appointment as Acting CEO of Whittington Health. Professor Geoff Bellingan, Medical Director for surgery and cancer board at UCLH will be taking over this role.

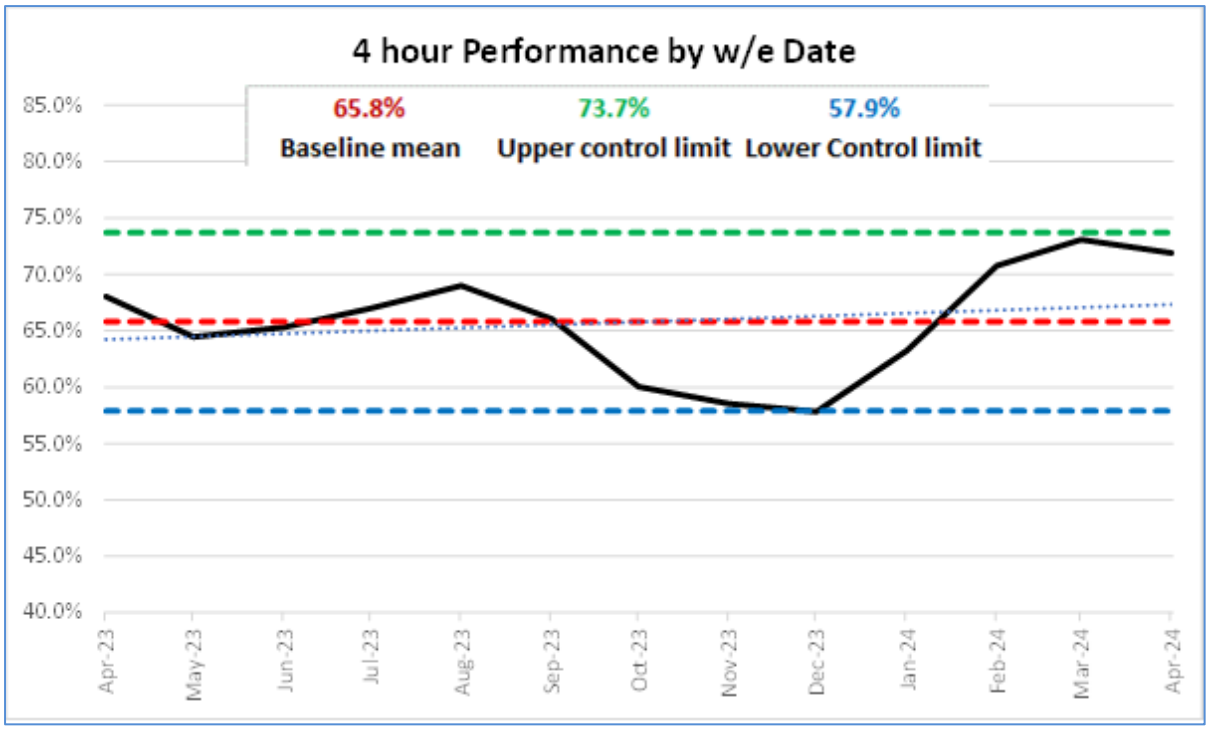
Dame Ruth May visit
Dame Ruth May, Chief Nursing Officer for England, visited our Tynemouth Road site on 10 April. She toured the site and met teams and was briefed on health visiting and school nursing services. In addition, Dame Ruth visited a tuberculosis vaccination clinic and met children in Care nurses and the Parent and Infant psychology service. On 16 April, after 40 years of NHS Service, she has announced her intention to retire. It is however a tribute to our nursing team that Dame Ruth has chosen to visit two of our services in the last 6 months.

Operational performance
The performance report is a separate item on this meeting's agenda. Headlines to note include the following:

- Emergency care: performance against the four-hour access standard in April was 71.9%, down from March's 73.1%. There were 364 12-hour trolley breaches in March 2024, an increase from 221 in the previous month.
- Performance against the 28 Day Faster Diagnosis cancer standard was 74.6% in March 2024 against a target of 75%. This is a drop of 3.1% compared to the 77.7% achieved in February 2024. Performance against the 62-day referral to treatment performance was at 65.9% in March 2024 against a target of 85%. This is an improvement of 0.3% compared to the 65.6% achieved in February 2024.
- Referral to treatment: performance against 18-week standard in April was 67.03%, representing a slight dip from March's 66.4%. There were 454 patients at the end of April who had waited more than 52 weeks for treatment and 9 patients who had waited longer than 78 weeks for treatment since their referral.

Performance against the 4 hour emergency department (ED) standard
There have been continued NCL sector pressures and the impact of other providers requesting frequent London Ambulance Service diverts have affected the overall performance for Whittington Health. An ED improvement working group has been established which focuses on these areas:

- Improving streaming pathways to the urgent treatment centre and primary care services and work to engage with primary care partners.
- Increased collaboration and streaming to ambulatory emergency care to improve pathways.
- Ensuring that paediatric ED consistently achieves greater than 95% performance



Visit to London Ambulance Service (LAS)
On 4 April, I visited the LAS headquarters to meet Daniel Elkeles, Chief Executive, and Dr Fenella Wrigley MBE, Deputy Chief Executive and Chief Medical Officer, Dr Jo Sauvage, Chief Medical Officer, NCL ICB, and Dr Nnenna Osuji, Chief Executive of North Middlesex University Hospital NHS Trust to discuss flows in NCL. Temporary post code changes are being trialled in our sector with reviews taking place via the Slow Operational Group and the NCL Senior Management Board. We also experienced the work of the LAS triaging and conveyancing teams.

NHS England (London) Chief Executive Officers' meetings
On 17 April, I was invited to attend an NHS England's breakfast roundtable meeting on productivity hosted by NHS England's Chair, Richard Meddings, and chaired by Chris Hopson, Chief Strategy Officer. I also attended the 13 May London Chief Executives' meeting which included discussions on the 2023 staff survey results, temporary staffing levels, and an update on 2024/25 plans. In addition, there was an agenda item on London United and Advantage, a community initiative which and is for children referred with low to moderate mental health needs. Whittington Health is part of this scheme and has been partnered with Arsenal Football Club.

All staff briefings
Staff briefings were held on 4 and 18 April and 2 and 16 May and were very well attended. The key areas covered included: publicising the violence and aggression policy which had been updated following feedback from staff, particularly those who make visits to patent's homes; a warm welcome for colleagues in the Barnet 0-19 service which has transferred to Whittington Health; highlighting the categories for

nominations for this year's staff awards; the improvements in emergency department performance against the four hour access standard.

Haringey SEND inspection outcome
I am really pleased to report that the Local Area Partnership Special Education Needs & Disabilities (SEND) inspection carried out by the Care Quality Commission and Ofsted between 15 January and 2 February 2024 achieved the highest rating possible, demonstrating three years of continuous progress. The inspection focused into the effectiveness of the arrangements to identify and meet children's needs and on improved outcomes. Whittington Health provides health visiting, school nursing, therapies, specialist nursing, looked after children services and community paediatrics in the London Borough of Haringey and will continue to work with our partners in education, health and care to build on this positive result and to deliver further improvements.

Maternity Incentive Scheme
Each year, NHS trusts need to submit data, audits, and information required for the NHS Maternity Incentive Scheme. We had to submit against 10 standards, each having multiple requirements to demonstrate the safety of our maternity service. We succeeded in meeting these exacting quality standards, demonstrating we provide a safe service to families. Whittington Health was one of only four NHS trusts in London who were assessed as having successfully implemented all 10 of the safety actions required.

UCL Medical School site visit
The UCL Medical School (UCLMS) Quality Assurance and Enhancement Unit conducted a very successful Trust site visit on 25 April 2024. UCLMS commended Whittington Health in continuing to deliver excellent clinical placements in years 4-6 of the MBBS programme, and for building on previous successes in creating a supportive learning environment and sense of belonging for students. The visiting team congratulated the Undergraduate Education Team for receiving an Excellence in Medical Education award in 2023/24. The Trust's efforts in improving transparency in undergraduate funding expenditure was recognised, with an ongoing commitment from the Trust to continue this work. Further initiatives to improve bidirectional communication between UCLMS and the Whittington Senior Leadership Team are planned, as well as boosting wi-fi access to enhance the student experience.

Transformative new sickle cell treatment
A new drug has been cleared by the National Institute for Health and Care Excellence that could prove transformative for many patients with sickle cell disease, including those at Whittington Health. The new drug, Voxelotor, is the first ever to be made available to all eligible patients on the NHS and is available in a pill form taken once a day. It could help up to 4,000 people reduce the need for blood transfusions and require fewer hospital appointments. It can also be used in conjunction with the long-established treatment hydroxycarbamide, or alone in those unable to take hydroxycarbamide. Whittington Health offered this drug as part of an Early Access to Medicines scheme. Dr Mullally, consultant haematologist at Whittington Health NHS Trust, commented: "I have had the privilege to see the difference this new drug has made to a number of my patients, and I'm delighted that this is now being made available for us to prescribe to all suitable NHS patients."

Dementia Action Week and Mental Health Awareness Week, 13-19 May
The Trust marked Dementia Action Week and helped to raise awareness that dementia is the UK's leading cause of death. The focus of this year's campaign was dementia diagnosis, as 1 in 3 people living in the UK with dementia do not have a diagnosis. At the same time, Whittington Health carried out activities to raise awareness of the need for activity and movement to help boost mental health and wellbeing. On 21 May, the Haringey Talking Therapies team delivered a webinar on how people can look after their mental health.

Too Hot to Handle report
I would like to thank Professor Joy Warmington, co-author of the report, who attended an open forum event held on 7 May with staff to discuss the issues raised in this publication, particularly the adverse experiences of ethnic minority staff working in the NHS. The forum provided a good opportunity to re-affirm Whittington Health's commitment to being an anti-discriminatory and anti-racist organisation which values all of its diverse patients and the contributions and perspectives of its equally diverse workforce.

Nursing and Midwifery Awards
Whittington Health celebrated the International Day of the Midwife and International Nurses Day on 9 May where nursing and midwifery teams showcased their departments. We also held an awards ceremony in the afternoon. I would like to congratulate all the staff who were nominated for an award and the respective winners:

Award category	Winner
Patient Choice Award	Joy Small
Nursing Associate of the Year	Katarina Pickles
Training Nursing Associate of the Year	David Darko
Health Care Assistant of the Year	Maria Mendoza
Maternity Support Worker of the Year	Carol Gardner (Antenatal Clinic)
Preceptee Midwife/Nurse of the year	Kirsty Billong
Student Nurse of the Year	Julie Chadee-Kidder
Student Midwife of the year	Valentina Trevisan.
Specialist Nurse/Midwife of the year	Bridget Akwa-Otu
Digital Innovation lead of the year	Suzanne Khamis (Midwifery)
Educator of the year	Lorraine Sweeney-Jones
Team of the year	Hysteroscopy
Midwife of the Year	Chika Okonkwo
Nurse of the Year	Spiwe Jolomole
Chief Nurse's award	Elaine McWillams.

National Administrative Professionals Day
On 24 April, I was pleased to attend Whittington Health's first ever Administrative staff awards to celebrate the great contribution that our administrative staff, particularly the junior staff, give to the organisation. I would like to thank all staff who were finalists in the awards and to congratulate these winners shown in the table overleaf:

Award category	Winner
Best Admin Professionals Team	Health records
Above the Call	Dezdemona Shkembi
Leadership Award	Sakshi Jain
Best Administrative Professional	Danielle Edwards
Innovation	Enfield school screening
Outstanding Contribution	George Sarfoh
Special recognition	Yeshindenber Mulate

Extra Mile Awards

Each month, Whittington Health staff nominate their colleagues for Extra Mile awards, to recognise their contributions, often in the background. I would like to congratulate the winners for April - Filipa Braga, Women's Health Clinical Governance Manager and the Child Development Centre reception and administrative staff team at Tynemouth Road. Filipa was cited for her work as clinical governance lead in our maternity services and has worked tirelessly to submit the extensive data and evidence needed for compliance with the ten standards which form part of the Maternity Incentive scheme.

Our reception and administrative teams are vital to the Haringey Child Development Centre (CDC). This dedicated administrative team makes sure that paperwork gets completed on time so that patients can make their appointments, and our friendly receptionists are the first to greet families, carers and children who step in through the door, reassure them and address any concerns they may have. In a recent CQC and Ofsted inspection of Haringey Local Area Partnership received the highest rating. This would not have been possible without the support of our administrative and reception teams.

Visits to system partners
On 19 April, I visited the new Highgate East Mental Health Hospital, part of North London Mental Health Partners and had a tour of the excellent facilities for patients and staff with Dr Vincent Kirchner, Medical Director and colleagues, Victoria Lawson, Chief Executive of Islington Council, Councillor Nurullah Turan, Islington's executive member for health and social care, Dr Jo Sauvage, Chief Medical Officer for the NCL ICB, and Jonathan Gardner our own Chief Strategy, Digital and Improvement Officer. It is fascinating to see the new building sitting alongside our own Jenner Building and wonderful to see facilities for physical and mental health co-located.

Michael Palin Centre
On 11 April, I was grateful to visit the Michael Palin Centre for Stammering and met Elaine Kelman, Head of Specialty, and learn about the wonderful work that takes place there to help children, young people and adults who stammer and their families through individually tailored therapy delivered by highly experienced specialists It was an honour to hear the universally positive reflections of a group of parents attending a week long course at the centre with their children. Furthermore, it was great to attend the Evening with Michael Palin event on 25 April, where some young people from the Centre interviewed Michael Palin. Whittington Health would like to thank everyone who donated to the Centre through their ticket purchases and through individual donations on the night.

In addition, on 3 May I visited our wonderful Security team, who do a great job in ensuring that staff and patients are safe when visiting the hospital site. On 15 May, I visited the Hornsey Rise and met Susan Gibbs, Operational Lead for the Islington Urgent Response Service and all the multidisciplinary team who respond to patients in their own home and provide the kit, training and service for remote monitoring.

Staff canteen subsidy
From May, over 60 members of Whittington Health staff based at Edgware Community Hospital will be able to access a discount of 30% on purchases made at the site restaurant. This benefit brings our staff into line with colleagues from other organisations who are based there.

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2024**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 6**
Committee Chair	Naomi Fulop, Non-Executive Director	
Executive leads	Clarissa Murdoch, Acting Medical Director, Chinyama Okunuga, Chief Operating Officer, and Sarah Wilding, Chief Nurse & Director of Allied Health Professionals	
Report author	Marcia Marrast-Lewis, Assistant Trust Secretary and Swarnjit Singh, Trust Company Secretary	
Executive summary	The Quality Assurance Committee met on 8 May 2024 and was able to take good assurance from the following items considered: • The management of patients with sickle cell disease who present to the emergency department presentation. • Q4 Maternity report • Q4 Board Assurance Framework Quality and Integration 2 entries • Haringey Special Education Needs & Disabilities (SEND) inspection • Serious Incident report • Quality Account priorities Committee members took partial assurance from the following agenda items: • Chair's assurance report, Quality Governance Committee • Trust Risk Register • Q4 Quality report • Q4 Patient experience report • Anti-ligature update report • Patient Led Assessment of Care of the Environment (PLACE) Annual Report • Q3 Learning from deaths report The Committee also reviewed the outcome of the Committee's annual self-assessment and terms of reference and agreed suggested amendments. Following discussion, the following areas were agreed to be reported to the Trust Board:	

	1. Infection Control - increase in C difficile rates and MRSA Bacteremia 2. Barnet 0-19 service 3. Ligature risks 4. Hospital Pressure Ulcers 5. Quality impact assessment process 6. PLACE work
Purpose	Noting
Recommendation	Board members are asked to note the Chair's assurance report for the Quality Assurance Committee meeting held on 8 May 2024 and to approve the terms of reference shown in appendix 5.
BAF	Quality 1 and 2 entries and Integration 2 entry
Appendices	1. Q4 Maternity report (without its appendices) 2. Q4 Quality report 3. Q4 Patient experience report 4. Q3 Learning from deaths report 5. Revised Committee terms of reference

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	8 May 2024

Summary of assurance:

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

The management of patients with sickle cell disease who present to the emergency department presentation

Committee members welcomed a presentation from Dr Vanessa Georgoulas, locum consultant and audit lead, based in the emergency department (ED). She explained that that sickle cell audits had been carried out annually since 2020 and the latest audit reviewed the ambulatory care pathway (AEC) to assess the improvements made, the time taken to offload patients from the London Ambulance Service (LAS) and the time taken to administer analgesia. Dr Georgoulas advised that the ED treated 131 patients with sickle cell disease over a 3-month period, of which 65 were analysed for the audit. The audit found that only 13% of these patients were suitable for the AEC, with the main reason being the low numbers was that sickle cell patients were more likely to attend the ED outside of the opening hours of the AEC.

The Committee learnt that significant improvements had been made with the time to analgesia which showed that 70% of patients seen were administered pain relief within the target time of 30 minutes and that 15% of patients had received analgesia within 15 minutes or less. On average, 88% of patients spent four hours in the ED with an average time of 12 hours and 32 minutes and a maximum time of 35 hours.

The Committee highlighted its concerns around the length of time sickle cell patients spent in the ED and access to treatments available to these patients. The Committee was assured that patients that presented at the ED were treated according to a protocol for analgesia within a specific period of time. Many patients in pain crises were familiar with the protocols and preferred to attend the ED overnight instead of admission to a ward which could result in a longer stay in hospital. It was confirmed that Thorogood ward had been established as a haematology unit and beds had been allocated as a specialist area for the treatment of sickle cell disease. Other improvements included the reinstatement of the Sickle Cell Service Group and the implementation of the Universal Care Plan which was also available on London Care Records.

The Committee noted the good progress made with shortening the time between first presentation at the ED and dispensation of analgesia looked forward to seeing further improvements being made.

Q4 Maternity report

The Committee took assurance from the comprehensive quarter four maternity report which detailed the following key issues:

- Level 3 safeguarding training of medical staff, maternity theatre and support worker staff had achieved 75% against a target of 85%. This was a Care

Quality Commission (CQC) must do action and work would continue to focus on improving the level of training compliance.

- The Trust was successful in achieving full compliance with all ten safety actions outlined in year five of the maternity incentive scheme and the rebate of rebated of the premium had been used to fund a full-time audit and guideline midwife role.
- The transformation of maternity triage with safe staffing levels put in place and the implementation of a telephone triage service between Monday to Friday with a view to extending it to cover weekends too.

The Committee discussed the role of independent midwives and their interaction with pregnant patients when they were admitted to hospital. The Committee was assured that independent midwives would work collaboratively with mothers, but once a patient was admitted, the Trust took over responsibility for care. Independent midwives were also permitted to support their clients in the labour ward, for instance as a doula.

The Committee considered the results of the 2023 National Maternity survey where areas identified for improvement were highlighted around postnatal care and breastfeeding. The Committee were assured that the findings of the survey were discussed with the Maternity and Neonatal Voices Partnership (MNVP) who would work with the Trust to develop and monitor an action plan to address these areas. Work with specialist infant feeding midwives would also be undertaken with the MNVPs, together with group sessions for families which would be held at the Trust's Education Centre.

The Committee observed that the survey had found that scores were significantly lower around dignity, respect, kindness and compassion during labour and birth. Sarah Wilding confirmed that this was echoed in complaints. She suggested that building a stable workforce specifically in midwifery would help, as well as a reduction in the use of temporary staff , while making sure that there was consistency in the level of cover available. In addition. Committee members were informed that kindness in maternity workshops had been held for staff.

Q4 Board Assurance Framework

The Committee reviewed the 2024/25 Board Assurance Framework for entries to the delivery of the Trust's quality and integration strategic objectives. The Committee discussed the total score for the Quality two entry and agreed that, despite the improvements made in the emergency department in relation to access against the four hour standard, the score should remained unchanged for the time being due to concerns about the level of 12 hour trolley waits.

Haringey Special Education Needs & Disabilities (SEND) inspection update report

The Committee received a summary of the key findings Local Area Partnership SEND inspection which was carried out in Haringey over a 3-week period from 15 January to 2 February 2024. The inspection looked at the effectiveness:

- of identifying children and young people's SEND.
- in meeting the needs of children and young people with SEND.
- of the area in improving outcomes.

The Committee was pleased to learn that the Haringey inspection achieved the highest possible rating and found that local area's partnerships created positive experiences and outcomes for children with SEND. The Committee was assured that work would continue to build on the positive results received and also to take action where improvements were needed.

Serious Incident report

Committee members considered the serious incident (SI) report covering February and March 2024. They noted that two SIs were declared in February 2024 and the Trust submitted two SI reports to the North Central London Integrated Care Board (NCL ICB) in February 2024. The paper also highlighted the learning shared with staff from two SIs which covered the following issues:

- The cardiac arrest of a patient after an elective procedure to treat urinary incontinence. Key areas of learning included that all patients who were reviewed in the high-risk pre-operative assessment clinics were seen face to face.
- The unexpected deterioration of a patient placed in seclusion in the ED. Key areas of learning included ensuring that patients placed in seclusion received 1:1 care and a review of the management of the patients between medical and psychiatric staff.

It was confirmed that the format of SI reporting would change and a greater focus on patient safety and learning would be reported to the Committee in line with the Patient Safety Incident Response Framework.

Quality Account Priorities

The Committee reviewed the proposed Quality Account Priorities for 2024/25 to be included in the 2023/24 Quality Account. The Committee was informed that quality priorities were developed following several engagement events with the public and stakeholders and were aligned to the Trust's corporate objectives for 2024/2. The priorities included:

- Ensuring patients are seen by the right person in the right place at the right time.
- Reducing health inequalities in our local population
- Improving access and attendance for appointments
- Improving communication with patients
- Improving the Trust environment to Improve patient experience.

The Committee discussed the proposed 2024/25 quality priorities and agreed that communication with patients was a key priority that should also cover communication with patient families about care and treatment. The Committee also agreed that work on a wayfinding strategy to better help disabled patients to improve patient experience should be included as a quality priority. It was also agreed to include a specific priority around mental health. The Committee noted that a revised draft report on quality priorities would be considered via email before the next meeting.

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 meeting held on 28 April 2024 where significant or reasonable assurance was taken from most of the items discussed. There were four items that the Committee could take limited assurance: • Patient Led Assessment of the Care Environment (PLACE) Annual Report • Ligature Assessment update • Quality impact assessment of cost improvement programme (CIP) schemes • Emergency planning report There were three areas of risk escalated by the Committee: the Trust's ligature review and assessment and pressure ulcers at the hospital site; and concerns raised around the quality impact assessment (QIA) process. The Committee noted an increase in the number of pressure ulcers in critical care and was informed that a detailed report would be provided for discussion at the next meeting. In terms of the QIA process in relation to CIPs , Committee members received assurance that the Chief Nurse and the Acting Medical Director continued to oversee the QIAs It was agreed that an update on the QIA process would be submitted to the Committee for assurance. **Trust Risk Register** The Committee reviewed the risk register report. It noted the addition of newly approved high risks in relation to the delivery of the Barnet 0-19 services, the increasing number of pressure ulcers in the community, the lack of a CT scanner on the same floor as the Critical Care team for 16 weeks due to upgrade works and the Community rehabilitation team's post-pandemic recovery risk The Committee discussed the new risk related to pressure ulcers and was informed that, despite the ongoing work to reduce the number of cases, the was some correlation between the increase in category three and four pressure ulcers and winter pressures. The Committee noted one increased risk around the failure to meet the 76% 4-hour target in the (ED), and the reduced risk scores for entries relating to radiology reports, the offload of patients from the London Ambulance Service to the ED and crowding in the ED. The Committee agreed that a detailed report on the delivery of the Barnet 0-19 service would be considered at the next meeting. **Q4 Quality report** The Committee reviewed the quarter four quality report. It noted that the number of inpatient falls had remained relatively constant over the year, at an average of 3.61 falls per 1000 occupied bed days which was well below the national average of 6.63 falls. The Committee was informed that clostridium difficile infections remained a challenge. There were 10 incidents in Q4 and the year ended with a total of 23 cases, against a trajectory of 13. The Chief Nurse and Director of Allied Health Professionals advised a round table discussion led by microbiology and infection control had taken place and looked at the key issues and causes for the increase in clostridium difficile infections. She also gave assurance that there would be a renewed focus on the cleaning of the environment and equipment. It was confirmed that there was one incident of

MRSA bacteraemia in Q4 which highlighted a need to carry out further work around peripheral canular lines. In terms of benchmarking, the Committee learned that clostridium difficile infections were more common in teaching hospitals than non-teaching, and that the Trust remained as a slight outlier, compared to NCL partners.

The Committee welcomed improvements made to the review and update of Trust clinical policies.

Committee members were apprised that Q4 ended with 122 incidents that required a duty of candour response, although an element of double counting may have contributed to high numbers as duty of candour responses were required for both physical and psychological harm.

The Committee discussed the occurrence of a category 4 pressure ulcers in the hospital site. It was discovered that the patient had been admitted to Mercers ward who deteriorated quickly. There was a recognition that patient placement and a junior workforce contributed to the pressure ulcer

The Committee sought assurance on the progress of actions identified in previous CQC inspections and received assurance from the Chief Nurse and Director of Allied Health Professionals who explained that a specific group had been established to focus on CQC preparedness and to work through actions.

The Committee also asked for assurance to come back on the rise in C difficile rates during the last year.

Q4 Patient experience report

The Committee discussed the patient experience report which outlined the following points:

- The Trust maintained a score above the 85% target for Friends and Family Test responses, against an NHS benchmark of 90.09%. The Trust continued to be an outlier for negative responses above the 5% NHS benchmark, at 5.74%.
- All Integrated Clinical Support Units remained above the NHS 85% benchmark during February and March 2024.
- Work would continue to engage community feedback through volunteers at community sites and the use of QR codes.
- The Adult Inpatient survey findings were scheduled to be published in August 2024
- During Q4 the Trust received 86 complaints and performance on response times was 63%, an increase of 16% on Q3.
- The themes identified from complaints continued to be around staff attitude, communication and medical care.
- An additional seven volunteers had been recruited, and 22 prospective volunteers attended the Trust's volunteer induction programme.

The Committee appreciated the efforts made to communicate the findings of the National Patient Survey to patients and visitors who could now view results on boards in outpatient areas. The Committee also agreed that more analysis should be provided on the number of patient attendances across the hospital compared against the number of FFT responses received.

Patient Led Assessment of the Care Environment (PLACE) 2023
The Committee reviewed the outcome of the PLACE inspection carried out in October 2023 and found that:

- There was a steady decline from 93.9% in 2019 to 85.3% in 2023 in cleaning, condition, appearance and maintenance.
- There was an improvement of 3.8% for food since the previous PLACE inspection.
- There was an improvement in scores for privacy, dignity and wellbeing, however, the trust remained 11% lower than the national average.
- There was a positive increase in disability scores and a slight negative decrease in dementia scores.

The Committee was informed that several mitigating actions had been put in place to address cleanliness which included the recruitment of additional staff. A deep dive review of domestic and portering staff was also undertaken to ensure that national cleaning standards were met. A PLACE working group would be established to oversee the improvements. Additional funding would also be secured to carry out a retail catering review to improve food and catering services for staff, patients and visitors. The Committee agreed that a follow-up performance report on actions should be provided to monitor progress.

Ligature risk assessment update
The Committee considered the ligature risk assessment report which set out the Trust's plans to reduce ligature risks in six main high-risk areas across the organisation following a programme of ligature risk assessments. The Committee was informed that some work had been undertaken and currently work was in progress to develop a project plan and costings to take the remedial work forward at pace. A ligature reduction expert had been recruited to review the reports of the six identified areas and would play a key role in the revision of the Trust's ligature assessment policy and a review and update of the training programme for anti-ligature risks.

The Committee noted the next steps planned to reduce ligature risks across the organisation and was assured of the mitigations in place.

Quarter 3 Learning from Deaths report
The Committee reviewed the report which covered the period 1 October to 31 December 2023 and highlighted the following:

- There were 118 inpatient deaths (excluding deaths in the ED).
- 21 adult structured judgement reviews requests (SJRs) were made.
- Eight out of the ten SJRs had been completed and found that the deaths were unavoidable.
- The Summary Hospital-level Mortality Indicator (SHMI) had increased to 0.99 but remained within the expected range. An audit of coding would be undertaken to determine whether there was any impact on the score.

The Committee discussed the level of deaths in patients with severe mental illness and also agreed to maintain a watching brief on the numbers of overall deaths at the Trust.

3.	**Present:** Naomi Fulop, Non-Executive Director (Chair) Amanda Gibbon, Non-Executive Director Baroness Glenys Thornton, Non-Executive Director Dr Clare Dollery, Acting Deputy Chief Executive Clarissa Murdoch, Acting Medical Director Chinyama Okunuga, Chief Operating Officer Swarnjit Singh, Joint Director of Inclusion & Trust Company Secretary Sarah Wilding, Chief Nurse & Director of Allied Health Professionals **In attendance:** Ruth Law, Consultant Geriatrician Paddy Hennessey, Director Estates & Facilities Kat Nolan-Cullen, Compliance and Quality Improvement Manager Anne O'Connor, Associate Director of Quality Governance Nicola Sands, Deputy Chief Nurse Carolyn Stewart, Executive Assistant to the Chief Nurse Phillip Lee, Associate Medical Director for Patient Safety Vanessa Georgoulas, Locum ED Consultant & Project Lead Kelly Collins, Associate Director of Nursing Emergency & Integrated Medicine Duncan Carmichael, Clinical Director Emergency & Integrated Medicine Alicia StLouis, Head of Midwifery Jane Grant, Head of Childrens & Young People Services Haringey Vanessa Cooke, Director of Operations Children & Young People Sarah Gillis, Associate Medical Director Learning from Deaths

Meeting title	**Quality Assurance Committee**	**Date: 8th May 2024**
Report title	Whittington Health Maternity Services Q4 Board Report	**Agenda item: 4.2**
Executive director lead	Sarah Wilding (Trust Board Chief Nursing Officer and Allied Health Professionals – Trust Board Maternity Safety Champion)	
Report author	Isabelle Cornet – Interim Director of Midwifery & Helen Taylor – Clinical Director for ACW-ICSU	
	This report provides a quarterly summary of the work being undertaken in the Whittington Health Maternity Unit. This report covers Q4 of the financial year 2023/2024 (January, February, March 2024). *Care Quality Commission (CQC) Standards* The medical workforce level 3 child protection compliance has reduced as the new trainees need training. The clinical governance obstetric lead is addressing the situation with the new trainee doctors in order to be compliant with this requirement. 1.00WTE guidelines midwife role for which 2 midwives have been recruited and share the role has proven to be a successful action in addressing the number of outstanding guidelines. The estates work to support achieving Birmingham Symptom Specific Obstetric Triage System (BSOTS)has commenced. *CQC Patient Survey 2023* The National Maternity Survey 2023, surveyed mothers who gave birth in February 2023, or mothers who gave birth in January – March 2023 as a boosted sample. Fieldwork, where patients are invited to participate, was April – August 2023 and the CQC benchmarking report was published on 9th February 2024. Following this report maternity in collaboration with the MNVP developed an action plan to address from the	

	bottom five areas identified. This will be monitored through PEG and QGC. *Maternity Incentive Scheme (MIS) Year 5* The Trust is fully complaint for all 10 safety standards. *Complaints and Compliments* In Q4 we received 6 complaints, from those 1 were approved. The key themes from the complaints were: Birth experience, Lack of communication, Lack of compassion, Staff attitude. *Maternity Dashboard* The Maternity Dashboard - POWER BI went live in November 2023. The themes identified from Datix/Sis/PSII for the 3rd and 4th degree tears are as follow: • There has been one 4th degree tear in January 2024. It is the first one since 2020. The notes and care have been reviewed by the Multi-Disciplinary Team and no care or service delivery problems were identified. • All notes and care for 3rd and 4th degree tears are reviewed weekly as part of the Multi-Disciplinary Team risk review meeting. • Compliance with perineal pathway noted at risk review meetings. • Obstetric Anal Sphincter Injury (OASI) care bundle incorporated into the maternity mandatory study days. • Perineal suturing guideline is in date and was approved in February 2024.
Purpose:	Provide an overview of maternity services to the committee
Recommendation(s)	*Note the contents of the report.*

Risk Register or Board Assurance Framework	
Report history	*None*
Appendices	Appendix 1 – CQC Action Plan Appendix 2 – CQC Patient Survey 2023 Appendix 3 – CQC patient Survey Comparison Appendix 4 – Perinatal Quality Surveillance Model Q4

Whittington Health Maternity Services Board Report Q4
8th May 2024

This report provides a quarterly summary of the work being undertaken in the Whittington Health Maternity Unit. This report covers Q4 of the financial year 2023/2024 (January, February, March 2024).

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.

Table 1: Fetal Monitoring Training Update Q4

FM Training Compliance (%)	**Goal**	**1st Jan 2024**	**1st Feb**	**1st Mar**
Staff Group				
Midwives	90%	97%	96%	96%
Consultant Obstetricians	90%	90%	95%	95%
Obstetric staff (all other grades)	90%	94%	94%	91%

Table 2: Fetal Monitoring Training Test Q4

FM Training test Compliance (%)	**Goal**	**1st Jan 2024**	**1st Feb**	**1st Mar**
Staff Group				
Midwives		85%	86%	86%
Consultant Obstetricians		74%	79%	75%
Obstetric staff (all other grades)		90%	94%	83%

OVERALL TEST FIGURES	85%	85.3%	87%	89%

Table 3: Training Figures for Maternity Emergencies and Multiprofessional training (PROMPT) Q4

PROMPT Training Compliance (%)	**Goal**	**1st Jan 2024**	**1st Feb**	**1st Mar**
Staff Group				
Midwives	90%	92%	92%	92%
Consultant Obstetricians	90%	95%	95%	100%
Obstetric staff (all other grades)	90%	94%	97%	97%
Anaesthetic Consultants	90%	80%	84%	95%
Anaesthetic Trainees	90%	88%	94%	94%
MSW	90%	93%	94%	94%

Table 4: Training Figures for Neonatal Basic Life Support

Neonatal Basic Life Support compliance (%)	**Goal**	**1st Jan 2024**	**1st Feb**	**1st March**	**1st April**
Staff Group					
Neonatal Consultants	90%	>90%	>90%	>90%	>90%
Neonatal Junior Doctors	90%	100%	100%	100%	100%
Neonatal Nurses	90%			100%	100%
Advanced Neonatal Nurse Practitioner (ANNP)	90%	100%	100%	100%	100%
Midwives	90%	92%	98%	98%	98%

Table 5: Children Safeguarding Level 3 Training Update Q4

Child Safeguarding level 3	**Goal**	**31st August 2023**	**31st December 2023**	**31st March 2024**
Midwives	85%	95%	87%	89%
Obstetricians & Gynaecology	85%	85%	68%	65%
Staff Nurse	85%	100%	80%	71%
MSW/NN	85%	89%	83%	84%

The drop in compliance for the Obstetricians, gynaecologist and staff nurses is due to new members of staff starting at the Trust and the new rotation of trainee doctors. The clinical governance obstetric lead is addressing the situation with the new trainee doctors in order to be compliant with this requirement.

One of the areas of concern highlighted by CQC was policies, guidelines, and procedures being out of date.

The MIS funds from year 4 allowed funding of a full time Audit and Guideline Midwife to be recruited. This is a job share (0.5WTE each) which commenced in January 2024. The post has been extended until June 2024, this is being funded by vacancies while maternity restructure is ongoing.

Maternity has a total of 125 guidelines (3 guidelines are currently being amalgamated into 1 guideline). 6 guidelines have been ratified and uploaded since the last Maternity Clinical Guidelines meeting on 07.03.24. There are 27 guidelines are currently under review. This is 21.6% of the maternity guidelines. From these:

- 1 is awaiting the final copy before being uploaded to the intranet
- 3 are owned by other ICSU's
- 2 are owned by the anaesthetic department
- 4 are owned by Gynaecology department
- 12 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.

Work has already commenced for guidelines requiring ratifying this year. Authors have been contacted and plans have been made for guidelines to be presented at the April and May Maternity Clinical Guidelines meetings.

The other area of concern emphasized in the CQC report was maternity triage. 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 was to fully implement BSOTS by the 18th of March 2024. BSOTS has been partially launched. The refurbishment was completed, telephone triage is in place Monday to Friday (8.00 to 20.30), with the view to extend to Monday to Sunday (8.00 to 20.30) by the end of April 2024. The training for the MDT team is ongoing.

Outstanding is completion of the triage assessment cards and agreement on process for documenting patient care. This is proving challenging as Careflow maternity does not have copyrights for BSOTS and maternity is committed to be paper light.

2.0 CQC Patient Survey 2023

The National Maternity Survey 2023, surveyed mothers who gave birth in February 2023, or mothers who gave birth in January – March 2023 as a boosted sample. Fieldwork, where patients are invited to participate, was April – August 2023 and the CQC benchmarking report was published on 9th February 2024.

Our National Surveys are undertaken by the Picker Institute, who work with 61 organisations, our results detailed in this report are in relation to those organisations known as the Picker average and includes results from the CQC benchmarking report, which provides a comparison against all other NHS trusts who provide a similar service. The CQC benchmarking report is a comparison against all other hospitals, therefore it is important to note that our Picker averages may not be the same as those in the benchmarking report. The CQC report is attached in **Appendix 2** and is the report for which an action plan is being established with the multi-disciplinary team including the Maternity and Neonatal Voices partnership (MNVP), and will be monitored once a month. **Appendix 3** compares the survey from 2023 to the one in 2022.

Picker management report itemised 296 Whittington Health mothers who were invited to undertake the survey, 118 responded (40%). The CQC benchmark report detailed 300 invited to take part, with 119 completed, this remains at a 40% response rate.

Below are the areas of success and the ones requiring improvement.

Areas of success

Top five scores (CQC)

- Antenatal Care:
    - B11. Were you given enough support for your mental health during your pregnancy? (9.5)

- Labour and Birth:
    - C5. And before you were induced, were you given appropriate information and advice with the risk assessment with an induction of labour? (7.7) – Also part of the top 5 scores in 2022.
    - C7. At the start of your labour, did you feel you were given appropriate advice and support when you contacted a midwife or the hospital? (9.1)

- Care after birth:
    - F12. Were you given information about any changes you might experience to your mental health after having you baby? (7.8)

- Postnatal care:
    - D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted? (8.7)

Areas for improvement

Bottom five scores (CQC)

- Antenatal care:
    - B15. During your pregnancy did midwives provide relevant information about feeding your baby?

- Care after birth:
    - F6. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby? (6.8)
    - F16. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this? (2.8)

- Postnatal care:
    - D2. On the day you left hospital, was your discharge delayed for any reason? (6.0)

- Feeing your baby:
    - E3. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby? (6.6)

Following this report maternity in collaboration with the MNVP developed an action plan to address from the bottom five areas identified. This will be monitored through PEG and QGC.

3.0 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 6: 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	Recruited to
5	MNVP - to support the Neonatal aspect of the MNVP - Requirement for Deliver SA7 of MIS Year 5	£7,000	Account created – for MNVP to use
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	Not used
	Total	**£266,046.26**	

4.0 Maternity Incentive Scheme (MIS) – Year 5

The maternity unit has received confirmation of compliance with the Maternity Incentive Scheme (MSI) Year 5 ten safety actions requirements for the financial year 2023/2024.

The Trust is awaiting the return of its contribution into the incentive funds, together with a share of unallocated funds.

5.0 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.

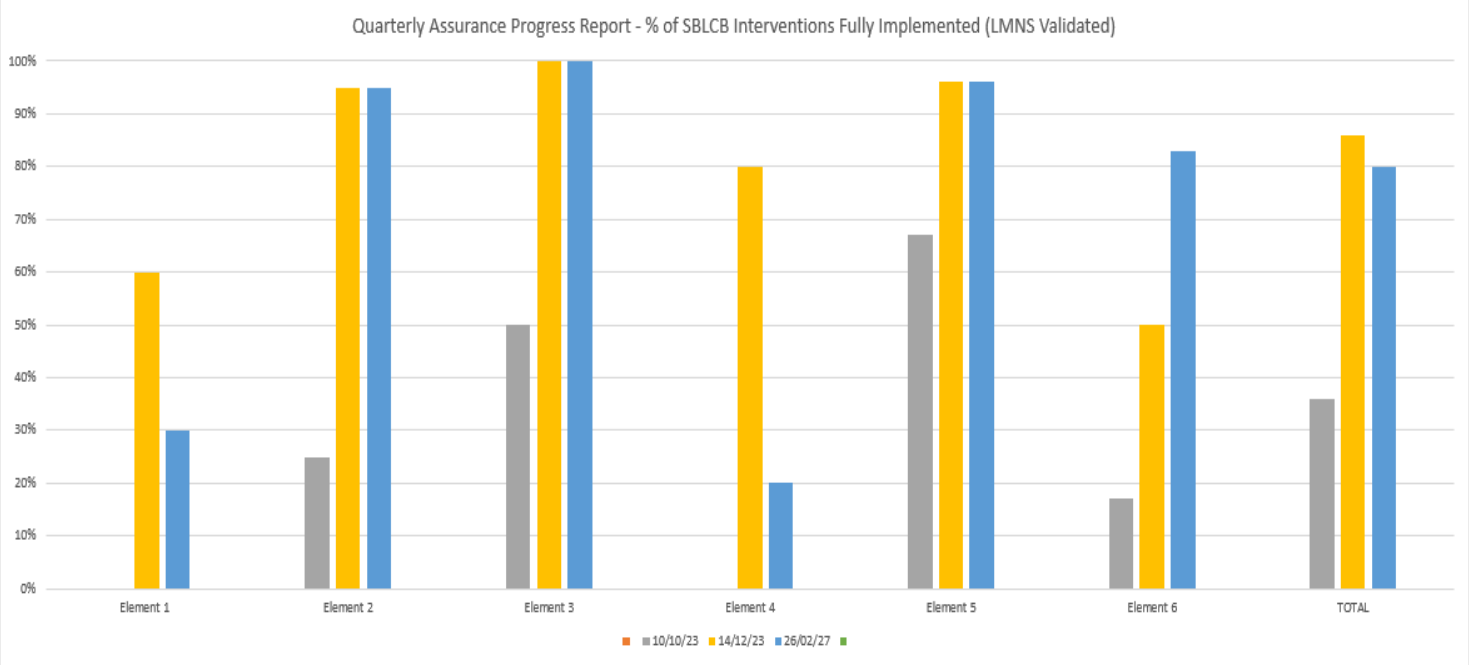
Version 3 of the Care Bundle (SBLCBv3) was published on the 1st of June 2023, followed by an implementation tool. The tool allows Trusts to track their progress with implementation of the interventions within the SBLCBv3, which will then serve as evidence in support of the maternity incentive scheme year 5 and 6 submission. It will also allow for informed quarterly discussions with ICBs.

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. Please see graph below that offers an overview of Q1 up to Q3 submission and compliance:

Table 7: Quarterly Assurance Progress Report



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.

The submission for Q4 is due on the 15th of July 2024.

6.0 Perinatal Quality Surveillance Model (**Appendix 4**)

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. Please see table below.

Table 8: Actions as a consequence of the surveillance model

	January 2024	February 2024	March 2024
Findings of review of all perinatal deaths using the real time monitoring tool	Soundproof room , Smoking Cessation Services, Partogram Soundproof room, Risk assessments at booking	EPR system and the challenges of finding and recording risk assessments Availability of interpreters Soundproof room , Smoking Cessation Services, Partogram Soundproof room, Risk assessments at booking	Lack of soundproof room remains the leading incomplete action, though there is a dedicated bereavement room. The plans for the estate transformation include a soundproof room. Availability of interpreters – a working group is being set up to ensure that the best possible interpretation services are available to families.
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 MNSI referral
Incidents graded as moderate or above and what actions are being taken;	Review of process following SURGE calls and agreement on accepting diverts from neighbouring units Access to clinical records from other units The Key themes were: • Term admission to NICO • Staffing levels • Medication	Review of sickle cell and thalassemia pathway with QA support The Key themes were: • Term admission to NICO • Staffing levels • Medication	None were graded as moderate or above. The Key themes were: • Term admission to NICO • Staffing levels • Medication • Lab-delays in reporting samples • Lack of civility
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	• Maternity Website • Ockendon Café • CQC Patient survey action plan • BSOTS
Themes / main areas from complaints	. 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

7.0 Start Well Programme and Public Consultation

The consultation ended on the 17th March 2024.

The Trust is awaiting the results and outcomes from the consultation.

The decision regarding the Start Well Programme is expected for winter 2024/2025.

8.0 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 January to March 2024 a new serious incident was declared – Datix number A108993.

Table 9: Actions undertaken to address findings from the SI investigations

Datix Ref	Description	Actions	Target date of report completion
A108993	A woman booked for antenatal care at a neighbouring unit where she had all her antenatal care. The woman attended this maternity unit triage at 40 weeks and 1 day, with history of reduced fetal movements. This was because the neighbouring maternity was on divert to this unit. This was due to neonatal capacity. The woman was not in labour. Following assessment, the CTG was classified as abnormal, and a decision was made for the baby to be born via emergency caesarean section category1. A term male infant was born in poor condition and transferred to the neonatal unit. The newborn had hypoxic-ischaemic encephalopathy (HIE) and meconium aspiration. The infant required therapeutic hypothermia and had persistent pulmonary hypertension requiring nitric oxide, therefore had to be transferred to a level 3 neonatal unit.	Implementation of a pathway for communicating to the MDT that this unit is in receipt of transfers and diverts from neighbouring units, at LMNS level. Implementation of a pathway for cascading this information and updates timely to the local clinical team. Implementation of a pathway to disseminate vital clinical information, across the LMNS, regarding pregnancy care and plans to the receiving units.	72hr report presented to WISH panel. Decision SI investigation – TOR agreed. Complex investigation involving another Trust, NCL surge.

9.0 Healthcare Safety Investigation Branch (HSIB) – Q3 2023/2024 –

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.

There were no cases referred to MNSI in Q4 2023/2024.

10.0 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 January to 31st March 2024, 4 cases met the eligibility criteria for PMRT review. The eligible cases were:

- One neonatal death for acrania shortly after birth – Acrania had been diagnosed antenatally and the family cared for by the FMU and bereavement team
- Three terminations of pregnancy for fetal abnormalities diagnosed during the pregnancy.

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.

11.0 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

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. The OPEL framework was presented at the Midwifery Leadership Day on the 28th March 2024. A simulation of a SURGE call is planned for May 2024, this will be multidisciplinary and conducted in the clinical area.

12.0 Complaints and Compliments

Complaints

In Q4 we received 6 complaints, from those 1 was approved. The key themes from the complaints were:

- Birth experience
- Communication (lack/ style)
- Caring/ compassion (lack)
- Staff attitude

For Q4 5 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. To explore avenues to improve the response times for complaints there was a meeting held with PALS and Stuart Richardson on the 7th March 2024 to review complaint response processes and discuss challenges that are impacting on efficiency of responses:

- Facilitation of cross ICSU complaints and coordination of responses
- Standardisation of draft review and draft version control
- Agreed ways of working – emails vs meeting to finalise responses.

Despite these meeting and weekly meetings with PALS facilitator, the response times remain a challenge. A senior midwife has been allocated temporarily until the end of June 2024 to coordinate complaints and establish a pathway with the MDTeam to prevent the reoccurrence of the situation.

Table 10 : **progress against outstanding responses for Q2 and Q3:**

Datix	Complaint	Update
53102	Referred 21.8.23. Lack of consent with examination, communication Delay due to high activity and redeployment of staff.	Now closed – The response was approved in Q4.
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 – This is now with PALS for quality review.
53199	Analgesia effectiveness-Epidural	Now closed – The response was approved in Q4.
53387	Lack of ICARE values during labour	This is now with PALS for quality review.
53950	Communication, language barrier.	This is now with PALS for quality review.

Compliments

Here are some examples of compliments received:

- **March 2024 -** We had a generous donation from a patient (who wishes to be anonymous) to purchase a portable ultrasound scanner for maternity services. This scanner will be located on Murray ward and MAU. The purpose of the scanner is to check for fetal heartbeat, presentation and to assess amniotic fluid.
- **February 2024 -** Received compliment and heartfelt appreciation for the exceptional care provided during the pregnancy and birth of their baby "We especially appreciate her additional visit to the postnatal ward the day after our baby was born. It was really comforting to see a familiar face and we are so grateful that the midwife then also took the trouble to check on how the discharge process was going and to expedite the process so we could go home"; "Our experience at the Whittington Hospital was one of genuine care and professionalism. Thank you for ensuring that our baby's arrival into the world was such a positive event."
- **January 2024 –** Received thank you card "Thank you so much for being our midwife, your care and compassion has made this experience all the easier. WE cannot thank you enough."

13.0 Legal Claims

In the quarterly report from NHSR there are 38 open 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
38	£231,305,526	£217,341,357	£11,149,745	£2,814,424	£196,965,080	£34,340,446	£34,340,446

14.0 Quality Improvement Projects

14.1 Baby Tagging

Baby tagging is an electronic system where an electronic tag and disposable strap are put on the baby. This is to protect them from abduction. This is in response to an SI and will enhance the Trust's safeguarding and abduction policies, which are scrutinised by CQC. The Baby Tagging system is now in place, following a successful business case. Staff were trained in February on how to use the system and changes to fire procedures. There is an e-learning module on our elev8 platform and resources on in the intranet including standard operating procedures.

14.2 Interpreters On Wheels (IOW)

NCL awarded the interpreting contract to DA Languages in 2023. The Trust is therefore unable to use its competitor, Language Line, for Interpreter on Wheels. DA are going to prioritise maternity for the tablet on wheels which they are developing. They have been unable to advise a timeline yet as to when this service will be available for the Trust. In the interim, DA are due to provide logins to an online platform which can be accessed from any device (smartphone, tablet, laptop, PC) for on demand video interpreting on Interpreter View.

14.3 Care Outside of Guidance

The number of women requesting care outside of guidance continues to increase, with 24 referrals to the Birth Choices Clinic in quarter 4. The NCL Place of Birth Decision Making Tool was ratified in January and provides support and guidance to staff in knowing the most appropriate pathway to support women in their choices for pregnancy and birth. This has also been supported by ratification of the Personalised Care Planning and Birth Choices: Care Outside Guidance Guideline in March.

Additional work towards supporting service users in their choices continues with a variety of opportunities, including a study day with charity Birth Rights attended by 31 members of the MDT, and a well-attended Women's Weekly session where a service user described her experience of the Birth Choices pathway.

14.4 Working with local Independent Midwives

To support choice and personalisation of safe care, we are reigniting work with our local Independent Midwifery (IM) colleagues. A workshop was held on 8th February and attended by 8 local IMs and Whittington maternity staff. We discussed our shared values, the ways we work well together, challenges and opportunities. Actions included a working group for development of a policy around collaborative working and shared care, and an information leaflet for service users who are employing an IM to explain how shared care works.

Following this, two independent midwives joined a Women's Weekly session in March to tell us more about their work and answered lots of questions from the team about how we work together.

14.5 New Maternity Website

Since last summer we have been working on the redevelopment of the Maternity website to make it more accessible to service users and professionals. This has taken a multidisciplinary approach and required support from many different teams. Special thanks to Sonia Parsons from IM&T and Aoife Tobin Communications Midwife for bringing this to fruition.

The site layout has been changed to make pages more accessible and information has been updated and condensed to make it easier to read. We hope this will provide service users the most accurate information about all our maternity services currently available here at Whittington Health. We have added other helpful resources to the website, with lots of links to other organisations and more current images of our different clinical areas. We hope this update will give service users another useful tool for use during their pregnancy and the postnatal period.

15.0 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 11: The dashboard below has been used to direct the actions outlined in table 8 above.

Maternity Perinatal Quality Surveillance Dashboard			Target	23/24 Q3			23/24 Q4		
				Oct-23	Nov-23	Dec-23	Jan -24	Feb-24	March-24
Clinical Metrics	Total Booking			300	270	245	310	288	301
	Booking by 9+6/40			68.5%	72.3%	71.4%	64.0%	63%	66%
	Livebirths (Term)			249	240	218	223	194	237
	Women in a Continuity of Carer pathway by 29 weeks						20	22	20
	Percentage of women on CoC pathway: BAME / areas of deprivation						30%	35%	33%
	Preterm Birth	≤26+6		0	0	0	0	0	
		≤36+6		17	16	19	15	12	
	Massive Obstetric Haemorrhage (≥1500ml)		≤3.3% - ≥4.6%	1.5%	3.2%	1.7%	3.9%	3.7%	2.3%
	Induction Of Labour	Primiparous	≤30.5% - ≥37.6%	26.0%	28.8%	28.7%	25%	33.7%	44.3%
		Multiparous	≤25.1% - ≥30.6%	25.0%	25.9%	20.9%	23%	26.3%	23.1%
	3rd and 4th Degree Tear	SVD – Primp	≤4.1 - ≥5.8%	16.7% (4)	0.0%	0.0%	3.6%	0.0%	3.6%
		SVD – Multip	≤ 1.5 - ≥2.1	0.0%	1.9%	1.9%	1.6% (1)	1.7% (1)	0.0%
		Instrumental – Primip	≤7.3% - ≥10.2%	11.5% (3)	2.9%	3.4%	4.3%	3.8%	0.0%
		Instrumental - Multip	≤4.8% - ≥7.8%	0.0%	0.0%	0.0%	12.5% (1)	0.0%	0.0%
	Maternal Readmission			5	5	0			3
	Term Admission to NICU		≤ 6%	7.2%	5.0%	6.0%	8.8%	7.2%	6.8%
	Pregnancy loss- non PMRT eligible (<22 weeks or termination)			0	0	0	1	0	3
	Stillbirth- PMRT eligible (>22 weeks, not termination)			2	0	1	0	0	1
	Neonatal Deaths			0	0	0	1	0	0
	Breastfeeding initiation rate within 48hrs of birth			93%	90%	88%	93%	93%	89%
Incident reporting	Maternity incidents moderate/above harm			2	0	2	2	1	
	Maternity Serious Incidents			N	N	N	N	1	0
	Maternity Never Events			N	N	N	N	N	N

	Coroner regulation 28 made directly to trust (Y/N)			N	N	N	N	N	N
	HSIB/CQC etc. with a concern or request for action (Y/N)			N	N	N	N	N	N
	Number of cases referred / accepted by HSIB			0	0	0	0	0	0
	HIE Cases (2 or 3)			0	0	0	0	0	0
	Notification to ENS			0	0	0	0	0	0
	Number of HSIB reports completed			0	0	0	0	1	0
	Maternal Mortality Rate	Direct		0	0	0	0	0	0
		Indirect		0	0	0	0	0	0
Staffing	Supernumerary Status of the Labour Ward			100%	100%	100%	100%	100%	100%
	Midwifery vacancies			28	16	15	15	16	18
	MW to birth ratio : BR+ recommendation (local review 01/2023): 1:22			1.21	1.22	1.19	1:18	1:10	1:19
	Number of times unit in amber status for low staffing			6	4	4	4	2	2

The themes identified from Datix/Sis/PSII for the 3rd and 4th degree tears are as follow:

- There has been one 4th degree tear in January 2024. It is the first one since 2020. The notes and care have been reviewed by the Multi-Disciplinary Team and no care or service delivery problems were identifies.
- All notes and care for 3rd and 4th degree tears are reviewed weekly as part of the Multi-Disciplinary Team risk review meeting.
- Compliance with perineal pathway noted at risk review meetings
- Obstetric Anal Sphincter Injury (OASI) care bundle incorporated into the maternity mandatory study days.
- Perineal suturing guideline is in date and was approved in February 2024.

16.0 Workforce 16.1 Midwifery

16.1 Workforce Midwifery

16.1.1 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.

Table 12: Supernumerary Status of the Labour Ward Coordinator

Month	LW Coordinator Supernumerary (Y/N)	If not – Comments: - Date and time - For how long? - Why was supernumerary status lost? - Birth Rate Plus? - Maternity Status (OPEL)	Was the situation escalated? (Y/N) If yes – to whom? If not	Who had oversight of the unit?	MIS compliant (Y/N)
January 2024	Yes (except in 1 episode)	17/1/24 at 1800hrs For 2 hours 1:1 in labour with abnornal CTG BR Plus -2.15 OPEL 1	Yes Bleep holder	Consultant	Yes
February 2024	Yes (except in 1 episode)	23/2/24 @ 1400hrs For 2 hours 1:1 care in labour due to staffing BR Plus -0.8 OPEL 1	Yes Matron	Matron	Yes
March 2024	Yes	Not applicable	Not applicable	Not applicable	Yes

16.1.2 Recruitment and Retention

2 new midwives have started their roles in this quarter.

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

The Theatre nurse team leader position has now commenced her role.

Regarding the band 6 and band 7 midwife vacancies although the vacancy is reported as 13.74 WTE, 5.35 WTE is withheld until June 2024 in order to cost for band 6 and 7 positions that are required for Ockenden, CQC and MIS compliance. The actual vacancy is 18.74 WTE. A maternity restructure proposal is in place.

Table 13: Vacancies at the end of March 2024

Roles	Band	Establishment needs - WTE	30th Sept 2023 – WTE vacancies	30th Dec 2023 – WTE vacancies	30th March 2024 – WTE vacancies
Midwife	8	11.00	0.00	0.00	0.00
Specialist Midwife	7	16.01	0.00	0.00	0.00
Midwife	7	17.21	0.00	0.00	0.00
Midwife	6	103.26	28.00	14.90	13.74
Labour Ward Nurses	5	8.00	4.00	4.67	3.00
Nursery Nurses and Specialist Maternity Support Workers	4	11.80	3.67	4.67	2.67
Midwifery Support Workers	3	30.30	1.01	0.30	2.30

16.1.3 International Recruitment (IR)

Since the start of the programme in September 2022 a total of 15 midwives have been recruited.

Any midwives recruited after January 2024 have been recruited via the capital midwife scheme but are not funded centrally.

Currently 3 midwives are due to start in May 2024. Another midwife has been locally recruited and is currently undergoing the OSCE process. Seven midwives have received their PIN numbers and 3 have passed their OSCE and are now awaiting PIN.

16.2 Obstetrics

16.2.1. Recruitment

There 2 new consultants starting in permanent posts in June 2023. These posts are both obstetrics and gynaecology.

16.2.2 Compensatory Rest Action Plan

The awayday has had to be moved to June due to diary clashes. A plan will be developed by the consultant team on how to deliver this requirement. Currently an adhoc arrangement is in place to provide compensatory rest after oncall.

16.3 Culture Work

The last staff survey results for the Obstetrics and Gynaecology medical teams were disappointing. As part of the away day the Organisational development team will be working with the consultants to identify one key action to improve the staff experience.

17.0 Maternity Digital Programme

- The roll out of Vitals has been delayed by three months due to system C delays but the team have been putting together the requirements for this roll out in anticipation of go live.
- The Chief Nursing Information Officer is working with UCLH to set up a process to provide the team read only access to EPIC. This will support the safe transfers of women and babies from UCLH.
- Over the next month all clinicians outside maternity in Whittington Health will be given 'read only' access to Medway maternity. This will support any clinical team caring for pregnant people will have access to their records and care plans wherever they are in the organisation. e.g. Emergency Department, Medical Admissions Unit, Critical Care etc.
- The BadgerNet business case requires some further work to be completed at the end of May. There maybe an opportunity to access some NCL funding to support its roll out.

18.0 Maternity and Neonatal Estates Programme

This is currently in a state of flux as the team is waiting the outcome of the Start Well consultation. There are a number of other estates projects the Trust is funding which include Fire Remediation and Power infrastructure. The Power Infrastructure is a key interdependency for the Maternity Estate project.

19.0 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.

20.0 Appendices

Appendix 1 – CQC Action Plan

Appendix 2 – CQC Patient Survey 2023

Appendix 3 – CQC Patient Survey Comparison

Appendix 4 – Perinatal Quality Surveillance Model Q4 2023/2024.

Meeting title	**Quality Assurance Committee**	**Date: 8th May 2024**
Report title	**Quality Report: Q4 2023/24**	**Agenda item: 4.3**
Executive director lead	Dr Clarissa Murdoch, Interim Medical Director Sarah Wilding, Chief Nurse and Director of Allied Health Professionals	
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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 Q4 2023/24, key highlights include: • The Trust had a target to reduce overall Trust attributable pressure damage by 20%, and full thickness pressure damage by 50% in 2023/2024 which has not been achieved, primarily due to full thickness pressure ulcer incidence in the community caseloads. A 10% reduction in overall Trust attributable pressure damage has been achieved in 2023/2024. • The number of community acquired Cat 3 & 4 pressure ulcers has increased from 15 to 42 in Qtr4 of this year compared to last year, the causative factors being multifactorial. Equipment provision from external contractors and concordance with planned care has been the main causative factors. Prevention and management of pressure ulcers in the community will be the focus of the first PSIRF learning event for the Trust, to take place in May 2024. • Through the last financial year there has been one category 4 pressure ulcer recorded (February 2024) in the hospital setting. • The number of inpatient falls has remained relatively constant over the financial year, at an average of 3.61 falls per 1000 occupied bed days. This is in comparison with the national average of patient falls of 6.63 • There has been a decrease (16) in the number of mixed sex breaches compared to Qtr3 (21) with critical care reporting a 75% reduction and surgical wards 50%. • <u>Infection Prevention</u> ○ MRSA = 1 Hospital acquired due to peripheral vascular device (YTD 2)	

- Clostridium difficile (C. Diff) infections = 10 in Q4. (YTD 23 against trajectory of 13).
  A C. Diff summit has been held to consider causation and possible remedies to reduce the number of infections, and included cleaning, staff engagement, antimicrobial stewardship and Probiotics for patients.

- The Summary Hospital-level Mortality Indicator (SHMI) for the data period Q3 at Whittington Health is 0.99, while this is in the expected range, this is an increase on previous SHMIs for the Trust. We are continuing to review all SJRs to look at reasons for this. The clinical coding team are also completing an audit to review the adequacy and depth of coding. Telstra Health are also regularly reviewing our data and presenting at Mortality Review Group.
- For Qtr4, there were no Priority 2 patients on an admitted pathway breached 78 Weeks.
- There are currently 122 incidents between Qtr1 2021/22 to Qtr4 2023/24 across the Trust that have outstanding Duty of Candour requirements.

- Sodium valproate working group – WH linked in to NCL Approach to NPSA alert. AMD for Patient Safety leading on WH aspects of alert. Neurologists engaged

- <u>PLACE Lite (2023) report.</u>

  - There has been a steady decline in Cleaning and Condition, Appearance and Maintenance results since the 2019 audit. While there is no definitive reason for this, recent evidence and feedback suggests that this is due to the high vacancy rate and turnover within both the operational Domestic Services and Estates Teams, a lack of periodic cleaning schedules and inefficient cleaning audits, insufficient audit membership and a lack of oversight and understanding of cleaning audits methods.
  - There has been an improvement of 3.8% in relation to food delivery, taste and texture.
  - Privacy, dignity & Wellbeing; There has been an improvement in scores however they are still around 11% lower than the national average.
  - There has been a positive increase in the Disability scores since last year and a slight negative decrease in Dementia scores.

- <u>External Reviews</u>

  - Haringey SEND inspection

    Haringey achieved the highest possible rating. The progress made over the last 3 years was recognised.

- <u>Clinical Effectiveness</u>

	○ A recent audit of time to analgesia for patients presenting with a sickle cell crisis showed 70.2% received this within 30mins. This - although slightly below our target of 80% - has been a significant improvement on the 40% figure in 2020. The average time to pain relief for these patients was 29.8minutes. The training module for sickle cell care has now been added to Elev8. ○ National Early Inflammatory Arthritis Audit (NEIAA) Outlier Notification as we have not had the capacity to see new referrals of patients with suspicion of early arthritis within the 3 weeks advised by NICE. In light of challenges such as this within the Rheumatology service, a business case has been submitted for consideration which outlines the demand and risk the service faces in its current position. A decision regarding the business case is yet to be made. ○ IT re-categorisation of Clinical Guidelines to align with policies is underway. ○ Sentinel Stroke National Audit Programme: State of the Nation 2023 report. The results highlighted the following areas for improvement: The increase in complexity of patients discharged from hospital will require a responsive, appropriately resourced, and flexible approach in delivering stroke rehabilitation at a similar intensity and dose to that which would be delivered in hospital. ○ There is a continued improvement in policies due for review with a reduction from 45% (Q3) to 37% (Q4) for all policies. Clinical policies for review = 9% (14% in Q3), Non clinical = 24% (27% Q3) and operation at 5% (4% in Q3) • <u>Simmons House Update</u> ○ Simmons House remains temporarily closed. ○ Staff redeployed whilst we work with NCEL who are leading a piece of work to consider provision of services across NCL. We remain committed to supporting and ensuring services for young people within the local area. ○ The externally commissioned serious incident review into the death of a young person at Simmons has been completed. ○ The coroner's inquest into the death will be held in June 2024.
Purpose:	Discussion and approval for Trust Board.
Recommendation(s)	Members are asked to approve for Trust Board: 1. Identify key issues of good practice to highlight to the Board. 2. 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 on 25th April 2024 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.

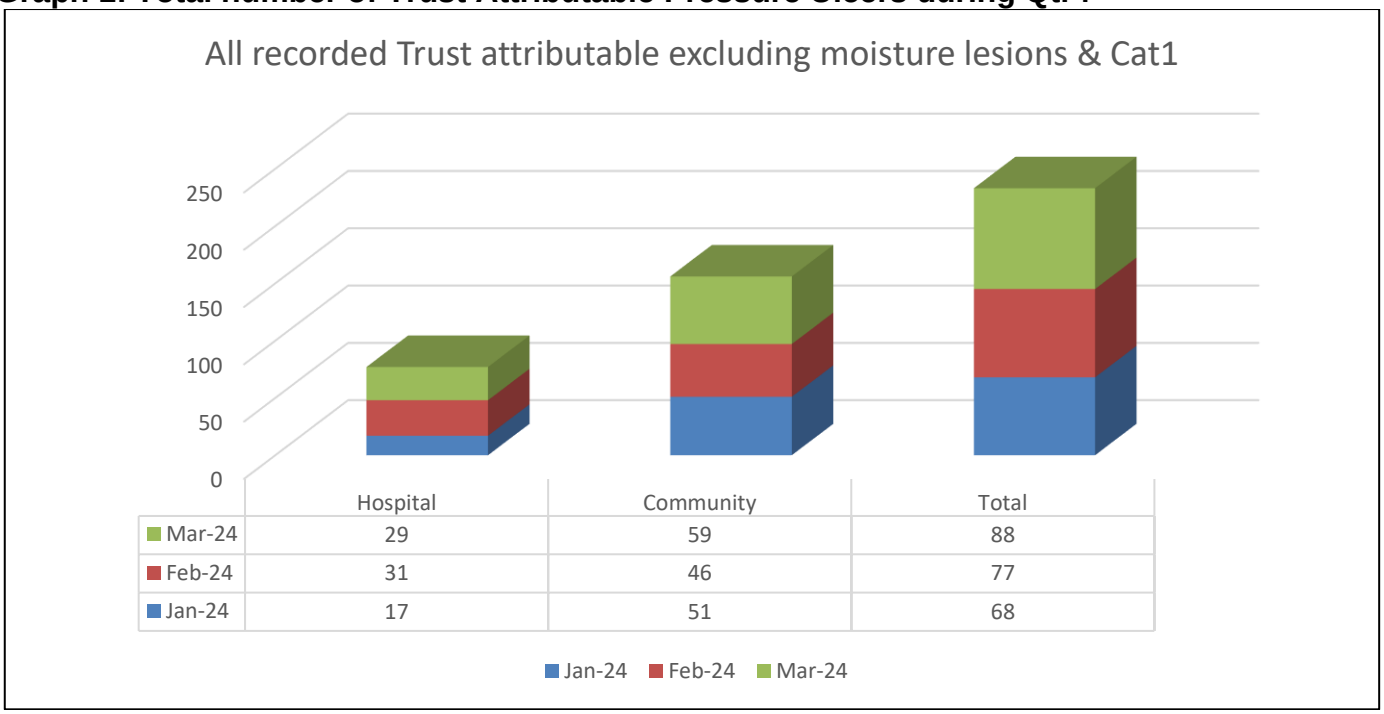
2 Patient Safety

2.1 Exception reporting

2.1.1 Pressure Ulcers

The data below aligns with pressure ulcer data presented at Trust Board. It 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.

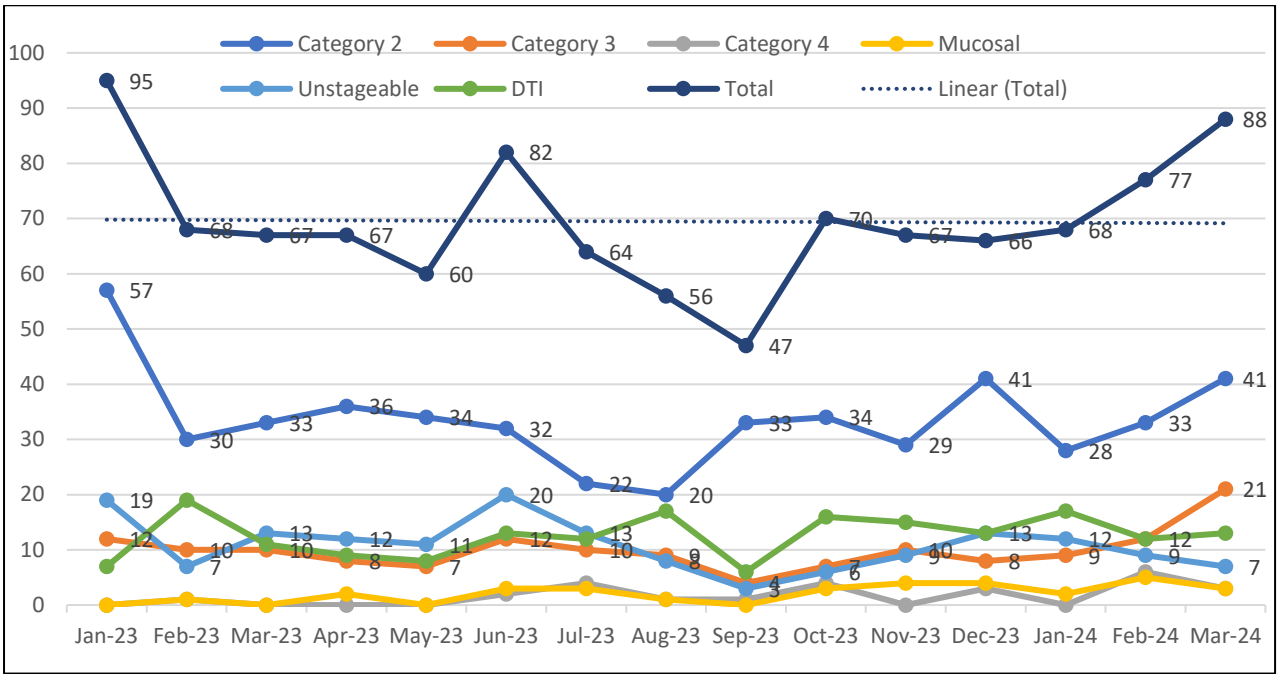
Graph 1: Total number of Trust Attributable Pressure Ulcers during Qtr4



	Hospital	Community	Total
Mar-24	29	59	88
Feb-24	31	46	77
Jan-24	17	51	68

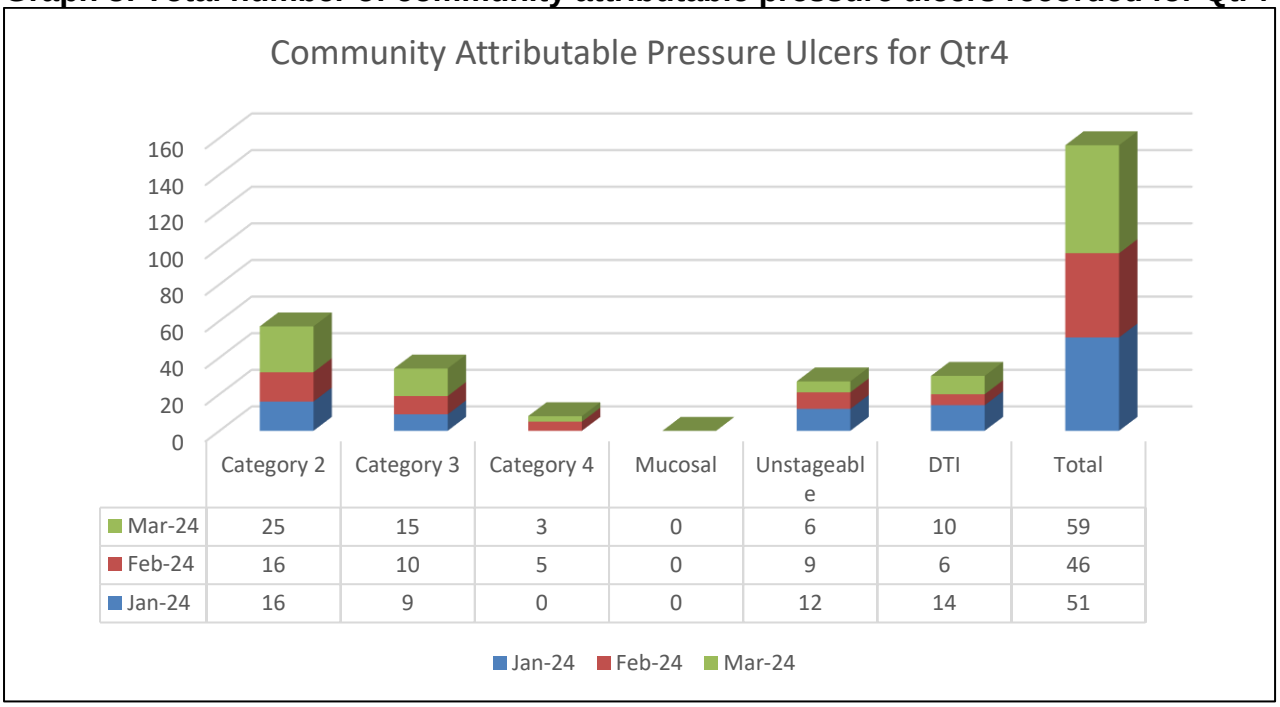
- There has been a slight increase in the number of recorded pressure ulcers in Qtr4 (233) compared to Qtr3 (219).

Graph 2: Trust Attributable Pressure Ulcers by severity



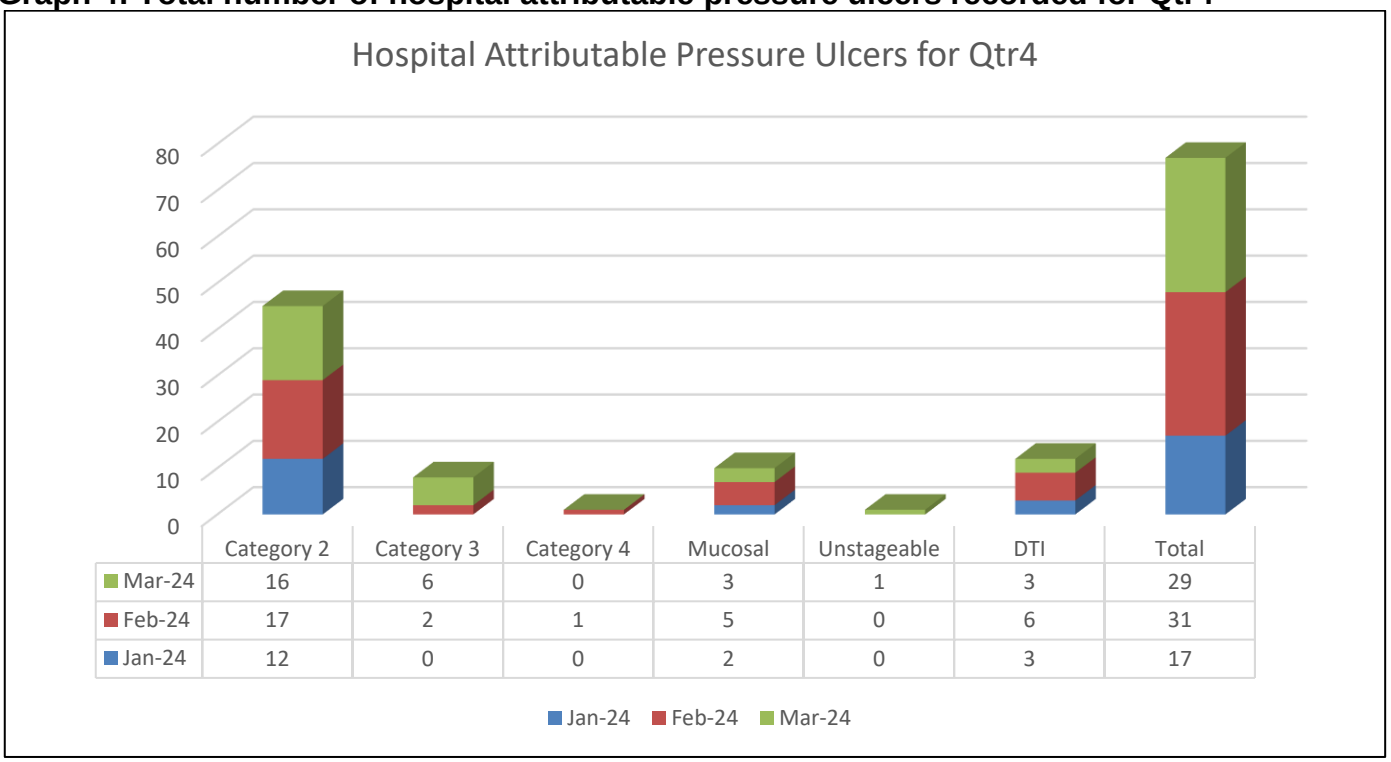
- Although there has been a decrease in the overall number of Trust attributable pressure ulcers compared to Qtr4 last year (241 in Qtr 4 22/23; 233 in Qtr4 23/24), and a reduction in the number of hospital attributable pressure ulcers, community attributable pressure ulcers has increased by 33.

Graph 3: Total number of community attributable pressure ulcers recorded for Qtr4



	Category 2	Category 3	Category 4	Mucosal	Unstageable	DTI	Total
Mar-24	25	15	3	0	6	10	59
Feb-24	16	10	5	0	9	6	46
Jan-24	16	9	0	0	12	14	51

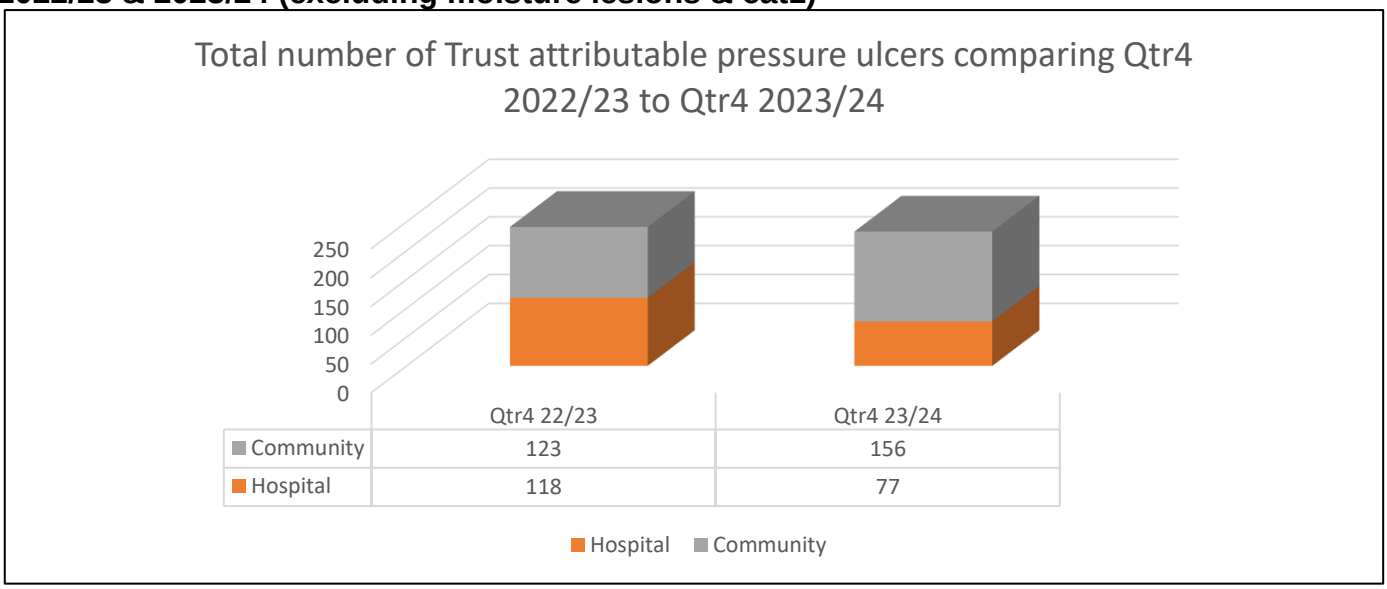
Graph 4: Total number of hospital attributable pressure ulcers recorded for Qtr4



	Category 2	Category 3	Category 4	Mucosal	Unstageable	DTI	Total
Mar-24	16	6	0	3	1	3	29
Feb-24	17	2	1	5	0	6	31
Jan-24	12	0	0	2	0	3	17

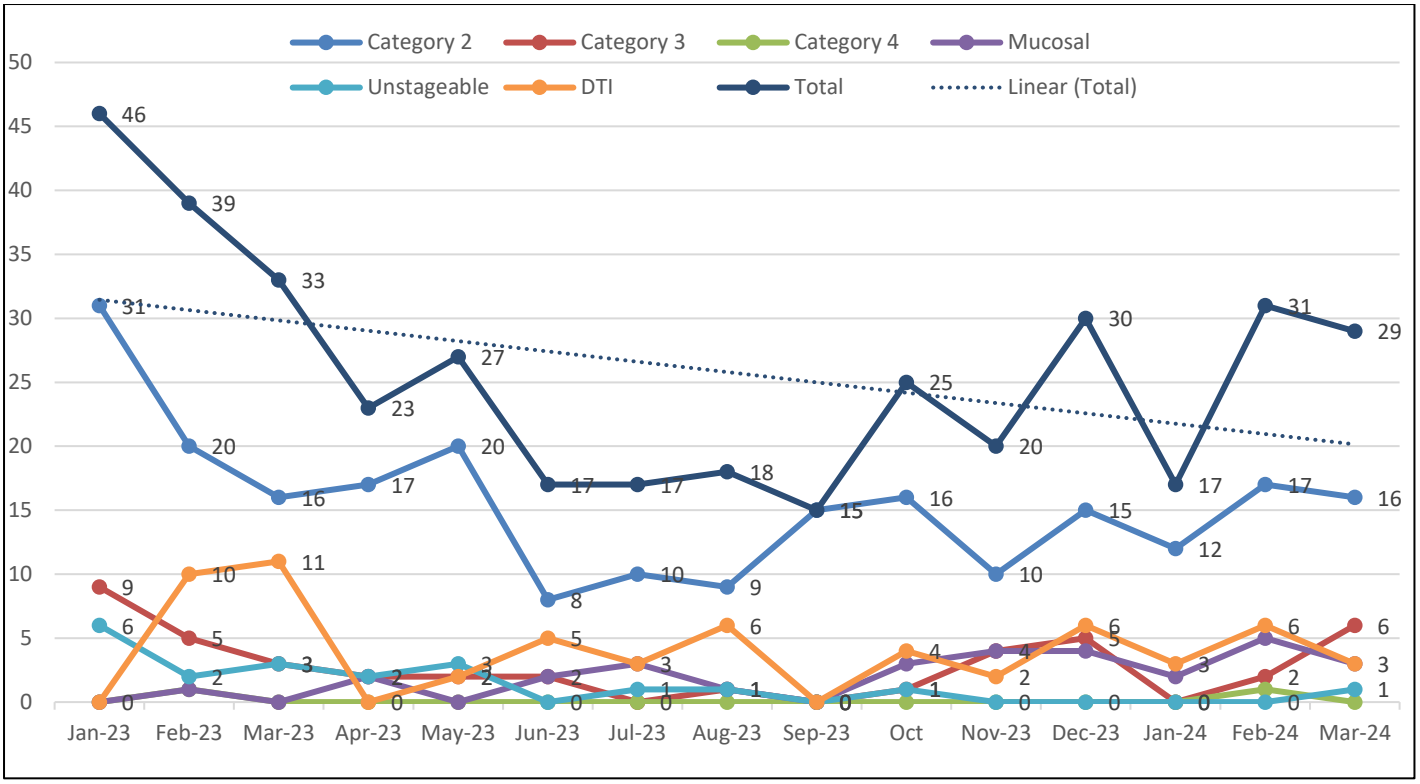
- The Trust had a target to reduce overall Trust attributable pressure damage by 20%, and full thickness pressure damage by 50% in 2023/2024 which has not been achieved primarily due to full thickness pressure ulcer incidence in the community caseloads. A 10% reduction in overall Trust attributable pressure damage has been achieved in 2023/2024.

Graph 5: Total number of Trust attributable pressure ulcers recorded comparing Qtr4 2022/23 & 2023/24 (excluding moisture lesions & cat1)



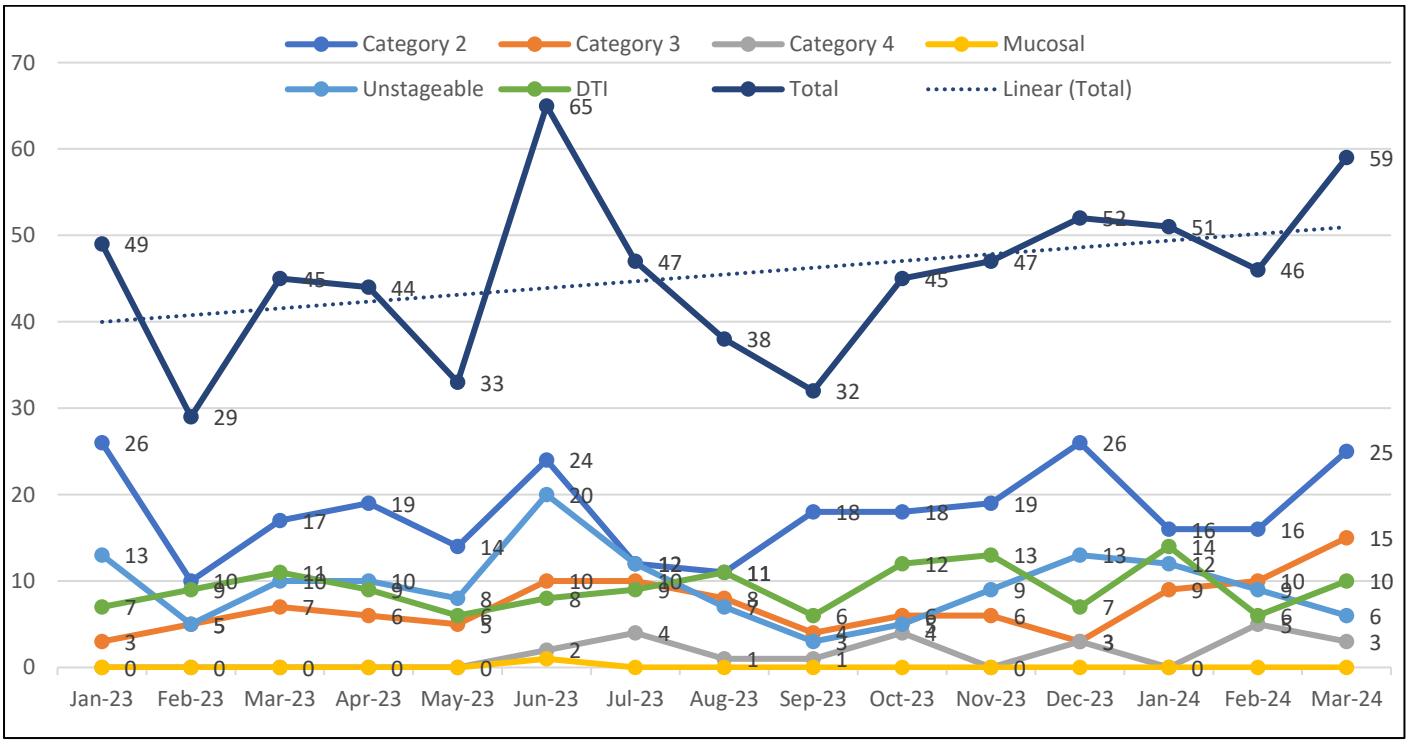
	Qtr4 22/23	Qtr4 23/24
Community	123	156
Hospital	118	77

Graph 6: Hospital attributable pressure damage January 2023 – March 2024

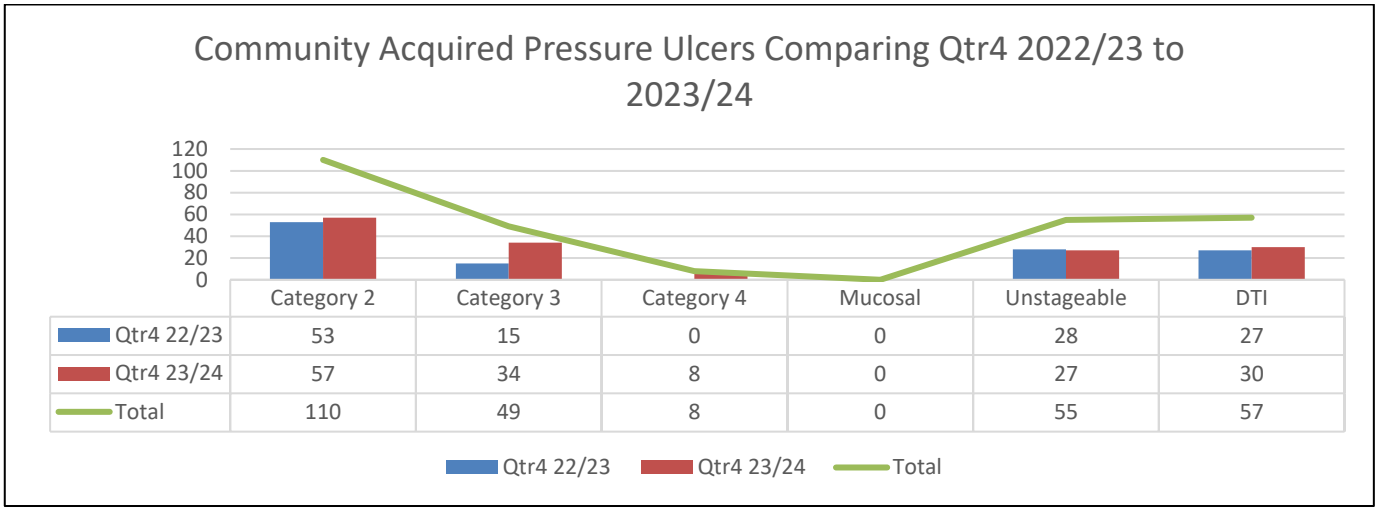


- Critical care remains the largest area where hospital acquired pressure ulcers are recorded, followed by Meyrick being the second largest area for pressure ulcer incidence. Device related mucosal pressure damage accounts for a large proportion of critical care related pressure damage.

Graph 7: Community attributable pressure damage January 2023 – March 2024



Graph 8: Number of community acquired pressure ulcers in Qtr4 compared to Q4 22/23



	Category 2	Category 3	Category 4	Mucosal	Unstageable	DTI
Qtr4 22/23	53	15	0	0	28	27
Qtr4 23/24	57	34	8	0	27	30
Total	110	49	8	0	55	57

- The number of community acquired Cat 3 & 4 pressure ulcers has increased from 15 to 42 in Qtr4 of this year compared to last year.
- The community acquired pressure ulcers have increased, particularly in relation to full thickness pressure ulcers, however implementation of timely and effective pressure area management plans have been inhibited and compromised by failures in externally contracted pressure relieving equipment suppliers to provide prescribed equipment, as well as challenges in patient and carer concordance with treatment plans. The equipment supplier issue is previously known and recorded on the Trust risk register.
- There are known issues with NRS (pressure ulcer relieving equipment company) for a number of 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.

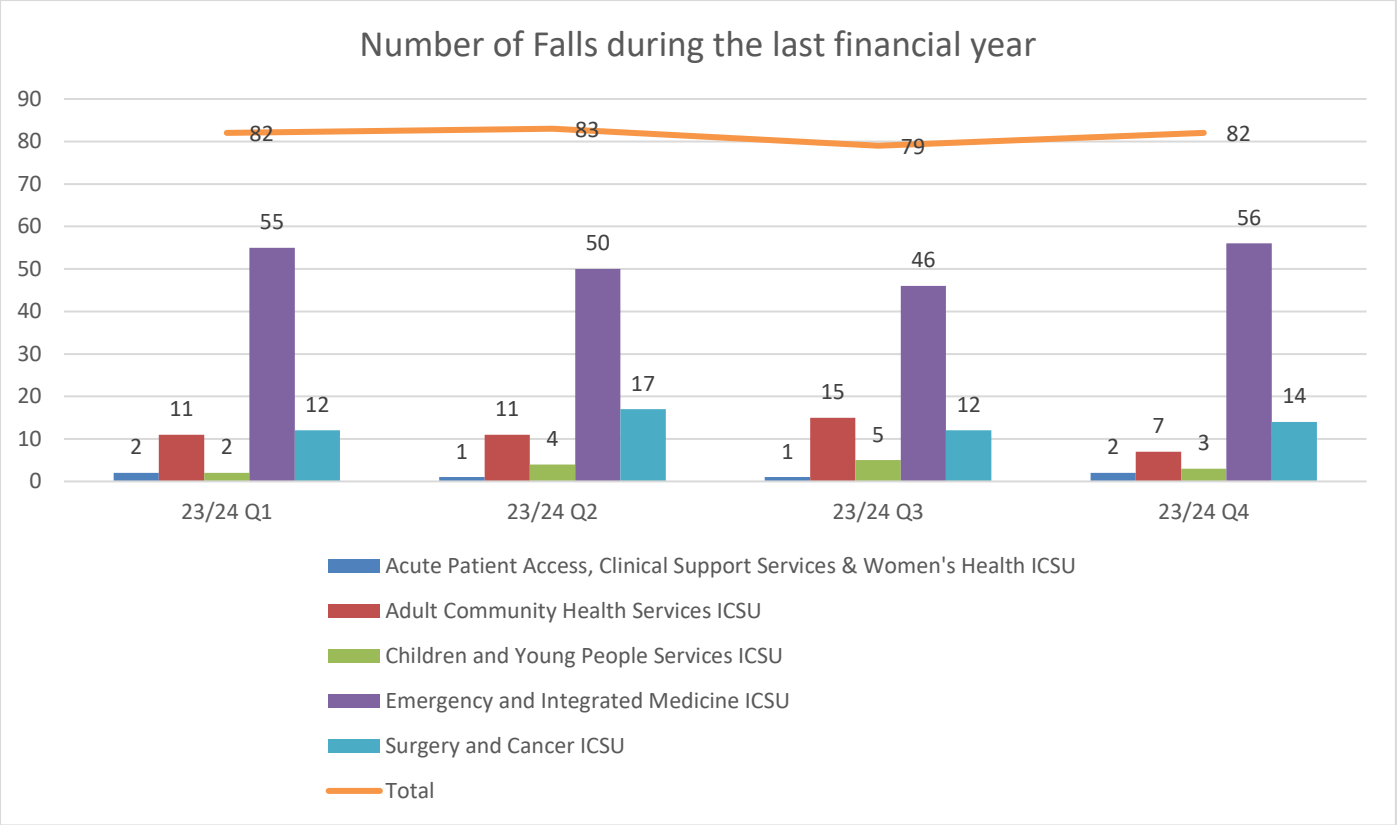
Actions to recover

- Trust Pressure Ulcer Group monitoring and supporting recovery.
- 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 May 2024
- NRS equipment related actions:
  - Raised with NCL ICB
  - Escalated to the Safeguarding committee
  - NCL raising concerns to Director of Adult Social Care who are the contract leads for community equipment.
  - Escalation via Chief AHP forum and again to NHS England – London
  - Monthly meeting with ICB contracts to raise issues with NRS and get contract management updated.
  - Individual urgent escalations continue via Associate Director of AHP and Haringey Borough Lead in ACS, Associate Director of Nursing in Children service, and OT/PT Clinical Manager in Emergency and Integrated Medicine.

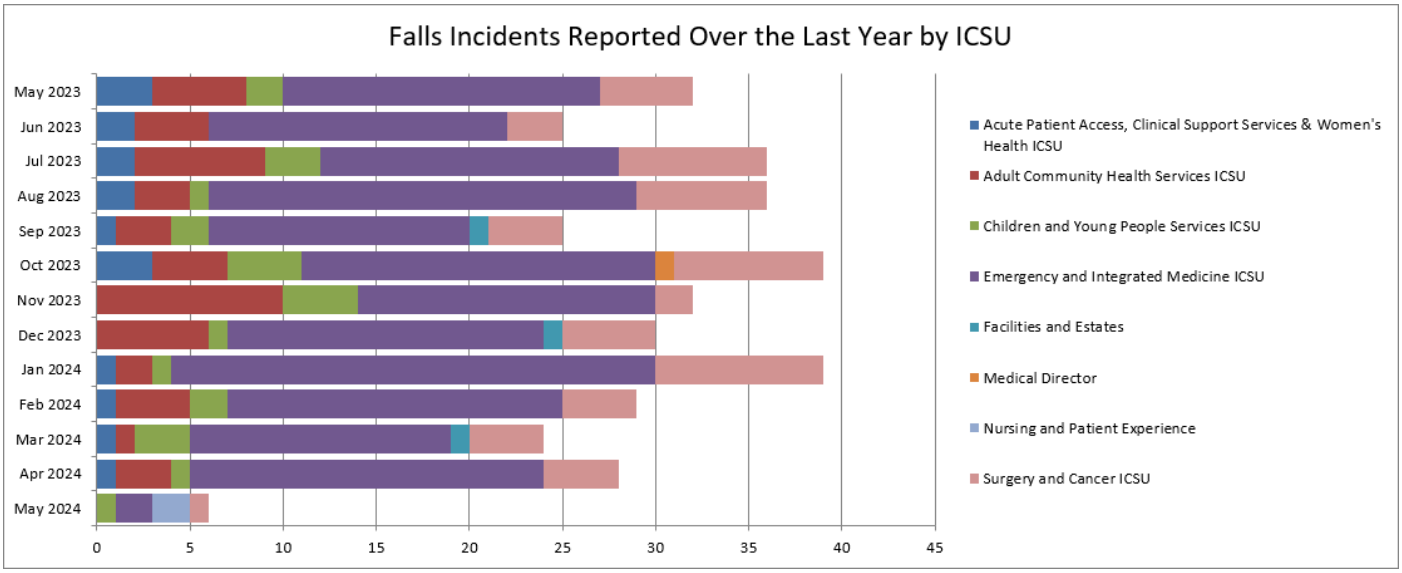
2.1.2 Patient Falls

- The number of falls has remained relatively constant over the financial year, at an average of 3.61 falls per 1000 occupied bed days. This is in comparison with the national average of patient falls of 6.63 ref: NHS Inpatient Falls Report - Vivid Care
- EIM reported the highest number of falls with acute medical wards showing an increase of 21% on Qtr3.Care of Older People wards remained the same.

Graph 9: Number of falls during the last financial year 2023/24 by quarter



Graph 10. Falls monthly data by ICSU



- One 72-hour report was completed and presented at Whittington Improvement Safety Huddle (WISH). The outcome was a 72-hour report with action plan and the actions will be managed in the Falls Group

Key learning from Falls incident

- Falls risk assessments to be completed at every opportunity
- Education around falls risks and quality of falls risk assessments.
- Further simulation training is to be set up on Hoverjack/appropriate method of retrieval.
- Consider 'Privacy & Dignity' questions when completing falls
- Increase awareness of Postural Hypotension
- Podiatry input for patients who are at high risk of falling.

2.1.3 Incident data and themes

Please note all data recorded for patient safety incidents excludes pressure ulcers as the data reported undergoes pressure cleansing and numbers may differ.

Table 1: Patient safety incidents recorded on Datix for Qtr4 by Directorate

Directorate	Jan	Feb	Mar	Total
Emergency and Integrated Medicine ICSU	92	97	119	308
Acute Patient Access, Clinical Support Services & Women's Health ICSU	95	95	113	303
Surgery and Cancer ICSU	50	44	56	150
Adult Community Health Services ICSU	49	47	51	147
Children and Young People Services ICSU	31	26	32	89
Facilities and Estates	18	21	45	84
Information Management and Technology	0	3	1	4
Strategy	0	2	0	2
Chief Operating Officer	1	0	0	1
Nursing and Patient Experience	1	0	0	1
Total	337	335	417	1089

- Table 2 details the top six categories reported in Q4. The coloured arrows within the share of incidents as a % indicate whether the percentage has changed to Qtr3.

Table 2: Top six categories for Qtr4

By Category	Total for Qtr4	Share of Incidents as a %	Change in order compared to Qtr3
Pressure Ulcer	337	24% (↑)	↔
Accident that may result in personal injury	138	10% (↑)	↑
Medication	120	9% (↑)	↑
Labour / Delivery	113	8% **(New)**	**New**
Implementation of care / ongoing monitoring / review	112	8% (↑)	↑
Admission, Appointment, Discharge, Transfer, Transport	107	7% (↓)	↓

- The top category (pressure Ulcers) remains the same as Qtr3.
- Due to focused training on incident reporting in Maternity, labour/delivery is new in the top six categories and the other remaining four categories remain the same but in a different order.
- The top six themes within the Patient Safety Incident Response Framework Plan (PSIRP) remain relevant to the incidents reported in Q4.

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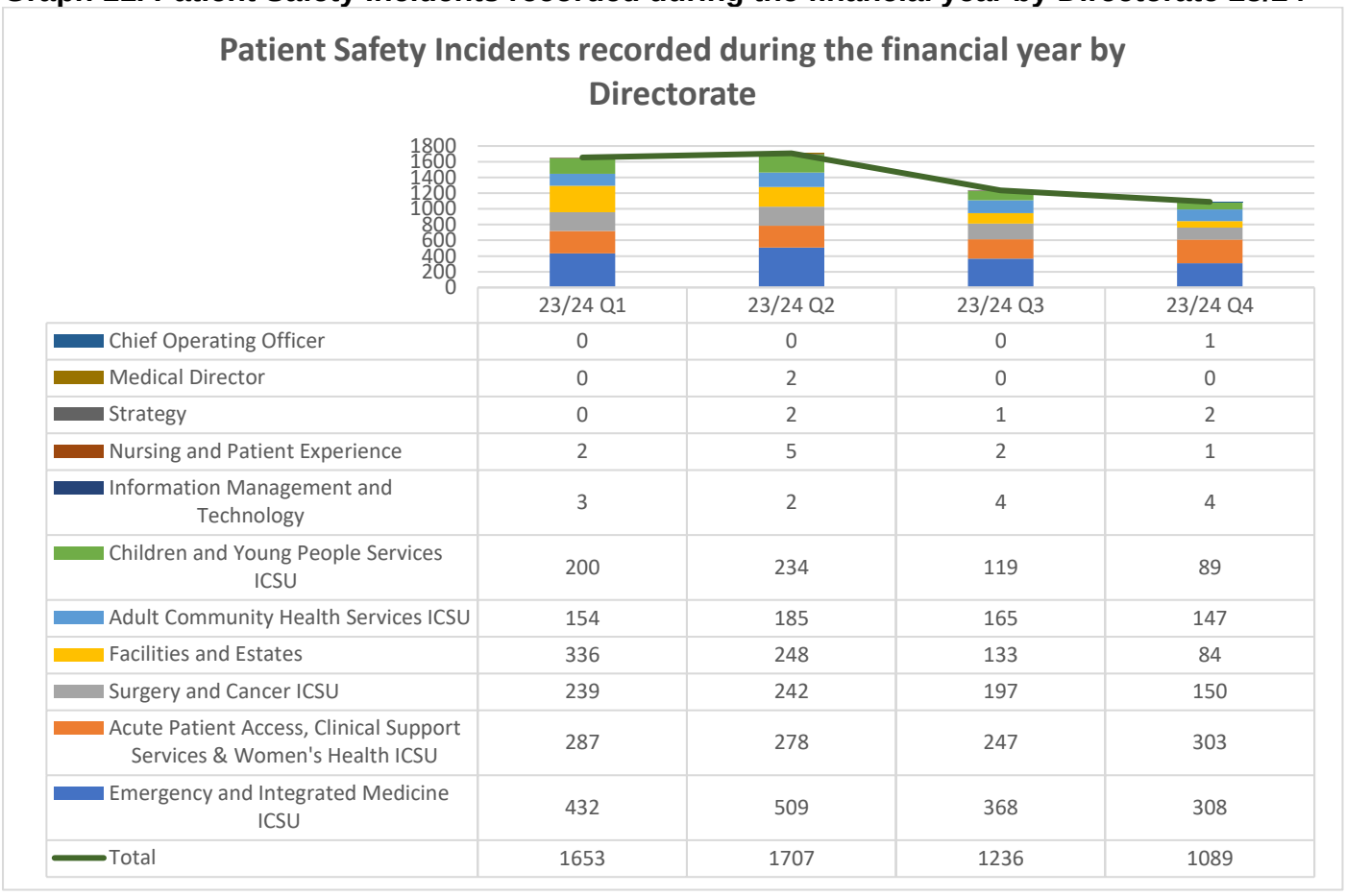
Table 3: Top six themes outlined in the Patient Safety Incident Response Plan

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

Graph 11. Patient Safety Incidents recorded during the financial year by Directorate 23/24



	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4
Chief Operating Officer	0	0	0	1
Medical Director	0	2	0	0
Strategy	0	2	1	2
Nursing and Patient Experience	2	5	2	1
Information Management and Technology	3	2	4	4
Children and Young People Services ICSU	200	234	119	89
Adult Community Health Services ICSU	154	185	165	147
Facilities and Estates	336	248	133	84
Surgery and Cancer ICSU	239	242	197	150
Acute Patient Access, Clinical Support Services & Women's Health ICSU	287	278	247	303
Emergency and Integrated Medicine ICSU	432	509	368	308
Total	1653	1707	1236	1089

- The number of reported incidents on Datix continues to drop since the implementation of LFPSE (Learning from Patient Safety Events) by NHS England

Table 4: Patient safety incidents recorded on Datix for Qtr4 by category

By Category	Jan	Feb	Mar	Total
Pressure Ulcer	104	138	95	337
Accident that may result in personal injury	47	57	34	138
Medication	39	29	52	120
Labour / Delivery	39	34	40	113
Implementation of care / ongoing monitoring / review	35	34	43	112
Admission, Appointment, Discharge, Transfer, Transport	37	33	37	107
Security	10	11	46	67
Diagnosis, failed / delayed	28	20	12	60
Treatment or Procedure	22	17	17	56
Patient Information (records, documents, test results, scans)	17	16	16	49
Medical Device	18	10	18	46
Confidentiality, Consent / Communication	9	13	15	37
Nutrition	2	11	12	25
Safeguarding	10	7	8	25
Other Skin Damage (Not Pressure Ulcers')	0	0	21	21
Mental Health	4	8	8	20
Estates and Facilities (Infastructure, Equipment and Resources)	6	8	4	18
Deteriorating Patient (actual or potential)	3	8	6	17
Abuse and Violence	4	5	5	14
Infection Control	2	6	5	13
Anaesthesia	0	1	3	4
Post-Operative Care	0	1	0	1
Sepsis	0	1	0	1
Total	436	468	497	1401

*This data does include pressure ulcer data

- The table 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 5: Sub-categories for accident that may result in personal injury

Sub-categories for accident that may result in personal injury	Jan	Feb	Mar	Total
Slips, trips, falls and collisions	37	27	18	82
Accident caused by some other means	5	10	8	23
Exposure to radiation, electricity, hazardous substance, infection etc	3	13	5	21
Manual Handling	2	4	0	6
Injury caused by physical or mental strain	0	2	2	4
Needlestick injury or other incident connected with Sharps	0	1	0	1
Scalding of patients	0	0	1	1
Total	47	57	34	138

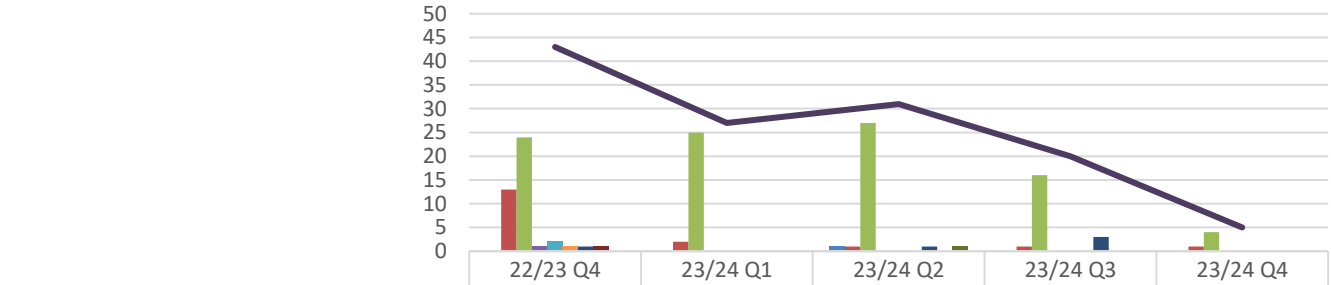
2.2 Mixed Sex Breaches

Table 6 : Mixed Sex Breach data taken from Datix on reporting Qtr4

	Jan 2024	Feb 2024	Mar 2024	Total
Surgical Wards (Coyle and Mercers)	0	1	0	1
Critical Care Unit	0	0	4	4
Total	0	1	4	5

- There has been a decrease (16) in the number of mixed sex breaches compared to Qtr3 (21).
- Critical Care saw a 75% reduction (12) and surgical wards saw a 50% reduction (1) in the number of recorded mixed sex breaches during Qtr4.

Graph 12. Mixed Sex Breaches reported by reporting quarter for the last year



	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4
Cavell Ward	0	0	1	0	0
Coyle Ward	13	2	1	1	1
Critical Care Unit (CCU) / Intensive Care Unit (ITU)	24	25	27	16	4
Day Treatment Centre Ward	1	0	0	0	0
Mercers Ward	2	0	0	0	0
Recovery room - Day Treatment Centre	1	0	0	0	0
Recovery Room - Main Theatres	1	0	1	3	0
Thorogood Ward	1	0	0	0	0
Victoria Ward	0	0	1	0	0
Total	43	27	31	20	5

2.3 Mortality

2.3.1 Summary Hospital-level Mortality Indicator (SHMI)

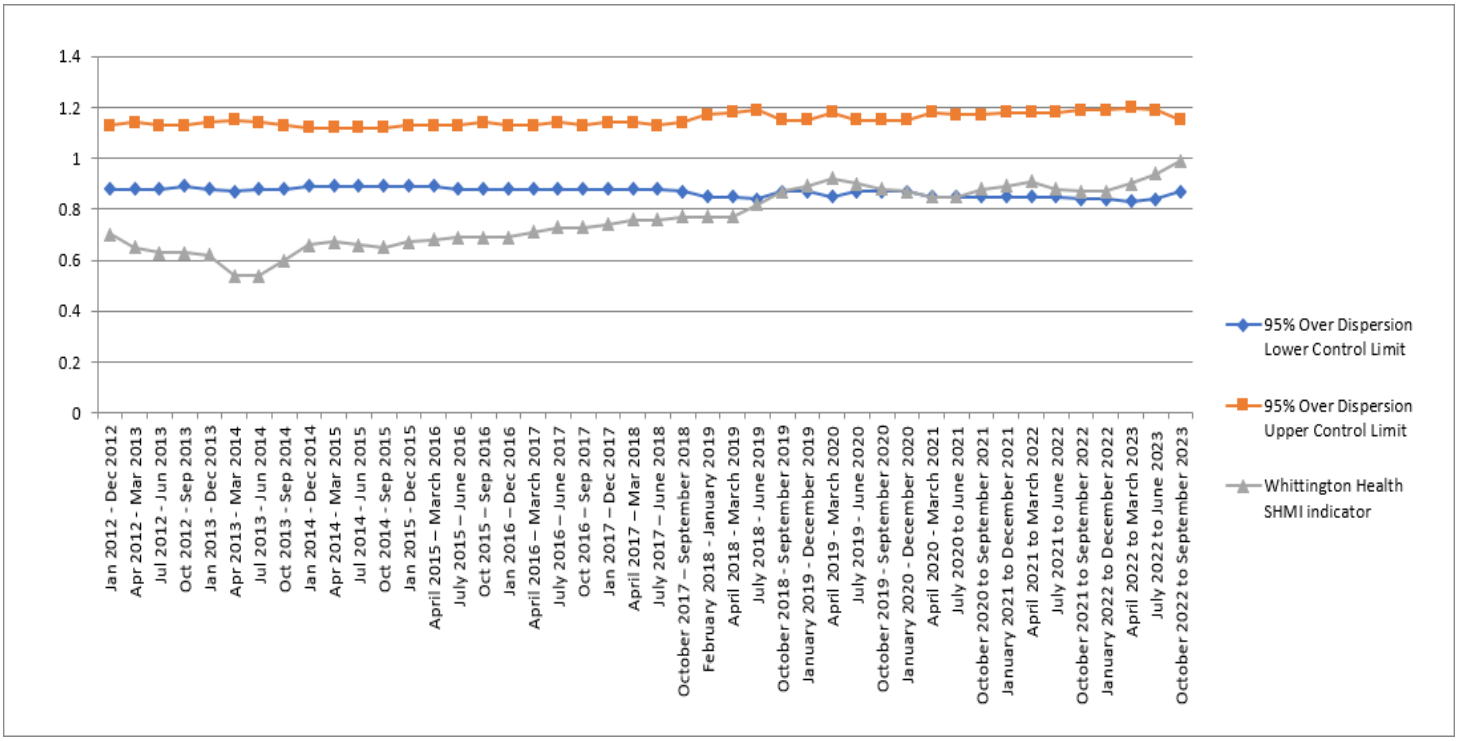
- The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. It covers all deaths reported of patients who were admitted to non-specialist acute Trusts in England and either die while in hospital or within 30 days.
- The most recent data available (published 8th February 2024) covers the period October 2022 to September 2023

Table 7: Whittington position within National SHIMI scores

Whittington Trust SHMI score:	0.99	Compared to 0.94 reported for July 2022 to June 2023 period
Lowest National Score:	0.62	Royal Surrey County Hospital NHS Foundation Trust
Highest National Score:	1.18	Norfolk and Norwich University NHS Foundation Trust

- 13 Trusts were graded as having a lower-than-expected number of deaths.
- 310 Trusts were graded as having a higher-than-expected number of deaths.
- 96 Trusts, including Whittington Health, were graded as showing the number of deaths in line with expectations.
- The SHMI represents a comparison against a standardised National Average. The 'national average' therefore is a standardised 100 and values significantly `below 100 indicate a lower-than-expected number of mortalities (and vice versa for values significantly above).

Graph 13: Whittington Health SHMI data from October 2022 to September 2023



2.4 Infection Prevention Control

2.4.1 Health Care Acquired Infections – COVID-19

May 2023 guidance introduced from 30th March UKHSA/NHSE letter 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 8. Overall case numbers of Covid for Q4 this year

	Jan -Mar 23	**Jan -Mar 24**
Community Acquired Pre-admission or up to day 2	223	97
Intermediate HAI Day 3 – 7 (hospital onset)	54	18
Probably HAI Day 8 – 14 (hospital onset)	58	7
Definite HAI Day 15 or more (hospital onset)	58	9
Totals	393	131

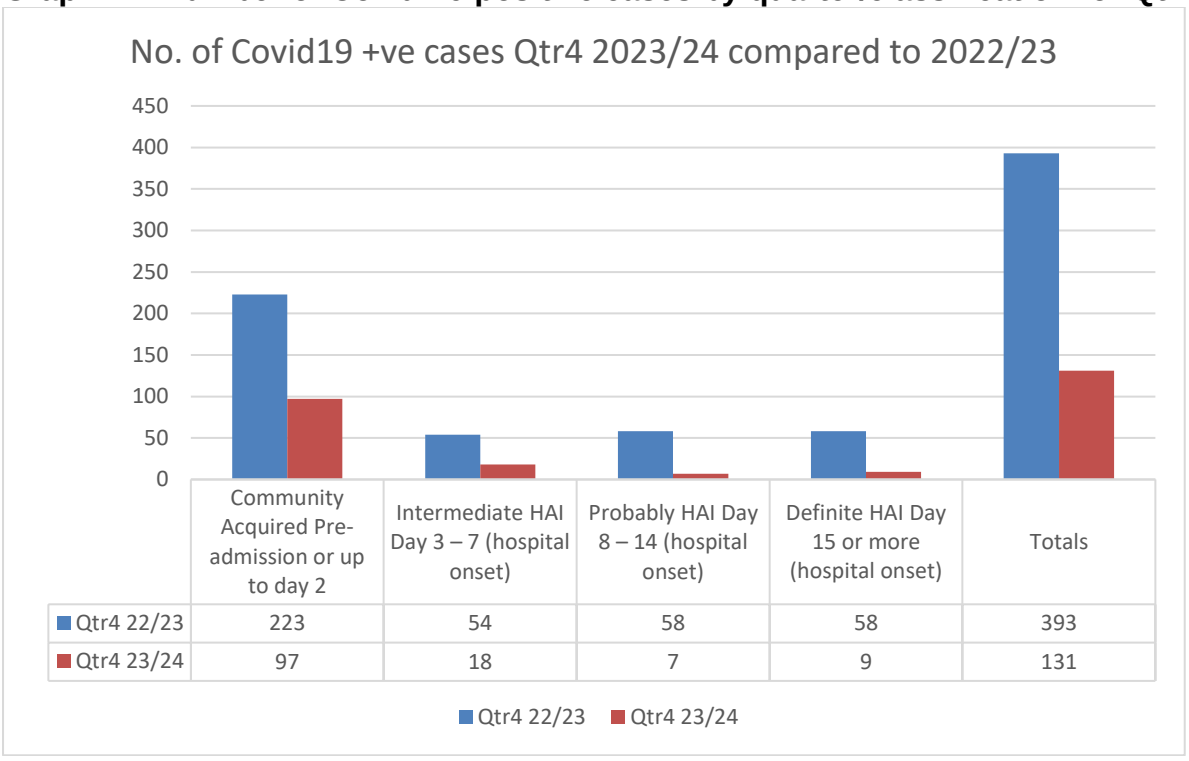
- There has been a reduced number of Covid-19 outbreaks, hospitalisations this quarter compared to last year.

- There were 4* outbreaks during Qtr4 all on acute medical wards and care of the elderly.
- January: Cavell, Montuschi, Cavell
- February: Cloudesley

- Significant (85%) decrease since this time last year in definite HAI (15 or more days)

- Significant (88%) decrease also in Probable HAI (8 – 14 days) and intermediate.

Graph 14: Number of Covid-19 positive cases by quarter/classification for Qtr4



2.4.2 Trust attributable blood stream infections (BSI)

- MRSA = 1 (zero tolerance)
- MSSA = 1 (There is no national threshold)

- The recorded MRSA was a patient who attended ED due to Hemoglobin Sickle cell anaemia (HbSS) and hyperemesis (17/40 gestation-twins); the patient has sickle cell. The most likely source of this bacteraemia is infected cannula site. and was peripheral vascular device (PVD) related. This is an avoidable MRSA BSI incident.

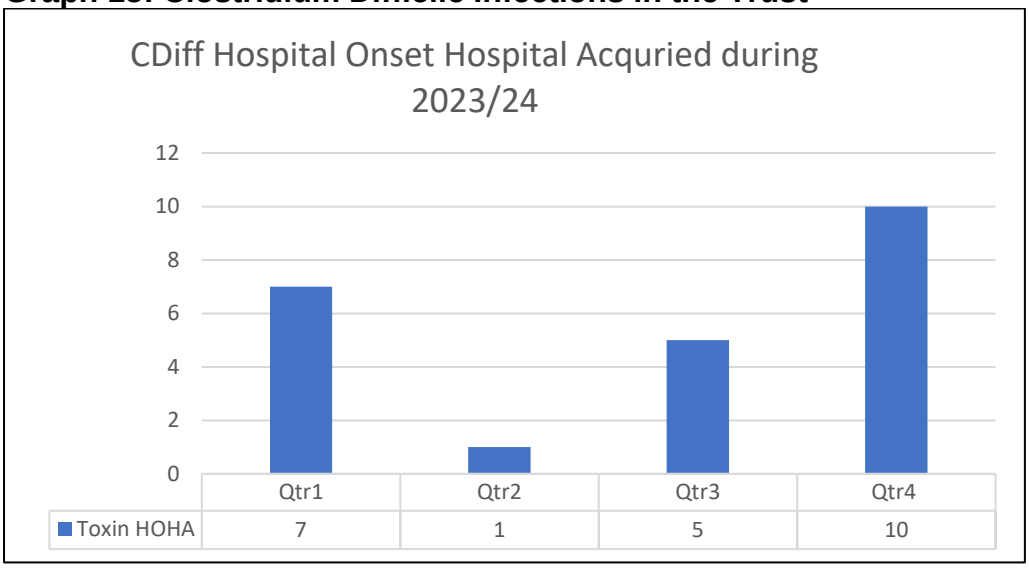
Key Findings:

- Good practice: The patient was screened for MRSA on admission as per trust policy-which was negative. Blood cultures were taken on the 12/03/2024 as part of septic screen and was MRSA
- Outcome: Patient is clinically improving.
- Lesson learned: Focused work on peripheral cannula care

2.4.3 Clostridium difficile infections

- Year to date (23-24), there have been 23 hospital acquired cases of Clostridium difficile infections (CDI) in the Trust against a trajectory of 13.
- 50% could not be ribotyped (Mercers, ITU, Nightingale, Cavell, ITU)
- Meyrick and Victoria cases are not related to another.
- Montuschi ribotype remains pending although will not be related to another in place and time.
- ITU, Cavell and Nightingale cannot be ruled out through transmission via the environment and / or equipment. There were five Clostridium difficile Infections hospital onset hospital acquired (HOHA). Cavelle, Victoria Meyrick, Critical Care

Graph 15: Clostridium Difficile Infections in the Trust



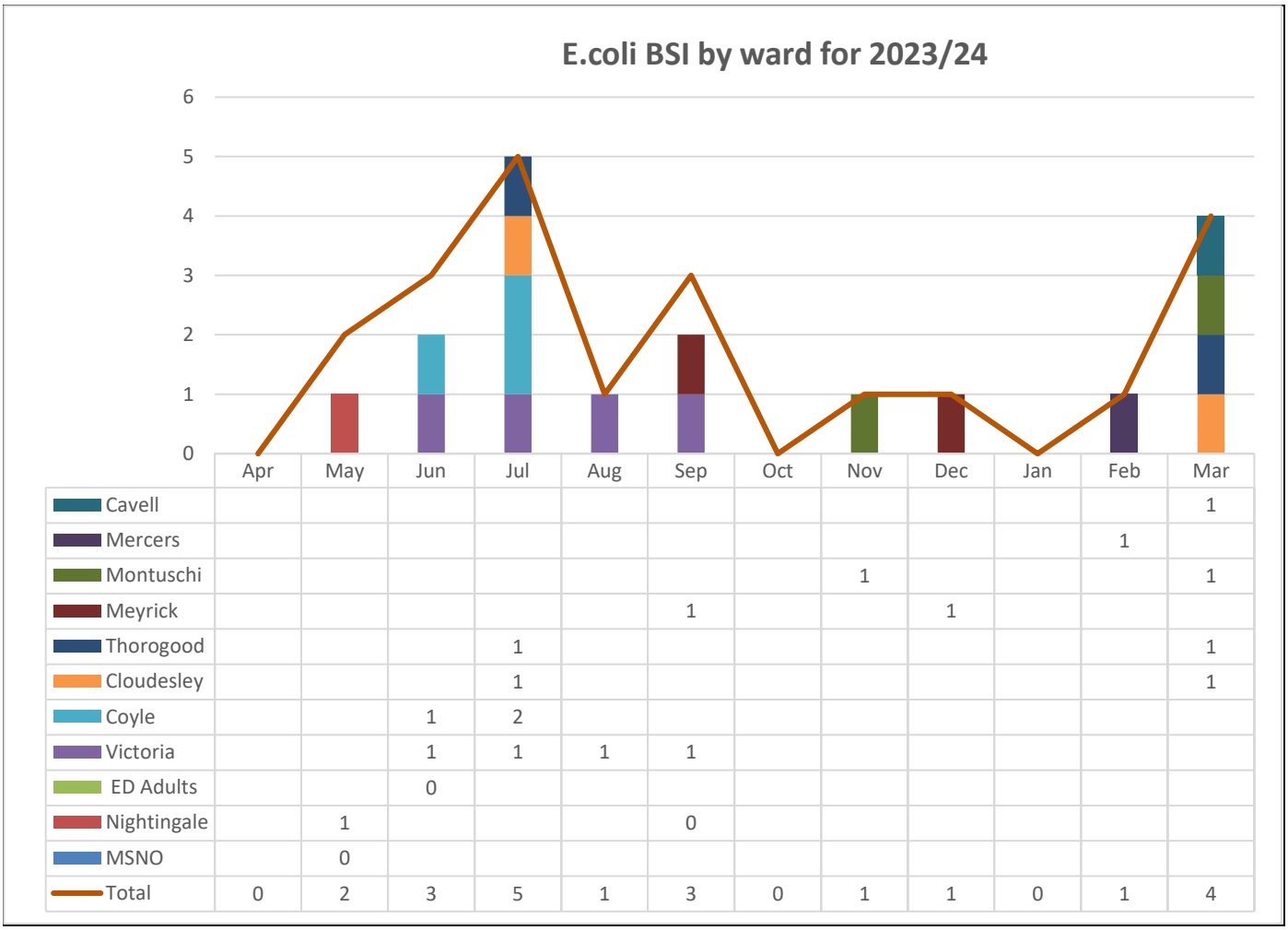
Key Findings

- Missed opportunity to diagnose earlier
- Missed opportunity to send stool samples earlier.
- Non-compliance of documentation
- Delay or unable to isolate according to policy.
- Normal bowel habit pattern unknown as not recorded.

2.4.4 Escherichia Coli Blood Stream Infections

- There were five E. coli Blood Stream Infections (BSI) during Qtr4, one on Mercers ward in February, one on each of the following wards for March:
  - Cavell
  - Montuschi
  - Thorogood
  - Cloudseley
- This brings to a total of 21 cases for the financial year.

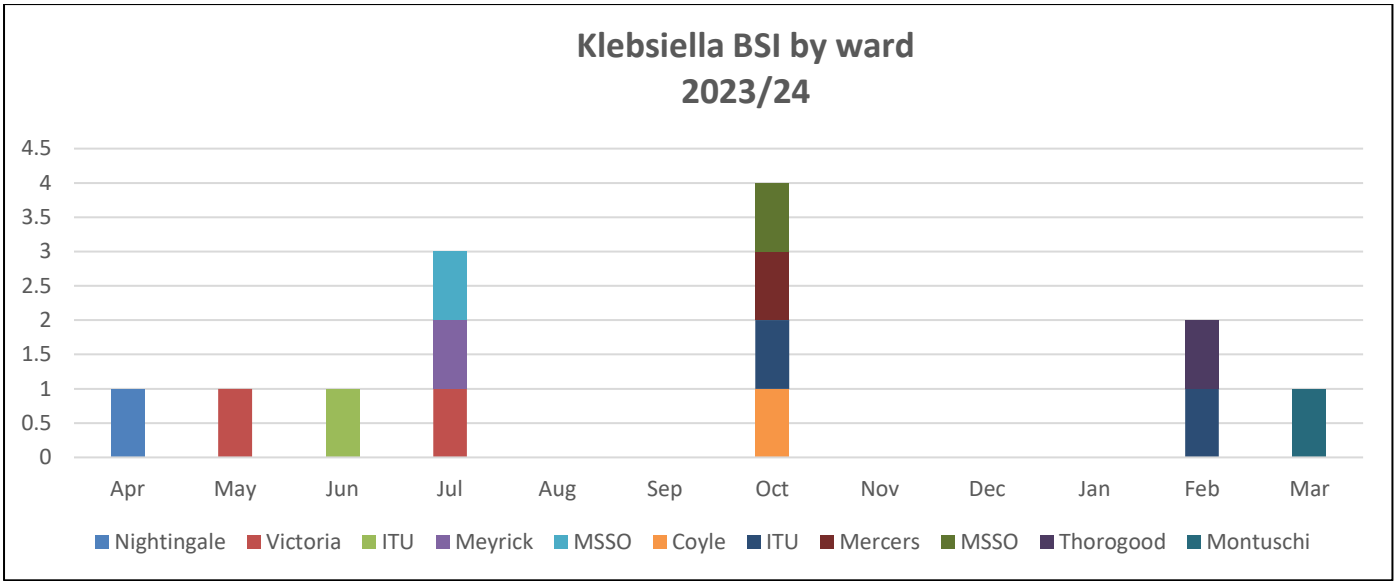
Graph 16: Location of E.coli BSI



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cavell												1
Mercers											1	
Montuschi								1				1
Meyrick						1			1			
Thorogood				1								1
Cloudesley				1								1
Coyle			1	2								
Victoria			1	1	1	1						
ED Adults			0									
Nightingale		1				0						
MSNO		0										
Total	0	2	3	5	1	3	0	1	1	0	1	4

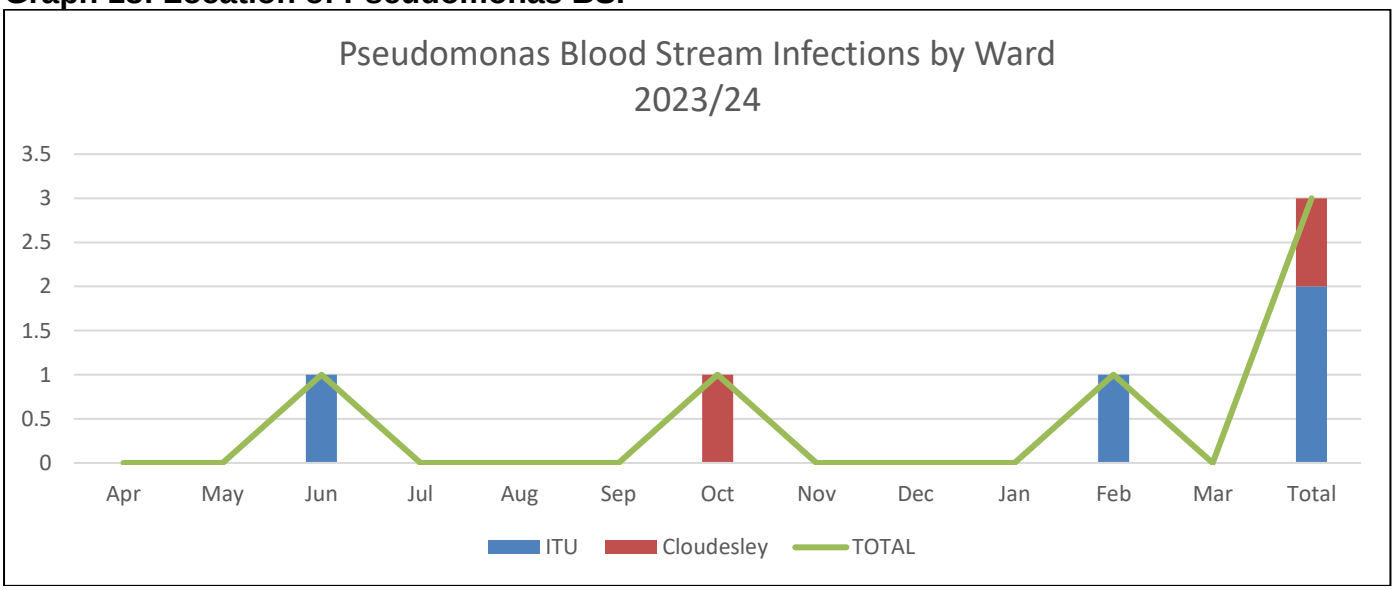
2.4.5 Klebsiella Blood Stream Infections

Graph 17: Location of Klebsiella BSI by location/month



2.4.6 Pseudomonas Blood Stream Infections

Graph 18: Location of Pseudomonas BSI



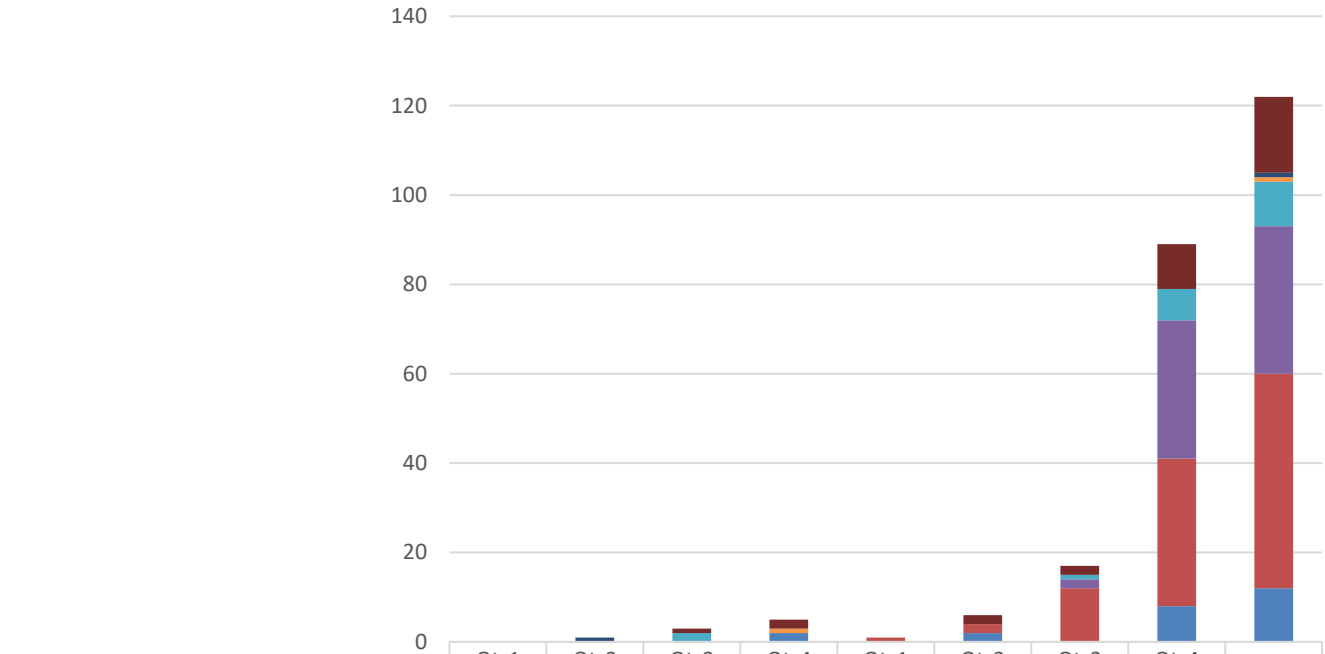
2.5 Duty of Candour (DoC)

- As of the 09th of November 2023, Datix was upgraded to include LFPSE (Learn From Patient Safety Events) in the incident's module.
- Before the LFPSE upgrade, the incident harm grading included both physical and psychological harm and referred to the incident (as a whole), however this is now separated the two gradings.

As a result, one incident may result in two DOC being attributed to a patient, for physical and psychological harm. Consequently, the number of DOC being reported has increased.

- There are currently 122 incidents between Qtr1 2021/22 to Qtr4 2023/24 across the Trust that have outstanding Duty of Candour requirements.

Graph 19: Outstanding Duty of Candour for incidents reported from Qtr1 2022/23 to Qtr4 2023/2024



	Qtr1 22/23	Qtr2 22/23	Qtr3 22/23	Qtr4 22/23	Qtr1 23/24	Qtr2 23/24	Qtr3 23/24	Qtr4 23/24	Total
Surgery and Cancer ICSU	0	0	1	2	0	2	2	10	17
Strategy	0	1	0	0	0	0	0	0	1
Information Management and Technology	0	0	0	1	0	0	0	0	1
Facilities and Estates	0	0	2	0	0	0	1	7	10
Emergency and Integrated Medicine ICSU	0	0	0	0	0	0	2	31	33
Children and Young People Services ICSU	0	0	0	0	0	0	0	0	0
Adult Community Health Services ICSU	0	0	0	0	1	2	12	33	48
Acute Patient Access, Clinical Support Services & Women's Health ICSU	0	0	0	2	0	2	0	8	12

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)

- For Qtr4, there were no Priority 2 patients on an admitted pathway breached 78 Weeks.

2.7 Safety alerts

- The Patient Safety Team have oversight of all 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 one new National Patient Safety Alerts (NatPSAs) in Qtr4.

Table 9: National Patient Safety Alerts received in Qtr4 2023/24

Date Issued	Reference	Alert Title	Status	Deadline
26/02/2024	**NatPSA/2024/003/DHSC_MVA**	Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials	All actions completed	08/03/2024

- During Qtr4 there was three new Safety Alerts.

Table 10: Safety Alerts received in Qtr4

Date Issued	Reference	Alert Title	Status	Deadline
25/03/2024	**DSI/2024/003**	Counterfeits and unbranded copies of LifeVac anti-choking devices may fail to work correctly or worsen choking incidents if used	Email sent out for staff to assess relevance.	N/A

Date Issued	Reference	Alert Title	Status	Deadline
12/03/2024	**DSI/2024/002**	MAGEC X System, NuVasive Specialized Orthopedics (NSO): UK suspension lifted	Email sent out for staff to assess relevance.	N/A
21/02/2024	**CEM/CMO/2024/001**	Valproate: important new regulatory measures for oversight of prescribing to new patients and existing female patients	Information Only - Staff Informed	N/A

- At the end of Qtr4, seven safety alerts remain open.

Table 11: Open Safety alerts at the end of Qtr4

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. 22/04/24: There has been a change of management within the team and Melanie Anderson	12/02/2021

			will be giving an update on this action	
31/08/2023	**NatPSA/2023/010/MHRA**	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls	A working group has been created to assign staff act ions.	01/03/2024

Issued	Reference	Alert Title	Status	Deadline
07/12/2023	**NatPSA/2023/014/NHSPS**	Identified safety risks with the Euroking maternity information system	Alert and action plan sent to staff.	07/06/2024
31/01/2024	**NatPSA/2024/002/NHSPS**	Transition to NRFit™ connectors for intrathecal and epidural procedures, and delivery of regional blocks	Only one more action awaiting completion: identify relevant clinical policies in the Trust to make NRFit relevant amendments	31/05/2025
05/02/2024	**DSI/2024/001**	Paclitaxel coated devices (PCD) used in the treatment of peripheral arterial disease	Email sent out for staff to assess relevance.	N/A
12/03/2024	**DSI/2024/002**	MAGEC X System, NuVasive Specialized Orthopedics (NSO): UK suspension lifted	Email sent out for staff to assess relevance.	N/A

25/03/2024	**DSI/2024/003**	Counterfeits and unbranded copies of LifeVac anti-choking devices may fail to work correctly or worsen choking incidents if used	Email sent out for staff to assess relevance.	N/A

- Five safety alerts were closed in Qtr 4.

Table 12: Safety alerts closed in Qtr4

Reference	Alert Title	Date issued	Closed
26/02/2024	**NatPSA/2024/003/DHSC_MVA**	Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials	29/02/2024
03/01/2024	**NatPSA/2024/001/DHSC**	Shortage of GLP-1 receptor agonists (GLP-1 RA) update	20/03/2024
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	14/02/2024
21/02/2024	**CEM/CMO/2024/001**	Valproate: important new regulatory measures for oversight of prescribing to new patients and existing female patients	21/02/2024
26/02/2024	**NatPSA/2024/003/DHSC_MVA**	Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials	29/02/2024

2.8 Headlines from Patient Safety Group sub-groups

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

2.8.1 Blood Transfusion

- The contract has now been signed with HSL. A new laboratory will also be built on level 5 to accommodate this change.
- There will be a re-audit of major haemorrhage blood collection. In August 2023 data showed a number of improvements, considerably that 7/8 porters followed the protocol and face to face porter training compliance is above 90%.
- Trust wide blood transfusion e-learning compliance is at 74%.
- An audit of Blood Administration Procedures in Practice in November 2023 showed that 50% of staff follow the recommended standards for checking blood components. Independent and double independent administration checks were presented to Back to the Floor in December 2023 to gage practice and raise awareness amongst senior staff and filter the message to all staff.
- The Blood Policy was updated in December 2023 to clarify independent administration procedures for one and two person checks.
- Nursing, ODP and midwifery e-learning compliance is 84%

2.8.2 VTE/ Thrombosis Group

- 9.2.1 VTE 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%).

2.8.3 Point of Care Testing Group

- The Samba II module will have an upgrade to Samba III module in Spring 2024. This upgrade will have a shorter run time.
- ITU have the quadruplex kit which tests for RSV, COVID, FluA, and FluB. Results of these tests are recorded on Medway.
- Two new bilimeter in NICU have been installed in NICU.
- The replacement Coaguchek meter at St. Ann's Hospital has been installed.
- There is poor compliance on EQA Blood glucose with Rapid Response Team (RRT)
- There is poor compliance with EQA POCT INR with dental team

3.0 Clinical Audit and Effectiveness

3.1 Q4 2023/24 clinical audit and service evaluation project status.

Teams continue to modify standard processes to ensure clinicians have access to timely guidance, enhanced support for learning (audit and research) and proactive quality improvement. Quality priorities are reviewed and assigned to the relevant area of quality governance.

Quality reports from the ICSUs - scheduled twice yearly - are received to monitor their clinical effectiveness and QI programme of work, to ensure alignment with local quality priorities and to ensure progress against the Trust quality priorities. EIM and SCD reports were received at the April 18th CEG meeting.

3.1.2 Clinical Audit and Effectiveness Progress
The table below shows the progress for 2023/24 as at completion of Q4:

Table 13: National and local audits progress as of Q4 2024/24

Project Category:	Complete	Completed - report outstanding /data submitted	On target	Not on Target	Not Participated	unable to submit	Carry forward to 2024/25	Total
Mandatory National Audits		54			1	1	5	**61**
National Audits	2	7		1			7	**17**
Local Audits	63	14		7			34	**118**
National Service Evaluations	1	2					6	**9**
Local Service Evaluations	16	5		1			14	**36**
Total	**82**	**82**		**9**	**1**	**1**	**66**	**241**

**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).*

It is to be noted that due to Trauma Audit & Research Network cyber-attack it was not possible to submit any data. A total of 450 suitable cases have been identified for retrospective submission.

A total 66 projects will be carried forward for completion to 2024/25.

3.2 Mandated National Audit 2023/24: KEY NOTE

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).

Immediate action:

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.

Trust response:

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

Currently, there is 1 clinic/week which is protected and dedicated to these patients. This requires expansion x3, plus more follow-up slots.

A Business case has been completed, to recruit more consultants, CNSs, pharmacist, advanced practitioner with USS skills and admin support. Additionally, one of the new consultant recruits will be given the Audit lead role. Additional to organisational approval, the consultant job descriptions will also require authorisation from the Royal College of Physicians.

Actions:

In the interim, a locum consultant has joined the Trust in order to support Dr Nuttall and Dr Fonseca with their clinical work.

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.

The service has also completed a risk assessment which is available on request

3.2.1 Q4 national audit report publications:

Table 14: National audit responses

Quarter	Published	Responses received to date	Comments
4	6	2	2 responses overdue and being chased. 2 response due April/May.

The relatively low response rate from clinicians is a cumulative result of various factors such as winter pressures, reduced clinical capacity and Industrial action. The Clinical Audit & Effectiveness Officer will continue to send reminders for reports to be reviewed.

3.2.2 Q4 National Clinical Audit Report publication: Example with overall assurance rating and proposed actions:

- **Sentinel Stroke National Audit Programme: State of the Nation 2023 report.**
  - SSNAP measures the quality and organisation of stroke care with the aim to provide timely information on how well stroke care is being delivered.

The overall assurance from this report is Amber.

The results highlighted the following areas for improvement:

a) The increase in complexity of patients discharged from hospital will require a responsive, appropriately resourced, and flexible approach in delivering stroke rehabilitation at a similar intensity and dose to that which would be delivered in hospital.

Over the next 12 months the following actions will be taken forward to address point (a):

- To improve on the responsiveness to stroke referrals by reviewing assessment pathway.
- To identify the level of intensity of stroke rehabilitation that can be provided within current staffing capacity.

- To continue to monitor the gap between recommended staffing ratio: referral numbers and feedback to Trust and commissioning body.

b) Vocational rehabilitation is a key component of a comprehensive community stroke service to facilitate return to work, remain in work or leave in a supported way.

Over the next 12 months the following actions will be taken forward to address point (b):

- NHSE vocational rehab toolkit for stroke to be shared with Haringey and Islington stroke team(s).
- To identify and monitor the level of vocational rehab support that can be provided within current staffing capacity and to feedback to Trust and commissioning body.

3.2.3 National Prostate Cancer Audit

The aim of the National Prostate Cancer Audit is to evaluate the patterns of care and outcomes for patients with prostate cancer.

The overall assurance from this report is **Green**.

Result	Action to be taken
Aim to complete key data on MDT	Audit to be presented at June 2024 local governance meeting. Juniors to complete a quality improvement project to change the documentation process in MDT.
Continue with active surveillance with low-risk localised disease.	No immediate action requited. To continue current plan and for the Oncology team to be informed.
Investigate why men with high-risk disease are not offered radical treatment.	Audit on reasoning of not offering radical treatment to high-risk disease individuals to be undertaken. Continue current practice as better than national average (72% compared to 69% nationally) but elicit if any risk factors of failure to provide radical treatment to high-risk disease patients
Care cancer alliance need to provide equal access/ implementation of innovative technologies/ treatments	To continue with current practice. Cancer care management team to provide updates on the outcomes of cancer patients referred to regional centres for radical treatments. Oncology update on use of hypo fractionated and ultra hypo fractionated radiotherapy as well as the use of apalutamide for metastatic disease in conjunction to systemic treatment. Introduce the use of transperitoneal biopsies; the timeframe of which will be discussed in the next business meeting in June 2024

3.3 Q4 Local audit: Examples with identified actions:

- **Dermatology Consent Audit**
  - This audit was performed to ensure current consenting for dermatology procedures is undertaken and that the form is completed in full for each patient. The data

collected was for one month duration (26 Feb – 26 March 2024). A total of 43 patients were reviewed.

- There were 32 criteria audited, of which 23/32 scored green with no further action required. A total of 4/32 scored red and 5/32 scored amber.
- The results were discussed at the local meeting, with the amber and red areas highlighted. Staff received appropriate reminders and education on the completion of the consent form. A re-audit will take place in 12 months.

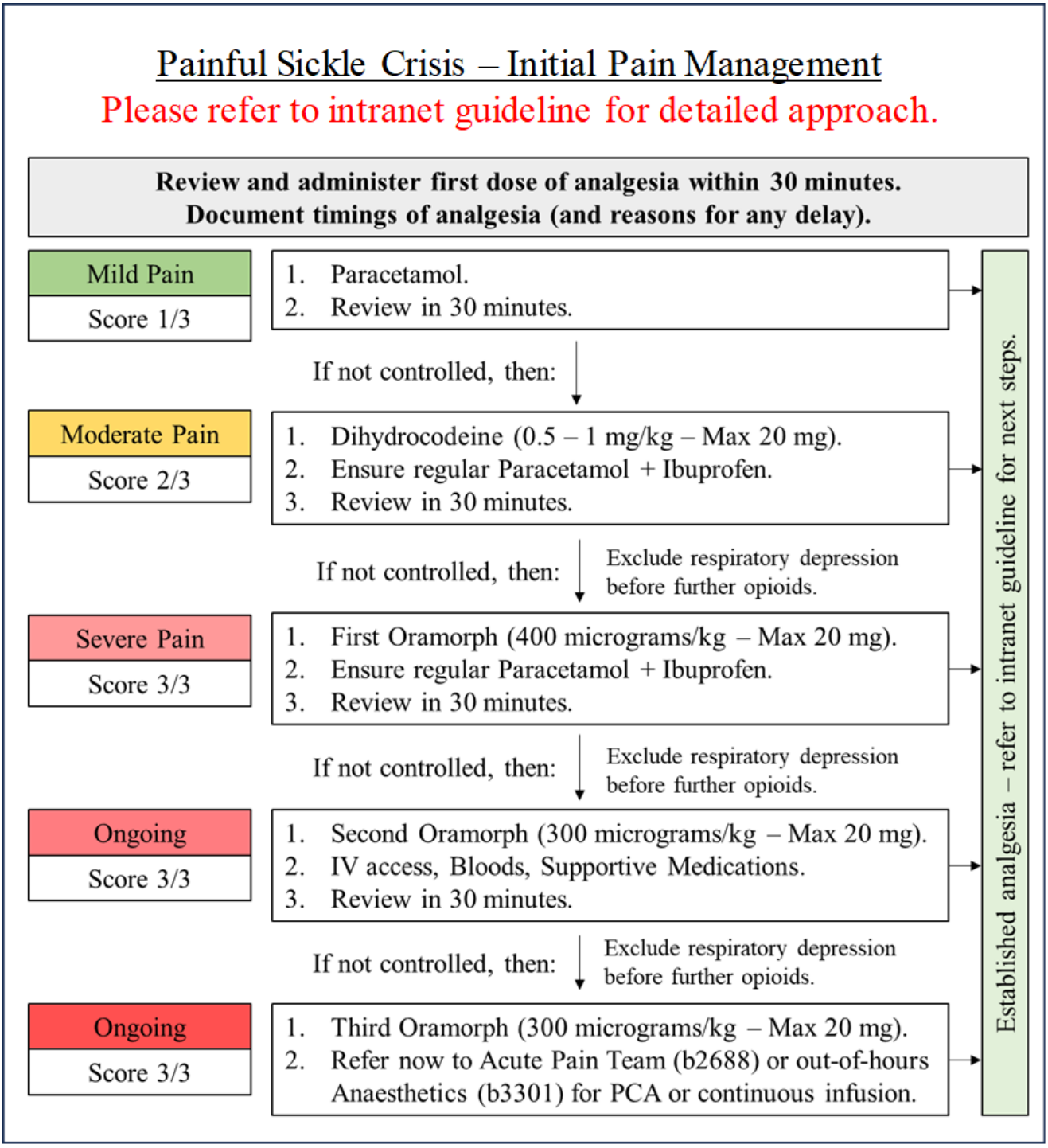
- **Painful Sickle Crisis – Are we giving timely analgesia?**

This audit reviewed the data of children with sickle-cell who are on the "red-alert" watchlist. The timeframe was April to October 2023. A total of 18 children were identified.

· Criteria	Results
· Initiating timely analgesia (NICE guidance states within 30 minutes of arriving in secondary care)	10/18 or 55%
· Are we prescribing the correct analgesia?	12/18 or 67%
· Are we appropriately escalating analgesia?	5/11 (45%) received escalated analgesia within 60 minutes. 4/18 (22%) required a PCA

Actions to be taken:

- To educate staff/doctors on IFOR, ED and CAU and prompt each other during each shift, and undertake refresher training for staff.
- Encourage Electronic Documentation in: Dose timings (especially ED/CAU).
- Check that medication has been given.
- To take forward the quick reference guide (as below) and update the full guideline accordingly.



3.4 National Confidential Enquiry into Patient Outcome and Death (NCEPOD):

- The following eight NCEPOD studies are 'live':

1. 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 submitted.

2. Crohn's disease: to review of remediable factors in the quality of care provided to patients aged 16 and over 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. Case submission complete, the organisational and clinical questionnaire returned. Report published, appropriately disseminated, and awaiting response.

3. 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. Initial feedback received from Dr Restrick. Report sent to Dr Gillis on request of Dr Dollery, for review at MRG and as pneumonia is a high cause of in-hospital death.

4. 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.

5. 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.

6. 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.

7. 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. Case submission completed.

8. 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.

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

1. Blood sodium

Three further new studies have seen chosen for next year:

1. Acute lower limb ischaemia
2. Acute illness in people with a learning disability
3. Emergency surgery in children

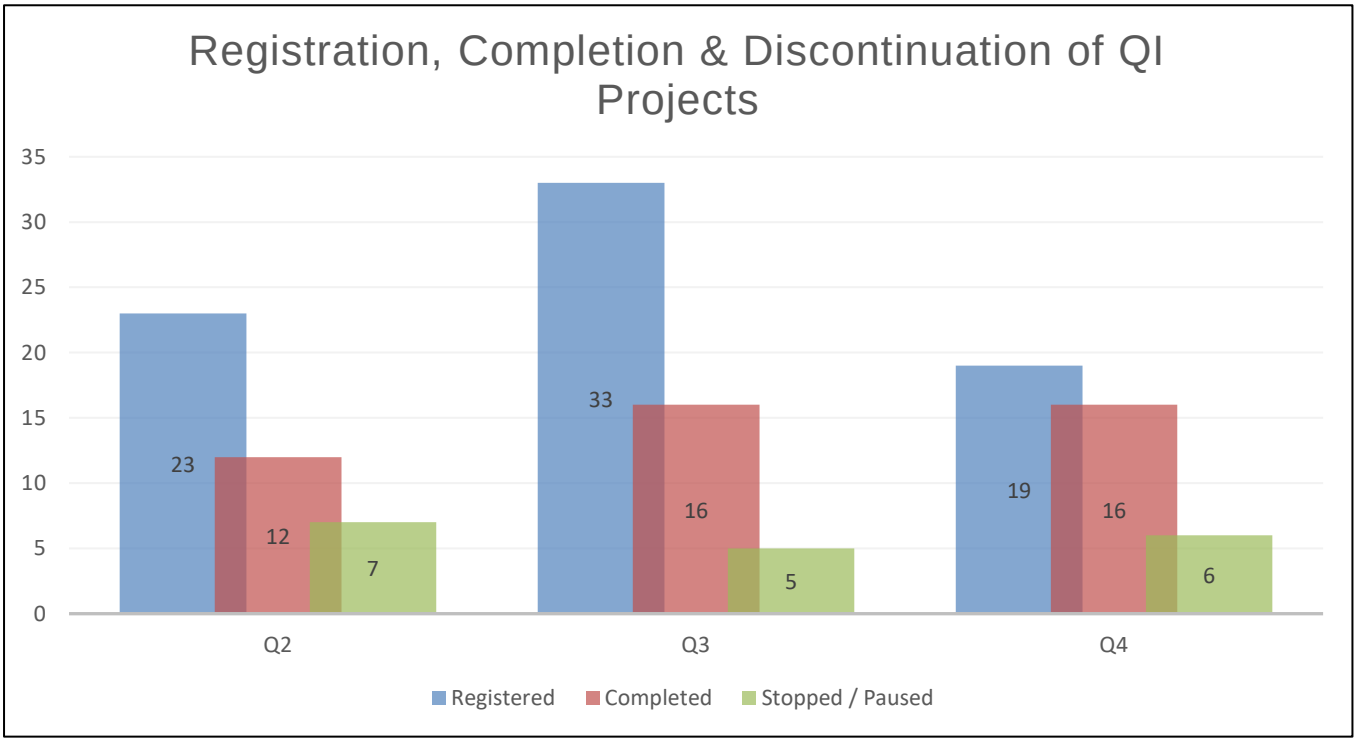
4.0 Quality Improvement Programme

4.1 Quality Improvement Projects (QIPs):

- A total of 19 new projects were registered in Q4 with representation from 5 ICSUs. This included 2 QIPs that are being conducted across multiple ICSUs.
- A total of 16 QIPs were completed, and 6 were stopped or paused. Reasons for stopped projects include:
  - No response to requests for updates
  - Project evolved into Research and redirected to Research team
  - Lack of uptake in project from wider team
  - Lack of impact, to reevaluate and recommence in future

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

Graph 20: Status of Quality Improvement Projects



4.1.2 QIP Results and Progress:

Results and progress for QI projects in Q4 include:

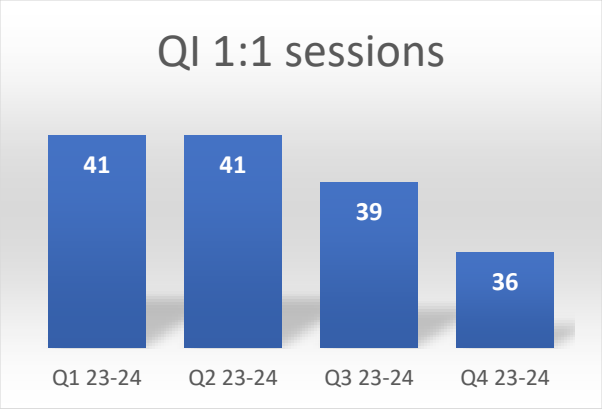
- **Improving staff access to training and development to reduce attrition (Health Care Support Workers):** Results demonstrated career progression is 3.8 times greater than when measurements commenced in 2018, and training has increased by 4 times the volume offered in 2021.

- **Service Improvement project to reduce the length of hospital stay for patients with decompensated heart failure:** This project has been implemented into practice as part of the Virtual Ward referral criteria under Cardiology. It was proven to reduce the length of hospital stay for patients who have recently been switched to an oral diuretic and need further monitoring. This project also improved patient satisfaction, freed bed space for the more acute cardiac patient and was a cost-effective solution. It also improved integrated working with long term community HF team.
- **Managing long OT/PT waitlists in REACH:** Waiting times have improved through use of opt in letters, second screening, cross cover and locum support.
- **Overtime clinics in Audiology to address long waiting times:** Waiting times have been reduced by 80.5%, and the pilot has been extended to 18-weeks due to the project success.

4.1.3 Encouraging, Empowering & Embedding QI

- Training:
  - The reduction in QI staffing cover during Q4 (1.0 WTE to 0.6 WTE) has impacted on the amount of training and QI support available.
  - One training session (Preceptorship QI) was delivered in Q4, to an audience of 21 staff. The training offered was reduced compared to previous quarters.

- QI Support:
  A total of 36 QI support sessions were provided during Q4, on an ad-hoc basis. Support included guidance on ensuring projects were registered with appropriate departments (Research, Clinical Audit, Service Evaluation, QI) and re-directed where necessary, supporting with measuring impact, presenting data, guidance on next steps of projects and support with external publication.



4.1.4 Adopting & Acknowledging QI:

Quality Improvement Project Achievements:

Two Whittington QI Projects are due to be presented at the beginning of Q1, 2024 at the International Forum on Quality & Safety in Healthcare in London:

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

4.1.5 QI Celebration, Awards & Events:

The EQIPT "Beyond Preceptorship" 23-24 cohort completed their programme, presenting their QI projects:

- Facilitating a positive communication environment for adults with learning disabilities at a day service (Daisy Sax, SLT): This project aimed to increase staff use of communication strategies with service users by 80% over a 6-month period. Bespoke training and resources were provided, and post intervention measurements demonstrated a 160.1% increase in use of strategies.

- Discharge Midwife QI Project (Kelly Scott & Samantha Coor, midwives): This project aimed to increase the number of women discharged (after giving birth) before 11am. They implemented the change idea of a discharge midwife to improve flow. The results demonstrated an increase from 8% to 74% of women and babies having their care transferred to community and found that patient satisfaction with discharge process improved significantly. As the project used staff already rostered, this project resulted in no financial cost and is now planned to be rolled out permanently.

The AHP Leadership Fellowship 23-24 cohort completed their programme and presented QI projects for each of their areas:

- Making Every Contact Count (Daniel Russell): The project, undertaken by the Vaccination Service, implemented screening for smoking, hydration, and loneliness. By Autumn 2023, 100% of all patients were screened against these criteria, with 41% of those identified as experiencing loneliness agreeing to onward referral, and 12% of smokers agreeing to onward referral.

- "I was just wondering…" (Lauren Longhurst): The project, undertaken within Islington CAMHS, implemented a SLT consultation service to support clinicians to feel more confident in providing accessible support and identifying the need for SLT intervention. 100% of attendees reported an increase in confidence and stated they would use the service again. The consultation model is now being rolled out to other AHP services within CAMHS, including OT.

- Improving Parent Attendance at Haringey OT Workshops (Rebecca Crouch): The project implemented multiple change ideas to increase attendance, identifying improvements in communication and changing the timing of workshops to gain higher attendance.

- Inpatient Weight Management Pathway (Eiman Salim): The project implemented a new pathway to support patients requiring weight management, identifying 75% appropriate referrals to the new pathway.

- "Sort it Out!" (Sophie Shieff): The project reviewed and improved referral triage processes within the SLT Camden LD service, implementing standardised pathways and processes, positively impacting client and service outcomes as well as increasing clinician confidence and satisfaction.

- Reducing the number of call and time spent location prescriptions in pharmacy (Raakhi Parmar): A new process was implemented within Pharmacy which resulted in calls reducing by 94% and time spent reducing by 98%.

4.2 Quality Account (QA), Q4 updates:

Q4 updates on the QA Priorities are reported below:

Table 15. Quality Account Q4 progress

Priority	Stream	Q4 Report
Reducing harm from hospital acquired de-conditioning	**Pressure Care**	In May 2023, an improvement meeting was held with representation from across the acute services, focussing on process mapping the patient journey from front door to discharge. This resulted in dynamic discussions about what works well and what can be improved, with key themes including Quality of Care, Documentation, Education & Training and Equipment. In response to this, Pressure Care was the theme for the month of June at Back to the Floor sessions. This is a visible nursing leadership programme, launched in April 2023, where each Wednesday, senior nursing and AHP leads take the time to return to the floor with the aim of providing and cascading education, identifying potential solutions to problems, and supporting junior staff with practical skills. The topics for Pressure Care included assessment and care plans; documentation; categorisation & escalation and equipment & surfaces. Sessions were well attended by senior leads and key areas for improvement were identified with opportunities for frontline staff to receive ad hoc training and support when gaps in knowledge and confidence were identified. During Q2 and Q3, electronic nursing documentation was reviewed and updated to include Pressure Care Assessment, with prompts to signpost nursing staff on what assessments and actions need to be done. An electronic documentation template for Pressure Ulcer Plan was drafted. The publication of this documentation is under

		review, in order to ensure that the documents are up to date with the NHSE Guidance released in November 2023 that changes the current Pressure Ulcer management and documentation, affecting categorisation, reporting and pressure ulcer assessment. Aside from the Quality Account goal set, wider improvements within Pressure Care have continued throughout the year, resulting in an overall reduction in the number of patients who have developed pressure damage attributable to Whittington Health. These achievements have included: • Amendments to the acute equipment delivery service, increasing from 5 to 6-day service and inclusive of bank holidays • Nomination of skin care ambassadors in over 90% of clinical areas • Guidance on skin assessment in range of skins tones • Hospital wards achieving 129- and 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 concluded 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	Flow Improvement Programme (related to Goal 2): https://whittnet.whittington.nhs.uk/mini-apps/news/newsPage.asp?NewsID=820 TWOC Pathway update (Jan 24): Completed - and pathway set up in September 2022. Reviewed in Jan 2024. Referrals from Acute side are very low - only 2 since the pathway went live. Rhea (lead DN for QI) Holly (BB service lead) and Alex Tyler (doctor from acute side) continue to work on making sure acute staff are aware of the pathway and send more referrals in for community TWOC and look at referrals coming from other sources including other HCPs and from primary care. We agreed to involve

		Comms for screensaver reminders, include in catheterisation training sessions and reviews of existing patients on DN caseload with link nurses with support of bladder and bowel to see if suitable for Community TWOC
	Nutrition	In Quarter 4, an audit of “What Matters to Me” was conducted for all patients with a diagnosis of dementia who were admitted to hospital. Of 41 patients, 32% had evidence of “What Matters to Me” uploaded to their electronic documentation. This percentage was noted to increase (45%) when there was active involvement from the Dementia CNS. Of those that had a “What Matters to Me” document, 100% had clear food preferences recorded that were personalised to the individuals.
Improving Access and Attendance for Appointments	**Zesty**	In Q4 23,214 registration invitations were sent to patients to sign up to Zesty. 8,558 of these were a first invite to register for the application and the average sign-up rate for the first invitations was 85.87%. In regard to being able to reschedule appointments: This functionality is still in the testing stage and it is hoped it will be piloted in Q1 24/25. 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. N.B: - Please note that patients may self-register without using the invitation link, even after receiving an invitation.

	Transport	There has been a reduction in complaints relating to DHL transport since the eligibility criteria has been extended to 12 weeks. Complaints are monitored via transport group and this reports to Health and Safety committee. However, some complaints are still being reported regarding escorts not being allowed on transport but patients who require escorts have to have a valid carer to be able to book this. Most complaints are from people who want their family member to accompany them, which is only allowed if they are their registered carer. DHL will not take people just to accompany a patient as they would be expected to make their own way to the hospital.
	Letters	During 2023, work was undertaken by IT and Quality Improvement to assess letters sent out for outpatient appointment. 1008 letter templates were identified as having a hospital site location associated with it. These were cross referenced with locations and 48 letter locations were identified. These locations have all been reviewed and cross-matched with signage and it was confirmed that letters correctly reflect signage in place. One letter location was identified as no longer in use and IT worked with the relevant service to remove this clinic location from the system. A new map and way-finder guide was produced with all letter locations and circulated to the way-finder volunteers. During 2023-2024, additional volunteers were recruited, with a key role of wayfinding in order to support people to find their appointments easily. Feedback has been received from service users about confusion caused by historical Covid signage, directing people via one-way routes in order to maintain distance. This signage has been reviewed by Communications and Estates and Facilities in order to facilitate removal of any signage that is no longer required and has the potential to cause confusion when directing people around sites. A challenge identified during the project is that when letter amendments are required, it requires significant manual burden, requiring each letter to be accessed individually. IT are reviewing options to create a central letter library for ease of access and allow changes to be made centrally.
	Woodgreen CDC	There are new banners and clear signage in Wood Green mall that direct patients to the CDC. Written information is provided in electronic and written formats to patients currently. Braille information is still being explored. Phlebotomy appointments are booked electronically and walk ins have stopped. Walk in appointments still available

		for X-ray. Swift queue has stopped overbooking of slots and there have been no further complaints since this was rolled out relating to appointments.
	Accessible information for LD	Website for accessible information for those with learning disabilities is now live. It includes information such as the hospital passport, posters for wards on LD and autism, patient stories on how their visits to hospital were from their point of view, Stopping the Over-Medication of children and young People with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) leaflets. There are plans to add videos and other useful links in Q1 2024/25.
Reducing health inequalities in our local population	**Sickle Cell**	Training: A project focussing on training staff continued during 2023-2024, with service users involved in the design and implementation of staff training to include education on the condition. Up to a third of ED staff had previously been trained, but this number reduced due to staff turnover. In quarter 2, 23 current nursing staff had received training, including education on the condition and potential bias, and further training sessions were delivered in February 2024, with 25 staff receiving training. An e-learning package has been added to the staff training portal to be completed by staff across the Trust. In Quarter 3, Sickle Cell was one of the topics for a Back to the Floor session. Back to the Floor is a visible nursing leadership programme, run weekly with senior nursing and AHP leads in order to educate, problem solve and determine solutions within clinical settings across the Trust. The session was led by the Sickle Cell Lead Nurse and an Expert by Lived Experience who shared their experiences and provided further education around time to analgesia, recognising and acknowledging pain, and how to improve the patient journey during hospital admissions. The session was well received, and the group discussed opportunities to improve the sickle cell pathway for patients when attending our hospital, as well as using the opportunity to raise awareness of the NHS England's Sickle Cell card. In addition to training provision, ED and Ambulatory care have implemented Sickle Cell Nursing Advocates within their services to aid sharing of learning and training materials. Pain Relief: A new data collection tool was developed to accurately capture time between attendance and first dose of analgesia. The accuracy of the data collection continues to be monitored to ensure that it accurately captures timings and does not result in duplicated data.

		Challenges in achieving the target have been impacted by Trust wide inpatient bed capacity pressures which impact on ED overcrowding and subsequent delays in treatment, particularly noted in December 2023. Although not quite at 80% target, an audit looking at patients who attended between October 2023 and December 2023 showed that 70.2% of patients received analgesia within 30minutes. This is a marked improvement on the 40% who received this within 30minutes in 2020, and it shows the impact of the work. The average time to pain relief from presentation was 29.8 minutes. The Sickle Cell Lead Nurse reported that service users are reporting an improvement in their waits, and this is shown by the data.
	Learning Disabilities & Autism	At the end of Q4, 57 staff in Tier 1 were compliant and 2 staff in Tier 2 were compliant with the whole training.
	Prostate Cancer	Two C Factor sessions, two prostate cancer support groups, two half day sessions of well-being self-compassion workshops, one new diagnosis session and one colorectal support group were held in Q4. During Q4 we also started the complementary therapy service offering 11 appointments a week. Currently focusing on massage/scar therapy and in Q1 24/25 we will be offering acupuncture appointments.

4.3 Sub-Committee updates:

4.3.1 Clinical Guidelines, Q4

- COVID-19 Guidelines: remain quality assured and categorised as ‘current’, ‘archived’ and ‘obsolete’. Guideline updates are dependent upon disease and case progression.
  - The emergence of a new variant and increase in case presentation at WH during Q3 may result in new and updated Covid-19 treatment guidelines. The Hub remains ‘Live’ and receptive to new requirements.
- Clinical guideline speciality reviews complete, Q4**:**
  The following guidelines have been reviewed with no or minor change:
  1. Atrial Fibrillation
  2. Heart Failure: Guidelines for Inpatient Diagnosis and Management
  3. Guillain-Barre Syndrome
  4. Refeeding Syndrome: Identification, Prevention and Management Guideline for Adults
  5. Childhood cancer- Management of the Newly Diagnosed Child/Young Person
  6. Anorexia Nervosa - managing adult.
  7. Enteral Tube Feeding - Capillary Blood Glucose (CBG) Monitoring and Diabetes Management
  8. Nutrition Support for the Adult Patient

9. Parenteral Nutrition for Paediatric Patients
10. Percutaneous Endoscopy Gastrostomy (PEG) in the adult patient
11. Nasogastric tube feeding for adults

- Clinical guidelines reviewed and deemed obsolete/no longer in use, Q4:
    1. Ropivacaine in a continuous wound infiltration device (Pain Buster) for midline laparotomies
    2. Rituximab Prescribing in Rheumatoid Arthritis
    3. Tocilizumab – Prescribing in Rheumatoid Arthritis
    4. Sweat Collection using Wescor Macroduct System in screening for Cystic Fibrosis.

- Drug & Therapeutics Committee guideline ratifications, Q4
    1. Supply and Administration of Nicotine Replacement Therapy (NRT) for adult inpatient tobacco users/smokers.
    2. Talc For Pleurodesis In Adult Patients - Guideline for use.
    3. Outpatient Parenteral Antimicrobial Therapy (OPAT) & Complex Oral Antimicrobial Therapy (COpAT)
    4. Anaphylaxis in Adults guideline

- Clinical Guidelines Committee review and ratifications, Q4
    1. Post Cardiac Arrest Management and Care Bundle (Adults)
    2. MEDL: Adrenal crisis (update)
    3. MEDL: Neutropenic sepsis
    4. MEDL: Upper gastrointestinal bleed

- Medical Emergencies Document Library Guidelines (MEDL Guidelines)
    1. During early March Q4, the first batch of CGC approved MEDLs were uploaded to the Trust Intranet. A new speciality header has been created to facilitate access and this has been added to the alphabetical guideline speciality page listing.
    2. Additionally, these MEDLs will be uploaded to the Microguide platform. The original plan was to launch on the Induction app; however, this was recently purchased by Accurx who, from May 1st are scrapping the document function. The CCIO, has liaised with Microguide to secure this add-on feature. Microguide already exists on the phones of every junior doctor.

  A simultaneous Intranet/Microguide Trust launch will follow the Microguide uploads.

Trust approved MEDLs:

1. Acute Pancreatitis MEDL
2. Acute PE MEDL
3. Bradycardia MEDL
4. Decompensated Liver Cirrhosis MEDL
5. Delirium MEDL
6. Hyperkalaemia MEDL
7. Hypocalcaemia MEDL
8. Last Days of Life MEDL
9. Lumbar Puncture MEDL

10. Paeds Traction MEDL
11. Refeeding Syndrome MEDL

4.3.2 Clinical guideline reporting workstream.

Subsequent to the summary presentation to the last CEG, work has continued to re-structure all online clinical guidelines published on the Intranet. Currently, clinical guidelines are displayed on specialty-specific Intranet pages where they can be viewed and accessed. However, in the Intranet Document Store where they are managed, clinical guidelines are assigned to a single document category – "Clinical Guideline" – meaning they cannot easily be sub-grouped or filtered by specialty for management reporting.

The new workstream aims to re-categorise and re-assign every online clinical guideline to new clinical guideline sub-specialties.

This replicates the earlier work on policy document re-categorisation but is both a complex and time-consuming process. Changes are being made on a live IT system; thus, it is important not to disrupt access to any existing published clinical guideline.

The work is expected to take 3 – 6 months to completion. Once finalised, instantaneous guideline reporting on individual speciality performance will be possible. In the interim, it is important that staff understand and appreciate the timescales and complexities involved, and the positive aspects and associated benefits of doing this work.

4.4 Policies, Q4

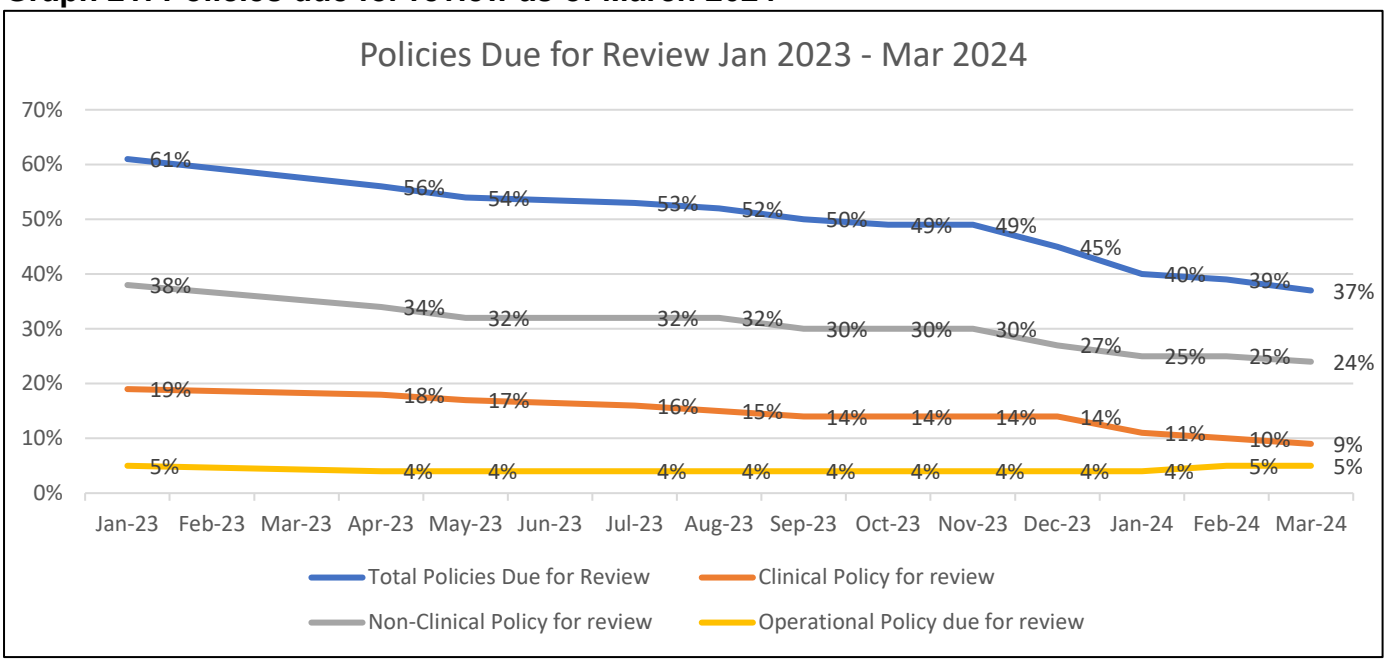
There are currently 280 online documents; 358 documents have been taken offline.

Of the 280 online documents, the below chart and pivot table shows the number of policies due for review, by category.

Clinical policies due for review have reduced to 9% in March 2024, from 18% in March 2023, and non-clinical polices due for review have reduced to 24% in March 2024, from 34% in March 2023. In total, overdue documents have reduced to 37% in March 2024, from 56% in March 2023.

We are moving in the right direction, however more work is needed to ensure all documents are up to date.

Graph 21: Policies due for review as of March 2024



Ongoing actions to improve compliance:

1. Monthly reminder of overdue policies sent to ICSUs and Corporate areas.
2. Discussions held with ICSU and Corporate department senior staff.
3. Top 3 urgent documents highlighted to ICSUs.
4. Corporate teams additionally prompted by the corporate secretary to update their overdue policies.
5. Staff member in the Quality Governance Team assisting with formatting policy documents, sending reminders and meeting with authors to encourage policy reviews.

4.5 List of NICE publications, Q4

During Q4, a total of 49 guidelines have been published with 10 necessitating a formal response. This demonstrates a slight percentage decrease on Q3 and follows the expected trajectory of quarterly publications.

Table 22: NICE guidelines published Q4

Q4 2023/24	January	February	March	Total
NICE Guidance	3	1	6	**10**
COVID Guidance	2		1	**3**
Highly Specialised Technology Guidance	1			**1**
Diagnostic Guidance	2			**2**
Interventional Procedure Guidance	3	1		**4**
Medical technology guidance				
Technology Appraisal Guidance	5	4	12	**21**

Health Technology Evaluation		1	4	**5**
Quality Standard	2			**2**
Evidence Summary			1	**1**
MIB - Medtech innovation briefing				
Total	**18**	**7**	**24**	**49**

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

5.0 Quality Assurance

5.1 CQC

5.1.1 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.
- Review of closed action wording has taken place with EIM and S&C ICSU's in Q4 to ensure that the wording still reflects the current climate and that actions that were previously closed are still adequately addressed since the previous inspection took place in 2019/2020. CYP ICSU action wording review is due to be held week commencing 22nd April. This was delayed due to key staff member leave.
- ICSU's are ensuring that an evidence base is available via ICSU teams' channels for assurance should it be required, ahead of a further inspection.

5.1.2 CQC action plan Maternity 2023

- There were 21 actions from the 2023 Maternity CQC inspection identified. Of these 12 are now closed with the remaining 9 being regularly monitored by Maternity. These relate to Maternity Triage, Maternity guidelines and Maternity workforce.

5.1.3 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. The remaining two actions are due to be completed by the end of April 2024.

5.1.4 CQC Engagement Meetings Q4

- There were no CQC engagement meetings held in Q4. One is booked to be held in Q1 24/25.

5.1.5 CQC Readiness

- A peer review program has been commenced 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.
- Learn innovate and improve meetings have been refreshed and occur monthly to enable the focus on CQC preparedness. These are chaired by the Chief nurse.
- ICSU's have been asked to set up teams' channels so that they have a central evidence base for CQC evidence, and the evidence will be quality checked by the compliance and QI manager with the ICSUs to ensure it is appropriate and provides a good level of assurance to the board.

5.2 External Reviews Q4

5.2.1 There was a Local Area Partnership SEND inspection which was carried out in Haringey over a 3 week period 15th January to 2nd February 2024.

Haringey achieved the highest possible rating: 'The local area partnership's SEND arrangements typically lead to positive experiences and outcomes for children and young people with SEND.

<u>Strengths:</u>

- Leaders in Haringey are ambitious and focused on improving the lives of children and young people with SEND. At an executive level, there is a deep understanding of how factors such as housing exacerbate the vulnerabilities of some families. Knowledgeable, culturally sensitive professionals offer direct support to families and provide advice on the navigation of SEND systems

- Health and education practitioners have developed training in response to changing needs within the local area, such as programmes for both speech and language and sensory needs delivered to nursery providers and parents and carers.

- The new speech, language and communication needs pathway is focused on developing knowledge and skills across the partnership, and school nurses deliver training on health interventions such as managing epilepsy and asthma education in schools.

- Leaders have used creative commissioning to reduce waiting times across the partnership. By creating the 'North Central London Autism Hub', they have increased capacity for rapid assessments.

- Young people who become involved with the Youth Justice Service benefit from a holistic assessment. Joined up working with SEND teams, health, schools and settings mean that children's needs are responded to, for example in returning to education following a serious offence.

- Since the last inspection, leaders have made considerable improvements in the quality of annual reviews, EHC plans and the application process. The majority of EHC plans are up to date and accurate.

Areas for improvement:

- Leaders across the partnership must ensure that individual plans and aspirations in preparation for adulthood are specifically discussed across education, health and care from an earlier age and clearly described and updated in EHC plans.
- Leaders across the partnership must ensure that recent changes, such as work to reduce waiting times and improve the quality of EHC plans, have a positive impact on a greater proportion of children and young people with SEND.
- Leaders at the NHS North Central London ICB must maintain the pace and traction around timely access to health services for children and young people with SEND.
    - The teams have done excellently and should be commended for the extremely positive outcome of the report. Improvements have been continual and sustained since the previous SEND inspection in 2021.

5.3 Quality Reviews Q4

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 Q4 15 quality visits were conducted in the following areas:

1. Podiatry, Hornsey Rise Health Centre
2. District Nursing, Hornsey Rise Health Centre
3. Virtual Ward, Hornsey Rise Health Centre
4. Theatres
5. Emergency Department
6. Outpatients Levels 1, 3 & 4
7. Cellier Ward (Post natal)
8. Murray Ward (Ante natal)
9. Victoria Ward
10. Coyle Ward
11. Meryick Ward
12. Thorogood Ward
13. Mercers Ward
14. Mary Seacole North & South
15. Day Treatment Centre.

The findings from the quality visits have been fed back to the areas the form of an action plan and this is being monitored at the learn, innovate and improve meeting.

Emerging recurrent themes from the quality visits are:

- 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.
- Completion of nursing documentation (Such as SSKIN bundles, PU documentation, Fluid balance charts and Nutrition information)
- Documentation being held across various systems, which can lead to errors and loss of information. (Such as Careflow, Rio and on paper)

5.4 Tendable usage Q4

- S&C ICSU and ACW ICSU are still low with compliance of mandated audits. This has been regularly highlighted at the Clinical Effectiveness meetings and ICSU quality meetings, a schedule of audits has been developed which breaks down the audits and spreads them across the month to assist staff in knowing when to complete them and ADON's are working with the Matrons to improve compliance.
- Compliance with IPC Tendable audits has dropped in Q3 and Q4 and has been raised with ICSU senior leadership to be improved.
- A task and finish group has been established to review the audits on Tendable to review the length and frequency of the audits in order to improve 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.

6.0 Recommendations

The Quality Assurance Committee is asked to note the three key quality messages from the Q4 Quality report:

1. The incidence of full thickness pressure damage remains a concern in the community.
2. Clostridium difficile (C. Diff) infections = 10 in Q4. (YTD 23 against trajectory of 13).
3. National Early Inflammatory Arthritis Audit Outlier Notification

Meeting title	**Quality Assurance Committee**	**Date: 8th May 2024**
Report title	**Patient Experience Report Q4 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 Q4 paper provides an overview of patient experience and covers Q4 2023/24, key highlights include: • **FFT -** Overall, the Trust maintained a score above the 85% NHS benchmark at 90.09% for positive responses during Q4. We continue to be an outlier for negative responses above the 5% NHS benchmark at 5.74% a decrease of 1.52% on Q3 (7.39%). • All ICSU's remained above the NHS 85% benchmark during February and March 2024. • During Q4 EIM reached above the NHS 85% benchmark in February (86% and March (87%) for the first time since April 2023. • During Q4, ED experienced a rise in positive responses by 11% to 81.66% from Q3 70.77%, and a decrease of 8% in poor and very poor responses from Q3 21.67% to Q4 13.52%. • **Complaints** -During Q4 we received 86 complaints. Complaint performance for Q4 was 63% an increase of 16% on Q3. • Themes continue to be around staff attitude (dismissive or uncaring) communication (poor or lack of communication between professionals/patients) and medical care (inadequate treatment) • **Engagement** -During Q4 an additional 7 new volunteers were recruited, and 22 prospective volunteers attended our volunteer induction, these will be placed during Q1. • As of 1st April 2024, all NHS trusts will be required to submit their volunteer numbers and hours, as a mandatory requirement reported to NHS England. • **Update** – Patient Experience and PALS and complaints are now part of the corporate welcome which commenced in April, with the focus being on empathy, complaint themes and feedback.	

	• **Good news story** - Ali Uygungul our inhouse Turkish Interpreter received an Extra Mile Award. Ali who has worked in the organisation for over 20 years and is well known and liked amongst staff and patients alike. • Welcome to the ward boards installed on adult inpatient wards.
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

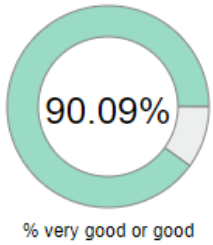
The Patient Experience quarterly report is designed to demonstrate Whittington Health's commitment to continuous learning, improvement, and patient experience. This report provides a systematic analysis of intelligence from patient experience, including key performance metrics, as well as themes and trends for Q4 2023-2024.

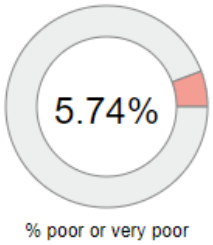
2. Patient Experience

2.1 Friends and Family Test (FFT)

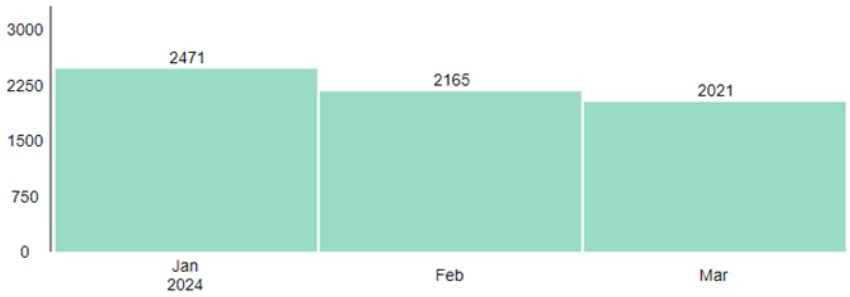
Overall, the Trust maintained a score above the 85% NHS benchmark at 90.09% for positive responses during Q4 with 6,657 responses received, a decrease of 553 on Q3 (7,210). We continue to be an outlier for negative responses above the 5% NHS benchmark at 5.74% a decrease of 1.52% on Q3 (7.39%). All ICSU's have remained above the NHS 85% benchmark during February and March 2024.

Percentages of Very good/good and poor/very poor
(FFT - All, 1 Jan 2024 to 31 Mar 2024)





Number of surveys completed each month
(FFT - All From 1 Jan 2024 to 31 Mar 2024)
6657 Surveys



Action: The patient experience team are in the process of obtaining 7 additional iPads to support the Trust with the collection of FFT with the support of volunteers. This will be extended to inpatient areas.

2.1.2 Outpatients

During Q4 the outpatient's department received a total of 1,124 FFT responses, a decrease of 174 (Q3 1,298). They continue to remain above the NHS benchmark of 85% for positive responses at 89.5% and above the 5% for negative at 5.78%.

Percentages of Very good/good and poor/very poor
(FFT - Outpatient, 1 Jan 2024 to 31 Mar 2024)

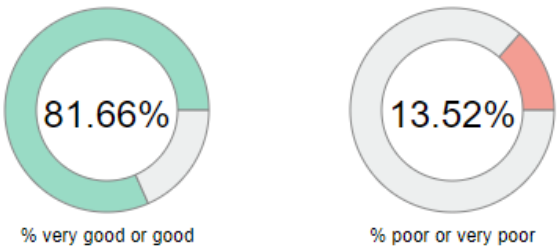
Action:

- Volunteers continue to provide support with the collection of FFT in outpatient areas and the team are actively recruiting volunteers.

2.1.3 Emergency Department

ED experienced a rise in positive responses by 11% to 81.66% from Q3 70.77%, and a decrease of 8% in poor and very poor responses from Q3 21.67% to Q4 13.52%. Survey comments consistently highlight concerns regarding waiting times and cleanliness. FFT responses have seen a decrease of 278 from Q3 1,772 to Q4 1,494. Feedback responses have been impacted by winter pressures, OPEL 4 and industrial action. Negative themes remain to be centred on waiting times, cleanliness, and staff attitudes.

Percentages of Very good/good and poor/very poor
(FFT - ED, 1 Jan 2024 to 31 Mar 2024)



2.1.4 Inpatient

Positive response rates have seen a decrease of 4% 90.16% during Q4 (Q3 94.16%) and an increase in poor and very poor responses from (Q3 1.82%) to 3.68% in Q4.

Percentages of Very good/good and poor/very poor
(FFT - Inpatient, 1 Jan 2024 to 31 Mar 2024)

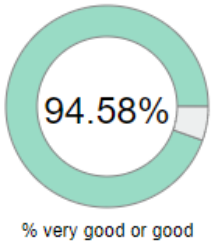
Actions:

- Volunteers will support the collection of FFT's in inpatient areas.
- The team are actively recruiting ward befrienders with the support of the EIM Quality Matron, who is providing an induction on how volunteers can get involved on the wards.

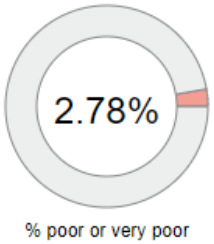
2.1.5 Community

Community services received a total of 2,122 FFT responses during Q4 a decrease of 325. Positive responses were 94.58% and negative 2.78% an increase of 1.7% on Q3.

Percentages of Very good/good and poor/very poor
(FFT - Community, 1 Jan 2024 to 31 Mar 2024)



% very good or good



% poor or very poor

Actions:

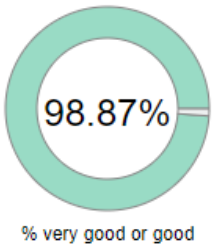
- The patient experience team are working with community services to ensure that all areas have FFT surveys in support of a larger piece of work taking place within ACS. The work centres on ensuring that all services have FFT's and QR codes associated to those surveys. In addition, support is being provided by the PE team and IQVIA to provide access to staff in those areas.

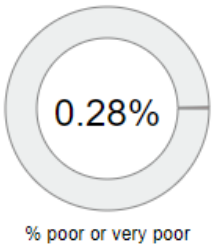
  Areas identified:
  - Anti Coagulation – In progress
  - Bladder & Bowel (3 more subservices within this Department) – Actioned
  - Heart Failure - Actioned
  - IAPT - Actioned
  - ICTT - Actioned
  - Leg Ulcer - In progress
  - Lymphoedema – In progress
  - MACCT (outstanding)
  - Diabetes Team (outstanding)
  - 3 new services in MAK – in progress

2.1.6 Maternity

Q4 saw a very slight improvement for positive response rates at 98.87%, an increase on Q3 98%, and a decrease in negative response rates which has been consistently decreasing since Q2 from 1.85% to 1.5% in Q3 and 0.28% Q4.

Percentages of Very good/good and poor/very poor
(Maternity Combined, 1 Jan 2024 to 31 Mar 2024)





Actions:

- Work continues in the implementation of FFT SMS for community postnatal. In addition to the FFT question the survey will include a question following the National Maternity Survey 2023 results where areas of improvement centred on providing enough support and advice with feeding your baby.
- The introduction of Postnatal FFT SMS has been delayed due to IQVIA system changes requiring input from our informatics team.
- During Q1 three new volunteers commence their role in maternity services, (1 mealtime, 1 ward befriender and 1 FFTs).

	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	Jan-24	Feb-24	Mar-24
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%	78%	86%	87%
		Children and Young People (CYP)	>85%	95%	97%	94%	95%	99%	97%	96%	96%	99%	97%	99%	95%	100%	98%	95%	95%	97%	97%	98%	95%
		Surgery and Cancer (S&C)	>85%	98%	97%	97%	98%	97%	96%	95%	96%	97%	97%	97%	97%	98%	93%	96%	95%	95%	96%	94%	91%
		Adult Community Services (ACS)	>85%	94%	81%	95%	92%	90%	91%	90%	89%	95%	93%	92%	91%	91%	93%	93%	94%	92%	91%	90%	91%
		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%	95%	91%	95%
		Trust	>85%	92%	89%	88%	89%	87%	91%	89%	89%	93%	90%	91%	89%	92%	90%	89%	89%	87%	89%	91%	90%
	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%	8%	10%	7%
		Children and Young People (CYP)	<5%	3%	2%	3%	2%	0%	0%	3%	2%	1%	0%	0%	0%	0%	1%	2%	2%	1%	0%	1%	1%
		Surgery and Cancer (S&C)	<5%	1%	1%	2%	1%	1%	2%	3%	3%	2%	2%	2%	1%	1%	3%	2%	2%	1%	2%	3%	4%
		Adult Community Services (ACS)	<5%	4%	11%	3%	4%	6%	3%	5%	6%	2%	0%	3%	3%	6%	4%	4%	3%	4%	3%	6%	6%
		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%	2%	6%	4%
		Trust	<5%	5%	6%	8%	7%	9%	5%	7%	7%	5%	6%	6%	7%	5%	6%	7%	7%	8%	7%	6%	5%
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%	83%	83%	85%
		Maternity	>85%	99%	98%	99%	99%	98%	98%	100%	99%	95%	98%	100%	0%	97%	96%	98%	99%	98%	98%	99%	99%
		Outpatients	>85%	88%	90%	96%	89%	96%	90%	92%	91%	95%	88%	95%	94%	96%	93%	90%	86%	86%	90%	90%	88%
	Overall Negative Experience	ED	<5%	15%	14%	21%	19%	20%	11%	17%	16%	12%	16%	16%	16%	12%	14%	23%	19%	23%	11%	13%	10%
		Maternity	<5%	0%	0%	0%	1%	1%	0%	0%	1%	0%	2%	0%	100%	0%	2%	2%	1%	2%	0%	1%	0%
		Outpatients	<5%	10%	9%	3%	9%	3%	6%	6%	5%	4%	6%	3%	3%	2%	4%	6%	9%	6%	4%	5%	8%
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%	50%	89%	50%
		Children and Young People (CYP)	>80%	50%	N/A	100%	100%	75%	100%	100%	100%	100%	83%	50%	100%	50%	50%	100%	50%	0%	100%	60%	50%
		Surgery and Cancer (S&C)	>80%	50%	25%	0%	25%	33%	17%	0%	50%	33%	17%	40%	44%	0%	20%	44%	17%	8%	67%	60%	63%
		Adult Community Services (ACS)	>80%	100%	100%	N/A	60%	100%	N/A	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	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%	38%	40%	60%
		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%	N/A	N/A	100%
		Estates & Facilities	>80%	0%	0%	N/A	0%	0%	N/A	100%	50%	33%	67%	100%	N/A	0%	100%	0%	N/A	100%	100%	100%	50%
		Trust	>80%	35%	47%	62%	50%	45%	56%	56%	65%	50%	49%	61%	63%	48%	54%	63%	45%	30%	62%	66%	61%

2.2 National Surveys

NHS England produces and uses a range of different surveys as a valuable source of feedback directly from patients and 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.

Our National Surveys are undertaken by the Picker Institute, who work with 61 organisations.

2.2.1 National Maternity 2023

In this report we detail the National Maternity survey results from both Picker and the CQC and include the top and bottom five in relation to both our Picker management report and CQC benchmarking report published on 9th February 2024.

Successes

- 89% F1 Involved enough in decisions about their care (postnatal)
- 81% B4 Given enough information about where to have baby
- 75% F20 Felt GP talked enough about mental health during postnatal check-up
- 72% F19 Felt their GP talked enough about physical health during postnatal check-up
- 54% F5 Saw the midwife as much as they wanted (postnatal)

Bottom five scores

Of our bottom five from our Picker report with the exception of 1 (D2), all are in line with the CQC benchmarking.

- F16 – Received support or advice about feeding their baby during evenings, nights or weekends.
- F6 – Felt midwives aware of medical history (postnatal)
- B15 – Provided with relevant information about feeding their baby.
- E3 – Felt midwives gave active support and encouragement about feeding.
- F15 – Received help and advice about feeding their baby (first six weeks after birth)

Actions:

- The maternity teams are developing an action plan in relation to the bottom five areas for improvement. In addition, the new FFT SMS for community postnatal will have an additional question asking about feeding your baby.

- The action plan will be monitored monthly at the maternity MDT meeting held every first Thursday of the month. The meeting is attended by the MNVP, midwifery staff and NNU staff. Updates will be provided to PEG.

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.

Highlights

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

Areas for improvement

- Accessing food outside of mealtimes
- Noise at night (being disturbed by other patients)
- Communication post procedure
- Cleanliness
- Inclusion in conversations with nursing staff

Actions:

- Patients were disturbed at night by noise, can request a “sleep well pack” this is promoted to staff through the screensaver. The sleep well packs include a postcard of tips to aid a restful night’s sleep.
- Ward patient information leaflets have been developed and placed at the bedside of each patient. Feedback from patients centred on not being aware of the leaflet and those who were aware thought it very useful. During Q1 we will trial the leaflets being attached to the side of the bedsides on Victoria and Mercers ward. The inpatient ward leaflet includes information on who to contact if they have a concern, how to obtain food outside mealtimes, carers information, sleep well packs, bedside handovers, and staff uniforms.

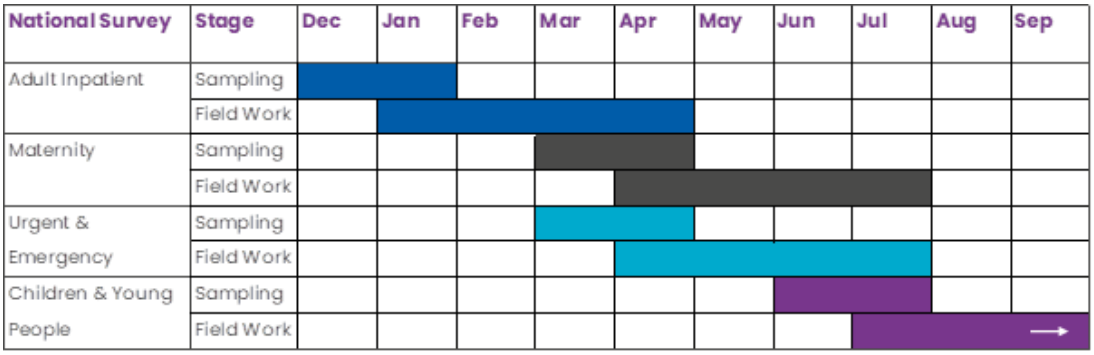
2.2.4 The National Survey Programme

National Adult Inpatient Survey 2023 - commenced with the patient sample in November 2023. Dissent posters informing patients of the proposed surveys were placed on wards to notify patients that they may receive an invite to participate. Field work takes place between Jan and April, with a publication date of August 2024 (TBC).

Cancer Patient Experience 2023 – seeks the opinions of patients who were treated for cancer as an inpatient or day case during April, May and June 2023. Publication of the Cancer Patient Experience Survey will be shared online alongside individual trusts, ICB and Cancer Alliance reports in the early summer of 2024. FAQs - National Cancer Patient Experience Survey (ncpes.co.uk)

2024 Surveys

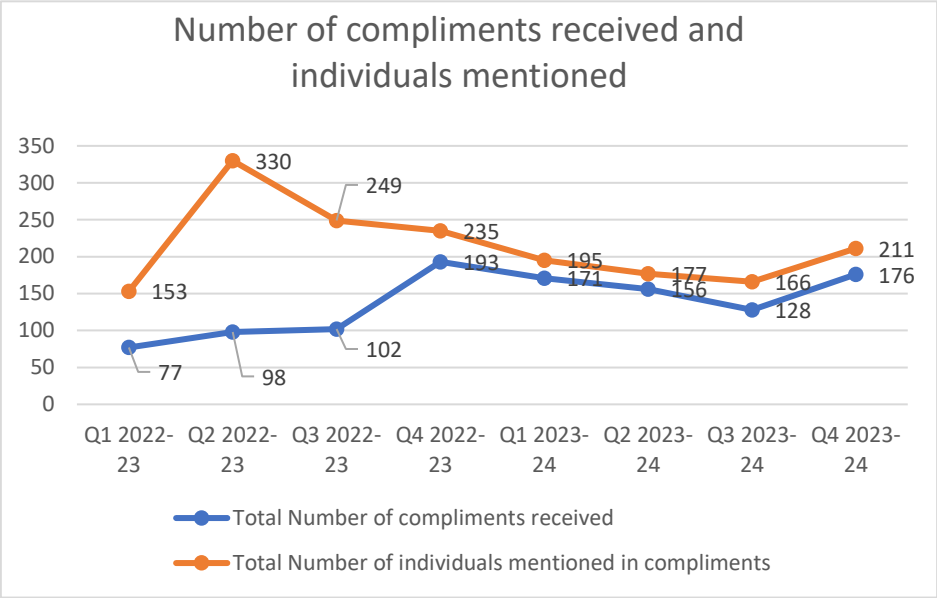
Urgent and Emergency Care: fieldwork April – July 2024, publication October 2024 (TBC)
Maternity: fieldwork April – June 2024, publication December 2024 (TBC)
Children and young people: fieldwork July – October 2024, publication March 2025 (TBC)
Cancer Patient Experience - April -June 2024, publication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



2.3 Compliments and Complaints

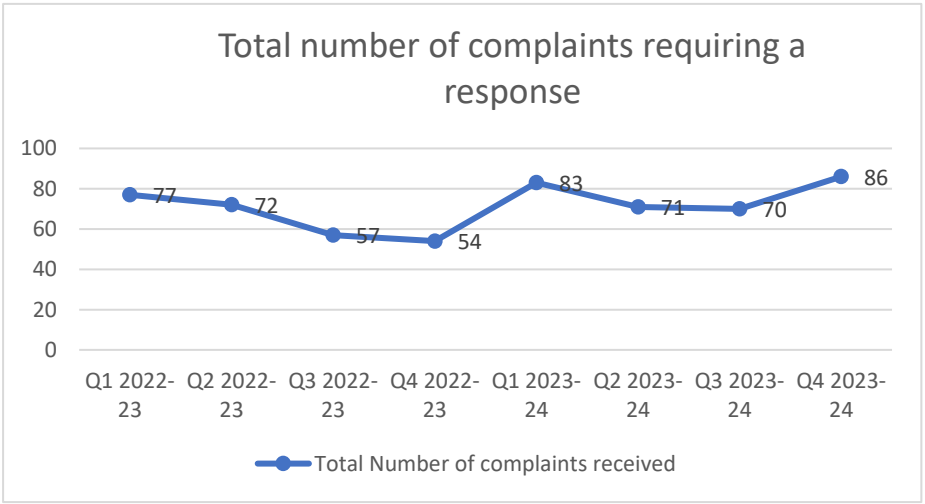
2.3.1 Compliments

The Trust received 176 compliments thanking 211 areas/or individuals, an increase on Q3. Below shows the volume for the year 2022-23 to date.

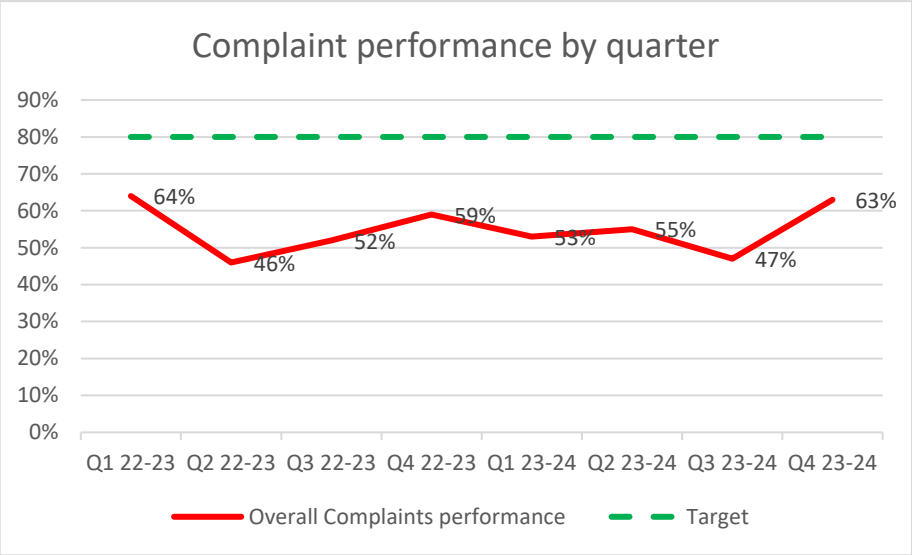


2.3.2 Complaints

During Q4 we received 86 complaints, this is an increase of 16. This includes a number of cases that have been de-escalated, without a full investigation being needed.



Performance against the 80% target has continued to be adversely affected during Q4 due to winter pressures, OPEL 4, industrial action and a number of historical complaints. The performance figure for Q4 was 63%, an improvement of 16% on Q3 (47%). The performance against the 80% target can be seen in the chart below.



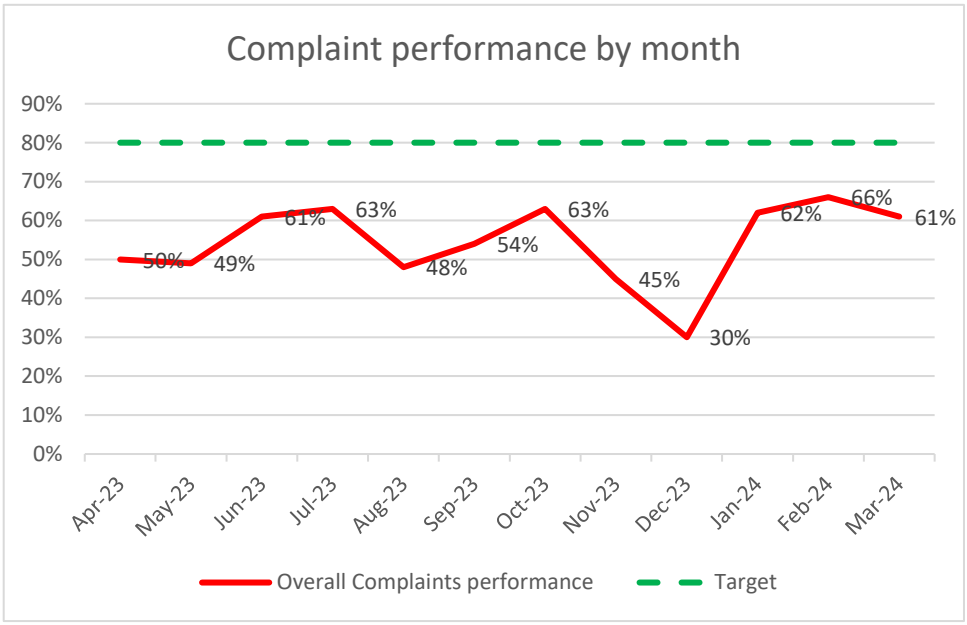
Of the complaints that closed during Q4, 9% (5) were fully upheld, 76% (41) were partially upheld and 15% (8) were not upheld, meaning that 85% of complaints were upheld in one form or another. This is broadly in line with previous quarters where around 80% of complaints were upheld.

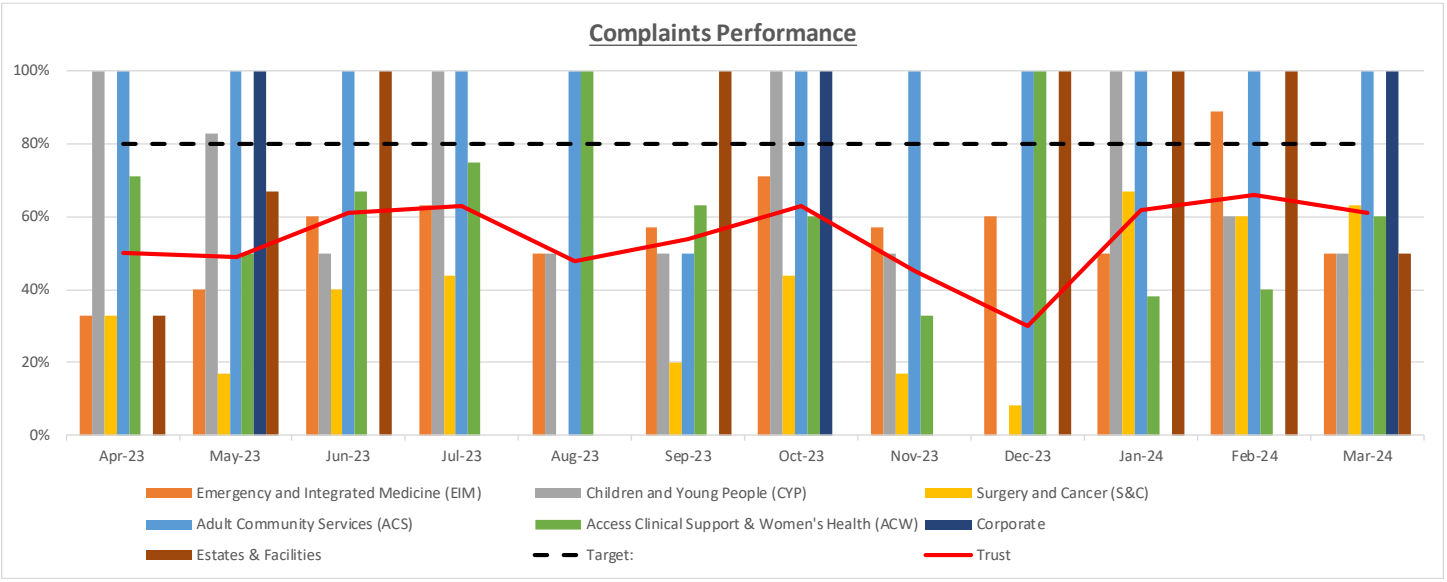
The three main themes identified from complaints during Q4 were as follows and are in line with Q3:

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

Complaint response timescales

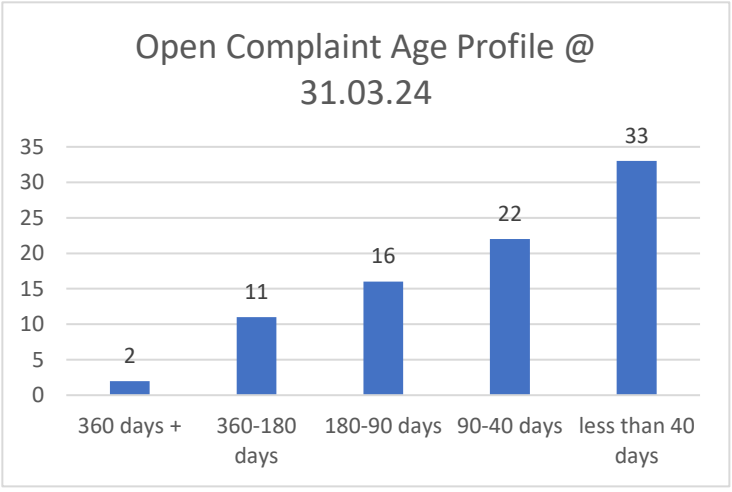
Of the complaints requiring a response in Q4 overall performance was 63% against the internal 80% target. This is an improvement on Q3 (47%) of 16%. Between Jan–Mar 2024 we saw an improvement on Q3, with the performance of 62% in January, 66% in February and 61% in March. The chart below shows the monthly performance from January 2023





Complaint backlog

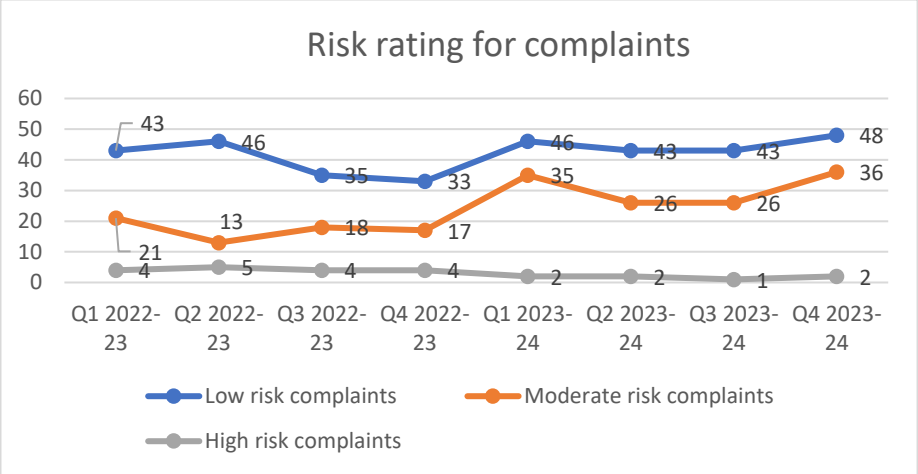
The adjacent chart gives a summary of open complaints awaiting a response and shows a number that are 180 – 360 days old. The PALS & Complaints team are working closely with colleagues in the ICSU to manage the backlog, currently concentrating on the oldest complaints, in line with the external complaints audit. Of the 2 complaints where the age profile is 360 days (S&C) one is awaiting advice



from NHS Resolution regarding possible compensation, and the second has been closed and a complaint response sent.

Risk-rating

The graph below shows the risk rating split for complaints in Q4. 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

12 complaints were returned as 'dissatisfied' where complainants asked for further comment or clarification during Q4, an increase from 6 in Q3.

Learning from Complaints

All complaints that are upheld require actions taken to be outlined 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 an inpatient with learning difficulties experienced problems and delays with their discharge medications, because the particular brand the patient was used to was not available through the hospital pharmacy.

Actions:

- As a result of the complaint, the issue was discussed in the Pharmacy department weekly meeting and the policy around discharge medications is to be reviewed along with the pharmacy standards around discharge medications. Pharmacy staff have also been reminded of the need to undertake the mandatory Oliver McGowan training. The specialist community learning disability pharmacist to visit the pharmacy department about supporting patients with learning disabilities and autism.

- The PALS & Complaints team have reviewed and updated the training materials and delivered two face-to-face training sessions in Q4, where 25 members of staff attended. Further training has been scheduled for April and May 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 through 'Teams' meetings as and when required.
- PALs and complaints sessions during the new starter corporate welcome.

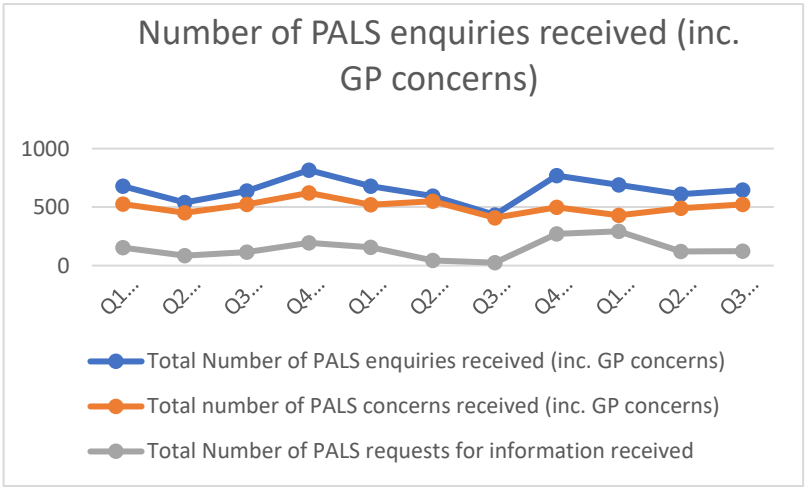
Parliamentary & Health Service Ombudsman (PHSO)

The Trust received two requests for information during Q4. We are awaiting further updates from the Ombudsman service as to whether these will proceed to a full Ombudsman investigation.

2.4 Patient Advice and Liaison Service (PALS)

During Q4 the Trust received 652 PALS contacts (including 27 concerns from GP Practices) these cover a range of themes mainly appointment waiting times, missing tests results, missing clinic, or discharge summaries (ED). Of the contacts received, 469 (72%) related to concerns and 183 (28%) related to requests for help/information.

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:

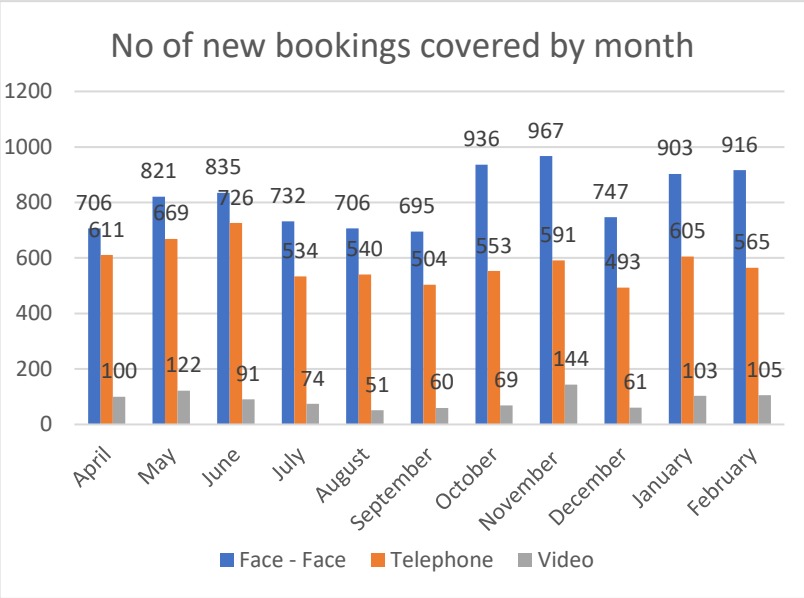
- Complaints training continues for staff on how to investigate complaints and the addition to the policy to ensure that all complainants receive a telephone call before the investigation commences as an opportunity to de-escalate and clarify concerns, and expectations.
- PALS enquiries related to not being able to get through to a clinic or appointments is now being tracked through Datix, to understand the number of PALs encounters that fall outside of the PALs remit to understand poor performance against which departments.

2.5 Voluntary Service

- During Q4 we recruited 7 new volunteers.
- 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.
- 22 prospective volunteers attend our induction in Q4, the induction is the final element of their recruitment and on-boarding, these volunteers be placed across the Trust during Q1.
- As of 1st April 2024, all NHS trusts will be required to submit their volunteer numbers and hours, and as of next year this will include demographic data.

2.6 Interpreting

The number of interpreting referrals received inhouse as prebooked Telephone Interpreting (TI), Face to Face (F2F) and Video Interpreting (VI) during January was 1,977 and during February was 1,973, a total of 3,950 and increase on (Nov/Dec 2023 (3,670). 10.1% of bookings received during January and February were received with less than 72 hrs notice - 398 (compared to 13.08% of bookings received the previous two months – 506).



3.Good news story

Ali Uygungul our inhouse Turkish Interpreter received an Extra Mile Award. Ali who has worked in the organisation for over 20 years and is well known and liked amongst staff and patients alike.

Welcome to the ward – boards have been installed on our adult inpatient wards. Work will now take place to instal boards in our outpatient areas.

Meeting title	**Quality Assurance Committee**	**Date: 8th May 2024**
Report title	**Quarterly Learning from Deaths (LfD) Report** Q3, 1st October to 31st December 2023	**Agenda item: 4.9**
Executive director lead	Dr Clarissa Murdoch, Interim Medical Director	
Report authors	Dr Sarah Gillis, Associate Medical Director LfD Ruby Carr, Project Lead for Learning from Deaths	
Executive summary	During Quarter 3, 1st October to 31st December 2023, there were 118 adult inpatient deaths (excluding deaths in ED) reported at Whittington Health (WH) versus 123 in Q2 2023/24. 21 adult structured judgement reviews (SJRs) were requested for Quarter 3 and 17 of these have been completed and presented at department mortality meetings. The Summary Hospital-level Mortality Indicator (SHMI) for the data period at Whittington Health is 0.99. Please note that while this is in the expected range, this is an increase on previous SHMIs for the Trust.	
Purpose:	The paper summarises the key learning points and actions identified in the mortality reviews completed for Q3, 1st October to 31st December 2023.	
Recommendation(s)	Members are invited to: • Recognise the assurances highlighted for the robust process implemented to strengthen governance and improved care around inpatient deaths and performance in reviewing inpatient deaths which make a significant positive contribution to patient safety culture at the Trust. • Be aware of the areas where further action is being taken to improve compliance data and the sharing of learning.	
Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register	
Report history	Has been presented at Mortality Review Group, & QGC 25/04/2024	
Appendices	Appendix 1: NHS England Trust Mortality Dashboard Appendix 2 : Newsletter	

Quarterly Learning from Deaths Report
Q3 2023/24

1. Introduction

1.1 This report summarises the key learning identified in the mortality reviews completed for Quarter 3 of 2023/24. This report describes:

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

2. Background

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

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

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

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

- Deaths where families, carers or staff have raised concerns about the quality-of-care provision.
- All inpatient deaths of patients with learning disabilities (LD) and autism.
- All inpatient deaths of patients with a severe mental illness (SMI) diagnosis. SMI is defined as schizophrenia, schizoaffective disorders, bipolar affective disorder, severe depression with psychosis. In addition to where these diagnoses are recorded in a patient's records, the use of Clozapine, Lithium and depot antipsychotic medication are indicative of these diagnoses. Please note that there is likely to be an increase in the numbers of these patients with the opening of Highgate East and increased admissions of patients with SMI
- All neonatal, children and maternal deaths.
- Deaths recommended by the Medical Examiner service as needing further review.
- All deaths in a service where concerns have been raised either through audit, incident reporting processes or other mortality indicators.
- All deaths in areas where deaths would not be expected, for example deaths during elective surgical procedures.
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had treatment relating to blood transfusion.
- All inpatient paediatric, neonatal, and maternal deaths.

3. Mortality Review Quarter 3, 2023/24

3.1 During Quarter 3, 2023/24 there were 118 adult inpatient deaths reported at Whittington Health versus 123 in Q2 of 2023/24.

3.2 During Quarter 3, 2023/24 there were 2 neonatal deaths reported at Whittington Health.

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

Table 1: *Death by Department/Team*

Department/Team	**Number of deaths**
Acute Admissions Unit (Mary Seacole North and South)	22
Cavell	13
Cloudesley	10
Meyrick	15
ITU	18
Nightingale (respiratory)	14
Coronary Care Unit (Montuschi)	2
Thorogood	5
Victoria	5
Coyle	6
Mercers	6
Eddington	2
Cearns	0
Theatres Recovery	0
Child/neonatal	2
Maternal	0
Total:	**Adults = 118 Paediatric/Neonatal = 2**

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

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

	Number of reviews required	**Completed Reviews**	**Outstanding reviews**
Adult Mortality Reviews	97	32	65
Paediatric Mortality Reviews	2	2	0
SJR	21	17	4

Feedback from mortality leads is that the ongoing Industrial Action has contributed to delays in completing these reviews. We also had a larger number of SJRs required as there were a large number of people who died who had a serious mental illness (SMI).

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

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

Department	**Number of SJRs**	**Number outstanding**
Acute Admissions Unit (Mary Seacole North and South)	2	0
Cavell	1	0
Cloudesley	1	0
Meyrick	3	1
ITU	4	0
Nightingale	3	0
Coronary Care Unit (Montuschi)	-	-
Victoria	-	-

Coyle	2	0
Mercers	1	0
ED	3	2
Thorogood	1	1
Total:	**21**	**4**

Table 3: *Reasons for deaths being assigned as requiring an SJR during Quarter 1, 2023/24*

Criteria for SJR	**Number of SJRs identified**	**Completed SJRs**	**Comments**
Staff/clinician raised concerns about care	5	5	
Family raised concerns about quality of care	-	-	One SJR was requested due to family concern which was also a coroner's referral. It is reflected in the coroners total below
Death of a patient with Serious mental illness	10	8	
Death in surgical patients	1	1	
Paediatric/maternal/neonatal/intra-uterine deaths	2	2	These deaths are subject to PMRT rather than an SJR
Deaths referred to Coroner's office without proposed cause of death	2	2	
Deaths related to specific patient safety or QI work	-	-	
Death of a patient with a Learning disability	1	1	
Medical Examiner concern	2	0	
Serious Incident investigations	-	-	
Unexpected Death	-	-	
Concerns raised through audit, incident reporting or other mortality indicators	-	-	
Definite COVID-19 Health Care Acquired Infection (HCAI)	-	-	
Total including Neonatal Deaths	**23**	**19**	

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

3.7 The aim of this review process is to:

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

- Identify potentially avoidable deaths and ensure these are fully investigated through the Serious Incident (SI) process and are clearly and transparently recorded and reported.

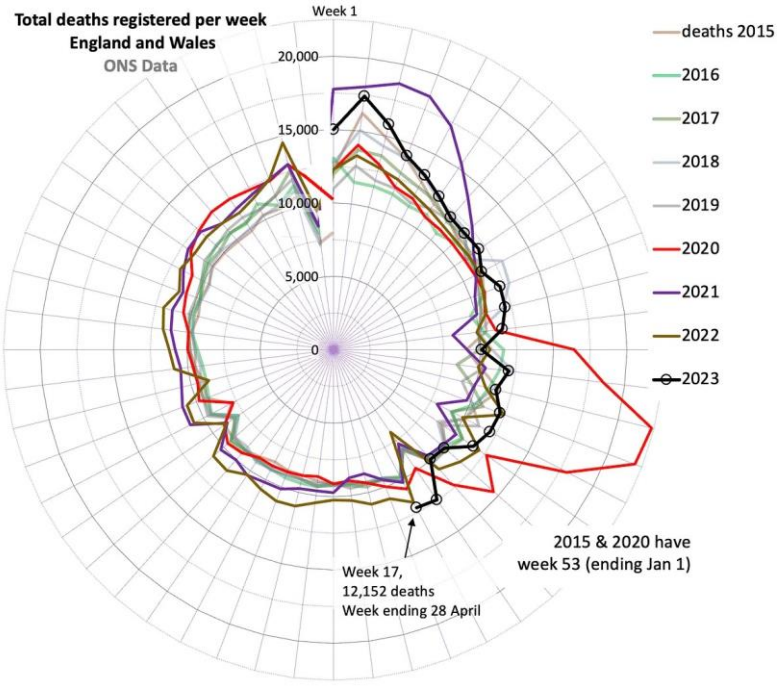
4. Mortality Dashboard

4.1 There were 118 inpatient adult deaths recorded in Quarter 3, 2023/24 at Whittington Health.

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

4.3 In the week ending 16 June 2023 (Week 24), 10,700 deaths were registered in England and Wales; 156 of these deaths mentioned novel coronavirus (COVID-19), accounting for 1.5% of all deaths. This was a decrease in all deaths compared with the week ending 9 June 2023 (Week 23), when the number of all-cause deaths registered was 10,940; COVID-19 accounted for 211 of these deaths (1.9%). Of the 156 deaths involving COVID-19 in Week 24, 68.6% (107 deaths) had this recorded as the underlying cause of death, which was a higher proportion when compared with Week 23 (64.5%).

Graph 1:Total Deaths Registered per week in England and Wales

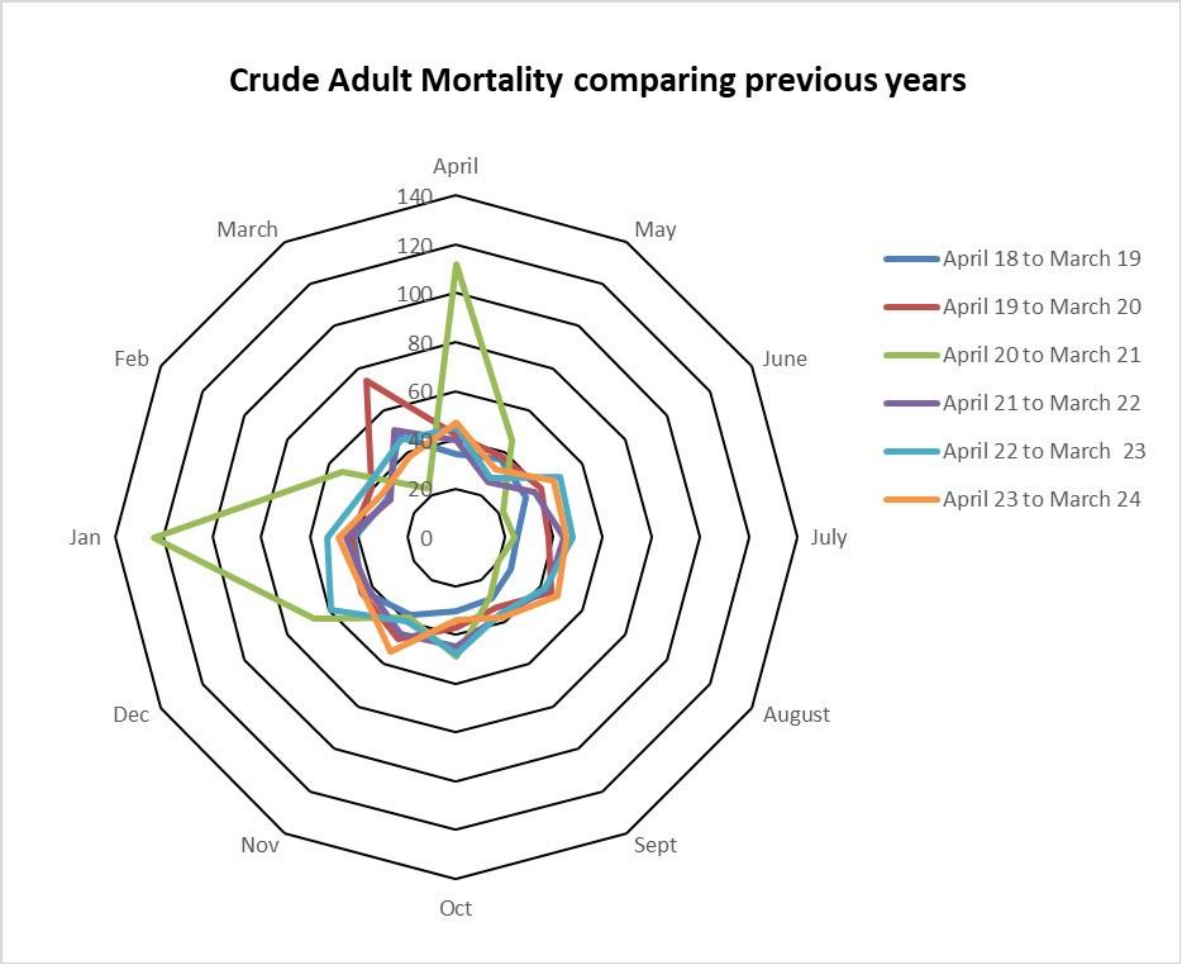


4.7 The radial graph below compares all causes of deaths (including ED deaths) in the Whittington hospital in 2018-19, 2019-20, 2020-21, 2021-22 with the year considered in this report 2022-23.

4.8 The number of inpatient and ED deaths in Q3 2023/24 was 132.

4.9 There was 1 learning disability death during Quarter 3.

Graph 2: Crude Adult Mortality at Whittington Health comparing previous years (April-December 2022)



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

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

Month	April 18 to March 19	April 19 to March 20	April 20 to March 21	April 21 to March 22	April 22 to March 2023	April 23 to March 2024
April	34	42	112	40	45	47
May	37	38	46	26	28	32
June	33	40	22	37	49	46
July	25	38	24	44	48	45
August	26	45	20	43	42	48
Sept	29	33	28	37	36	37
Oct	30	37	49	45	48	34
Nov	37	48	38	46	40	54
Dec	44	45	67	42	59	44
Jan	42	43	124	45	53	
Feb	32	40	54	31	42	

March	48	74	23	51	46	

5. Summary Hospital-level Mortality Indicator (SHMI)

5.1 The Summary Hospital-level Mortality Indicator (SHMI) for the data period July 2022 to September 2023 at Whittington Health is 0.99 which is as expected. Historically the SHMI was low at the Whittington (below expected range). We are continuing to review all SJRs to look at reasons for this. The clinical coding team are also completing an audit to review the adequacy and depth of coding. Telstra Health are also regularly reviewing our data and presenting at Mortality Review Group.

6. Themes and learning from mortality reviews Quarter 3 of 2023/2024

Examples of good end of life care:

6.1 Reports cited multidisciplinary and multispecialty discussions regarding treatment decisions, TEPs and DNACPRs in patients with end stage MS and a patient with end stage sarcoidosis.

6.2 In multiple reviews there was felt to be good communication with families of patients.

6.3 There was noted be excellent end of life care in a number of patients with a SMI, including referrals to MHLT and palliative care.

6.4 In one patient who was declining some treatments, where there was clear communication and checking the patient was competent to make these decisions.

6.5 In a patient with severe respiratory disease there was good recognition that they were dying, and that ongoing aggressive intervention was not appropriate. Palliative medications and care were offered in a timely manner.

6.6 In a patient where there was preoperative recognition of high mortality risk, this was communicated to the family preoperatively. The patient had good supportive perioperative care delivered on the surgical ward.

6.7 Evidence of excellent care in patients with LD, reviewers commented that hospital passports had been reviewed, Learning Disability specialist nurse referrals were made promptly, unrestricted access to carers/ support workers and family visiting and referral to palliative care.

Learning around communication:

6.8 A long stay surgical patient with multiple medical comorbidities was not flagged to the liaison care of the elderly team. It is unclear from documentation whether surgical wound was regularly reviewed. It was later found to be open and infected. There was lack of clarity about assigned responsible consultant.

6.9 A DNACPR was put in after a cardiac arrest call was put in, where they may have been opportunities to discuss this prior. Subsequently there was excellent involvement of palliative care.

6.10 No palliative medications were prescribed in one patient despite recognition that the patient was at EOL.

6.11 Important to document safety netting for patients being discharged from hospital.

6.12 Surgical patient who had previously been WBCOC and DNACPR, who was recognised to be unstable post operatively. A DNACPR was not reinstated post operatively, subsequently a cardiac arrest call was put out.

6.13 There was an initial delay in recognition of a young patient with malignancy. Initially the patient was not admitted and returned to ED. When he returned, he was given some symptomatic relief, but when referred to palliative care was in significant distress. His illness was rapidly progressive, plus communication was difficult as he was unable to speak English.

Excellent care was highlighted in a number of reports:

6.14 Good management of acute medical problems of the patient, including the challenge of assessing and managing fluid status in multi morbid patients with both heart failure in sepsis.

6.15 Comments on excellent care for patients being actively resuscitated adhering closely to guidelines, including reports of excellent MDT communication about ceasing ongoing CPR.

6.16 Evidence of appropriate referrals to SNOD (Specialist Nurse for Organ Donation) and timely identification of Brain Stem Death.

6.17 A patient with status epilepticus which was refractory to medications, and with no clear reversible cause. However, there was good management of their infection and underlying morbidities.

6.18 Timely transferred to ITU with no delays, where good quality neuroprotective management was delivered.

Other reports cited concerns:

6.19 Unexpected death after ambulatory care episode where treatable condition was promptly diagnosed and treated effectively. However, no indication that this was preventable death.

6.16 Care which could have been improved in a patient with AKI secondary to sepsis and gentamicin, CVVH was not started, although planned.

6.17 A patient with profound septic shock, where despite documented recognition and a plan to refer to critical care, the patient was not referred to critical care. The patient became known to critical care via an AKI alert from the laboratory. The prognosis was however very poor from the outset.

6.18 A patient with necrotising fasciitis developed new chest sepsis. There is a potential that a delay in discharge or readmission from critical care could have decreased the risk of death. However, the patient was reviewed a few hours prior to death by ITU cons and felt not to require readmission, but then unfortunately had an unwitnessed cardiac arrest on the ward.

6.19 Challenging to obtain syringe driver from medical physics when patient in emergency department.

7. Dissemination of Learning

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

7.2 Lessons from mortality reviews are included in the Trust-wide newsletter Safety Matters and specific cases have been the subject of patient safety forum presentations. A new brief newsletter is being trialled.

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

Appendix 1

NHS Whittington Health: Learning from Deaths Dashboard - December 2023-24 — Department of Health

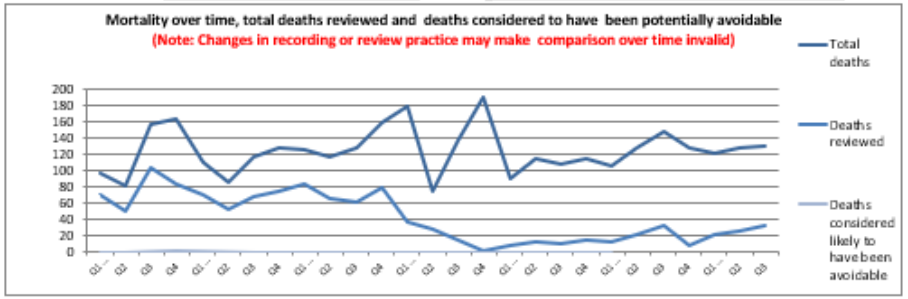
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
43	54	5	18	0	0
This Quarter (QTI	Last Quarter	his Quarter (QTI	Last Quarter	This Quarter (QTD	Last Quarter
129	128	32	26	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
378	504	78	71	0	1

Time Series: Start dat 2017-18 Q1 End date 2023-24 Q3



Total Deaths Reviewed by RCP Methodology Score

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

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	his Quarter (QTI	Last Quarter	This Quarter (QTD	Last Quarter
1	3	1	3	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	2	6	0	0	0

Appendix 5: Committee terms of reference

Quality Assurance Committee terms of reference	
1.	**Authority**
1.1	The Board of Directors hereby resolves to establish a Committee known as the Quality Assurance Committee (the Committee). The Committee has no executive powers other than those delegated in these terms of reference below, subject to any amendment at future Board of Directors' meetings.
1.2	The Committee is authorised by the Trust Board to act within its terms of reference and provide scrutiny in terms of quality and safety for all services provided by the Trust. The committee is authorised to obtain such internal information as is necessary to exercise its functions and discharge its duties. It is authorised to conduct deeper reviews of services with supporting evidence from all parts of the integrated care organisation and to escalate findings as necessary to the Trust Board.
1.3	The Committee is also authorised by the Board to obtain external legal or other professional advice, if it considers this necessary, via the Trust's Company Secretary.
2.	**Role**
2.1	The role of the Quality Assurance Committee is to provide assurance to the Board of Directors that high standards of care are provided by the Trust and, in particular, that adequate and appropriate quality governance structures, processes and controls are in place throughout the Trust to deliver: i. The continuous and measurable improvement in the quality of services through the following key areas: • Patient safety and clinical risk; • Clinical audit and effectiveness; • Patient experience; • Health and safety; and • Quality improvement. ii. the establishment and maintenance of effective risk management and quality governance systems within the organisation so that the Trust Board can be assured that the Trust: • has adequate systems and processes in place to ensure and continuously improve patient and staff safety (particularly the implementation of the new Patient Safety Incident Response Framework), quality, clinical effectiveness, and risk management; • has effective structures in place to measure and continuously strive to improve the effectiveness of care;

2.2	• responds to patients' feedback about their experiences and take appropriate action; • promotes a culture of openness and transparency across the Trust which values innovation and improvement. • has mechanisms in place to share learning and good practice in order to share learning and to raise standards • effectively implements and delivers its quality improvement and patient experience strategies
2.3	The Board Assurance Framework and risk register will be standing agenda items at each meeting. The Committee will utilise the role of non-executive director champions to provide additional assurance to the Board on specific issues related to quality of care and safety of patients and staff.
3.	**Membership**
3.1	The Quality Committee will be appointed by the Board of Director and its membership shall be made up of the following postholders: • Non-Executive Director (Chair) • Non-Executive Director (Deputy Committee Chair) • Non-Executive Director • Medical Director • Chief Nurse and Director of Allied Health Professionals (lead executive director for the Committee) • Chief Operating Officer • Joint Directors of Inclusion
3.2	The Committee will be able to co-opt patient representatives as members.
4.	**Quorum and attendance**
4.1	The quorum necessary for the transaction of business shall be four members, of which two Non-Executive Directors (NEDs) and either the Medical Director or Chief Nurse must be present. All NEDs can act as substitutes on all Board Committees.
4.2	A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee. In the event that an executive director member of the committee is unable to attend a meeting, they are required to send a deputy director from their directorate in their stead Deputies will not count towards a quorum.
4.3	The Committee Secretary will keep a register of attendance.
4.4	The following members of staff will be in attendance (or send a

	representative) at committee meetings: • Deputy Chief Nurse • Associate Medical Director • Associate Director of Quality Governance • Integrated Clinical Service Units (ICSUs) Clinical Directors/Associate Directors of Nursing • Heads of Safeguarding • Head of Patient Experience • Quality and Compliance Manager • Director (and/or Deputy Director) of Estates & Facilities • Lay members • Assistant Director, of Quality, NCL Integrated Care Board (observer)
4.5	The Committee is empowered to request any other office employed by the Trust to attend meetings for the purpose of providing advice, clarification, recommendation or explanation in respect of any matter that falls within the responsibilities of the Committee.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.
5.2	Committee meetings will be held every two months, with a minimum of six per year. Additional meetings may be arranged to discuss specific issues, but any such meetings should be infrequent and exceptional.
6.	**Administration**
6.1	The Secretary of the Committee will be the Executive Assistant to the Chief Nurse & Executive Director of Allied Health Professionals.
6.2	The Quality and Compliance Manager will ensure the effective and efficient management of the Committee under the leadership of the Committee Chair and Chief Nurse.
6.3	Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Quality and Compliance Manager and approved by the Committee Chair prior to circulation.
6.4	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, one full week before the meeting. Supporting papers will also be sent out at this time.
7.	**Duties**
7.1	The Committee will carry out the following duties for the Trust Board: i. to ensure that all statutory elements of clinical (or quality) governance are adhered to within the Trust;

	ii.	monitor, review and implement quality assurance and risk management strategies and action plans, including quality assessments for all cost improvement plans;
	iii.	fulfil the following obligations for risk management: • review the Corporate Risk Register entries (defined as risks of >15, as per the Risk Management Strategy Framework) • seek assurance that risks to staff and patients are minimised through the application of a comprehensive risk management system • contribute to the annual review of the Trust's Risk Management Framework
	iv.	receive and review reports from each ICSU twice per year, with a focus on areas within the ICSU quality report which are below target, as well as areas of excellence;
	v.	review, recommend to the Trust Board for approval and monitor implementation of the Trust's Clinical Quality Strategy;
	vi.	review and recommend to the Trust Board, the organisation's annual Quality Account for publication;
	vii.	monitoring organisational compliance against the Care Quality Commission's Essential Standards of Quality and Safety, and providing assurance to the Trust Board that effective systems are in place to monitor compliance (i.e. internal peer review programme);
	viii.	seek assurance on the following areas: • Improvement in closing the health inequalities gap across the local health population. • patient safety issues through regular reporting, including, learning from serious incidents, infection control, and clinical incidents • that there are robust arrangements in place for the management of safeguarding adults and children and a system in place for managing patients who are Deprived of their Liberties at Whittington Health. • clinical audit and effectiveness through regular reporting, including national audits, NICE guidelines, and recommendations from relevant external reports • patient experience through regular reporting, including the friends and family test, survey outcomes, complaints, Patient Advice & Liaison Services, and equality and diversity • that appropriate action is taken in response to adverse clinical incidents, complaints and litigation • the research programme and associated governance frameworks is implemented and appropriately monitored • health and safety through regular reporting, including fire safety, health and safety assessments, medical equipment and estates • delivery of the trust's quality improvement and patient

	experience strategies • completed quality impact assessments • the outcome of PLACE inspections and actions taken to address areas for improvement. ix. maintain oversight of all relevant national and external reports; x. undertake regular quality and safety walkrounds across hospital and community sites to look at safety, culture and staff engagement providing feedback to the Board, when necessary; and xi. approve the terms of reference and membership of its key reporting forum, the Quality Governance Committee.
8.	**Reporting**
8.1	Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.
8.2	The draft minutes of Committee meetings shall be formally recorded and presented at the next meeting for approval.
8.3	A Committee Chair's assurance report produced by the Trust Company Secretary in partnership with the Committee Chair and lead executive director will be presented to the subsequent Board meeting, this enabling the Board to oversee and monitor the functioning and effectiveness of the Committee.
8.4	The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.
8.5	The Committee will receive annual reports in relation to (but not limited to) infection prevention and control, safeguarding adults and children, complaints and compliments, research and development.
8.6	The Committee will receive and review submissions to national bodies and make recommendations for sign-off by the Trust Board
8.7	The following groups will report regularly to the Quality Assurance Committee: • Quality Governance Committee • ICSU Boards
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee Chair's assurance reports and any such verbal reports the Committee Chair may wish to provide. In addition, the Committee will produce an annual report

	of delivery of its annual work plan and terms of reference.
9.3	These terms of reference were approved by the Board of Directors in May 2024 and will be reviewed, at least annually.

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2024**
Report title	**Safeguarding Adults and Children Annual Declaration 2023/2024**	**Agenda item: 7**
Executive lead	Sarah Wilding Chief Nurse & Director of Allied Health Professionals	
Report authors	Linda Salt, Interim Head of Children's Safeguarding, and Therese Renwick, Head of Vulnerable Adults	
Executive summary	• Whittington Health NHS Trust (WH) is committed to achieving and maintaining compliance with national regulation, standards, and guidance to ensure that children, young people, and vulnerable adults are cared for in a safe, secure, and caring environment • The Chief Nurse and Director of Allied Health Professionals holds the position as Executive Lead for safeguarding children and adults. The Head of Safeguarding Children and Head of Vulnerable Adults report directly to the Chief Nurse • A Bi-Annual Safeguarding Report is produced which is reviewed by the Safeguarding Committee, Quality Governance Committee and Quality Assurance Committee. • Whittington Health is an active member of two local Safeguarding Children's Partnerships in Haringey and Islington. The Section 11 (Children Act 2004) audits into safeguarding compliance across the Trust are completed, as required. • The Trust is a member of the local Safeguarding Adults' Boards in Haringey and Islington. The safeguarding adult partnership audit tool is completed for both Boroughs. • The WH Joint Safeguarding Committee meets quarterly to discuss all matters pertaining to safeguarding, domestic abuse, use of Mental Capacity Act, Deprivation of Liberty Safeguards, the Prevent strategy and monitors Local Safeguarding Practice Reviews/Rapid review/Safeguarding Adult Review and Domestic Homicide Review recommendations. A new post, Head of Vulnerable Adults, has been created to reflect the increasing awareness of the safeguarding adult agenda, and will initially be focussing on creating mental health and domestic abuse pathways within the	

	Trust. • WH operates a Safer Recruitment Policy to ensure the workforce is appropriately safe to discharge its safeguarding responsibility. • A revised Safeguarding Allegations Policy was launched in October 2023, to ensure a robust process is in place for allegations made by patients, families and/or carers and other professionals, against Trust staff.
Purpose:	Approve the annual statement of assurance
Recommendation(s)	The Board of Directors is asked to: i. read and understand the Trust's responsibility for safeguarding children, young people and vulnerable adults ii. be assured that the Trust continues to follow statutory requirements (Children's Act 2004, Local Safeguarding Children Boards procedures and Pan London Safeguarding Children Procedures) to protect children at risk of abuse and neglect iii. be assured that the Trust follows its statutory requirements in relation to the Care Act 2014 and Mental Capacity Act 2005 working in partnership with local and our neighbouring social care services
Risk Register or Board Assurance Framework	Board Assurance Framework risk **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	Annual declaration
Appendices	None

Annual Safeguarding Declaration 2023-2024

1. SUMMARY DECLARATION

1.1. Whittington Health NHS Trust (WH) is committed to achieving and maintaining compliance with national safeguarding standards and guidance to ensure that children, young people, and adults are cared for in a safe, secure, and caring environment.

1.2. The WH Safeguarding Children team works closely with the Safeguarding Adults lead to ensure a collaborative 'Think Family' approach exists to safeguard the entire population the Trust serves. This includes fully embedding strategies linked to protection from domestic abuse, child sexual exploitation and adhering to the Prevent strategy in protecting vulnerable groups from radicalisation. This approach also includes a focus on transition from child to adulthood which is often a period of increased vulnerability for young people.

1.3 Safeguarding and promoting the welfare of children and vulnerable adults is of paramount importance to the organisation. Their welfare is embedded across every part of the Trust and in every aspect of our work. The Trust has controls and arrangements in place through audit, review and quality improvement led by skilled and competent named professionals, supported and challenged by the Trust Board and the NCL ICB.

1.4 The Board Director responsible for safeguarding is the Chief Nurse and Director of Allied Health Professionals. Joint Safeguarding Committee meetings are held quarterly with accountability to the Trust Board through to the Quality Assurance Committee. The committee reviews the Trust's responsibility across children and vulnerable adults.

2. SYSTEMS AND PROCESSES

2.1. Disclosure and Barring Service (DBS) checks are carried out on all staff commencing employment. Staff working with children and/or vulnerable adults require an enhanced level of check.

2.2. A Designated Officer (currently the Head of Safeguarding Children post holder) is employed to investigate and advise regarding safety within the workforce.

2.3. The Designated Officer works closely with Local Authority Designated Officers (LADO) in Local Authorities Children's Social Care to escalate concerns regarding staff behaviour in respect of potential risks posed by their behaviour in relation to their employment.

3. POLICIES

3.1. The Trust has child protection and safeguarding adult's policies and systems which are reviewed regularly. These are overseen by the WH Quality Assurance Committee and Joint Safeguarding Committee, both of which report into the Trust Board.

3.2. The Trust has a specific process in place for following up children and young people who miss appointments and systems for identifying children where there are safeguarding concerns. A policy called 'Was Not Brought' Policy supports staff in this area.

3.3. Safeguarding training is a priority for all staff, with various levels of training depending on their role. Training is provided in accordance with the Safeguarding Children Intercollegiate Document (2019) and the Adult Safeguarding: Roles and Competencies for Health Care Staff (2018). They are designed to ensure staff possess the correct knowledge, skills, and competencies to carry out their duties in relation to safeguarding children and adults.

4. ASSURANCE

4.1. The Chief Nurse holds the position as Executive Lead for safeguarding children and adults and the Heads of Safeguarding report to the Chief Nurse.

4.2. A Safeguarding Annual Report is produced which is reviewed by the Trust Board. This report covers both children and vulnerable adults.

4.3. Whittington Health is an active member of two local safeguarding children's partnerships in Haringey and Islington. The Section 11 audits into safeguarding compliance across the Trust are completed as required.

4.4. The Trust is a member of the local safeguarding adult's partnerships in Haringey and Islington and attends the annual Board challenge sessions.

4.5. The WH Joint Safeguarding Committee meets quarterly to discuss all matters pertaining to safeguarding, and the committee monitors external case review recommendations to ensure they are implemented and embedded in the WH safeguarding processes.,

5. DECLARATION

5.1. This summary provides the Trust Board with assurance that the trust is meeting its statutory requirements in relation to safeguarding children, young people, and adults in its care.

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2024**
Report title	Eliminating Mixed Gender Hospital Inpatient Accommodation Statement of Assurance 2024-25	**Agenda item: 8**
Executive lead	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals	
Report author	Deborah Clatworthy, Deputy Chief Nurse	
Executive summary	This paper provides an annual statement of assurance that patients who require inpatient/day case care are cared for in single gender accommodation. Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The Trust is committed to providing every patient with same gender accommodation to help safeguard their privacy and dignity when they are often at their most vulnerable. Patients who are admitted to hospital or come in for a planned day case should only share the room or ward bay where they sleep, with members of the same gender, and use same gender toilets and bathrooms which are close to their bed area. There are some exceptions to this where sharing with people of the opposite gender maybe necessary. This should only happen by exception and will be based on clinical need in areas such as critical care units, emergency care areas and some high dependency observation bays. In addition to clinical need, other reasons for exceptions would be, during a major incident, pandemic or to maintain infection prevention and control isolation. The requirement to ensure patients are appropriately isolated due to infection prevention continues. This, coupled with a small bed base, has resulted in a higher number of mixed gender breaches on the adult wards. The consistently high bed occupancy has also meant that the Critical Care Unit has not been able to transfer patients to the in-patient beds within the optimum timeframe. In these instances, every effort is made to rectify the situation as soon as is reasonably practicable and staff will take extra care to ensure that the privacy and dignity of patients and service users is maintained.	

	It is important to note that there are currently a series of changes to the NHS Constitution that are under consultation. One of which is the emphasis on biological sex and not gender. If agreed, this sets out that placing transgender patients in a single room is permissible under the Equality Act 2010 when it is appropriate, such as respecting a patient's wish to be on a single sex ward. Should these changes be included in the new NHS Constitution, the policy and statement of assurance will be updated to reflect this.
Purpose:	To review and approve this paper.
Recommendation (s)	The Board of Directors is asked to agree: i. the statement of assurance is agreed by the Trust Board and then published onto the Trust Internet and Intranet. ii. that any monthly reporting of breaches is contained within the Trust Board Performance Report as reported to Commissioners.
Risk Register or Board Assurance Framework (BAF)	Board Assurance Framework risk **Quality 1** - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients and families, due to errors, or lack of care or lack of resources, results in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation. **Quality 2 -** Due to a lack of capacity, capability, and clinical attention and continuing pressures from the pandemic, there is an inability to meet elective recovery and clinical performance targets, resulting in a deterioration in service quality and patient care such as: • long delays in the emergency department and an inability to place patients who require high dependency and intensive care • patients not receiving the care they need across hospital and community health services • patients on a diagnostic and/or treatment pathway at risk of deterioration and the need for greater intervention at a later stage.
Report history.	
Appendices	None

Eliminating Mixed Gender Hospital Inpatient Accommodation
Statement of Assurance 2024-25

1. INTRODUCTION

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

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

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

1.4 The Trust is responsible for ensuring that all patients and relatives/carers as appropriate, are aware of the guidance and are informed of any decisions that may lead to the patient being placed in, or remaining in, mixed gender accommodation.

1.5 Decisions to mix genders will be based on the patient’s clinical condition and not on constraints of the environment or convenience of staff.

1.6 There may be exceptions during a major incident, pandemic or to maintain infection prevention and control isolation.

2. WHAT DOES THIS MEAN FOR PATIENTS

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

- The ward bed bay will only have patients of the same gender.
- The toilet and bathroom will be single gender and will be close to the bed area.

- It is possible that there will be patients of different genders on the same ward, but they will not share the sleeping area. Patients may have to cross a ward corridor to reach the bathroom, but patients will not have to walk through differently gendered areas.
- Patients may share some communal space, such as day rooms or dining rooms, and it is highly likely that they will see patients of other genders as they move around the hospital (e.g., on way to X-ray or the operating theatre)
- It is probable that visitors of another gender will come into the ward or bay and may include patients visiting each other.
- It is almost certain that nurses, doctors, and other staff of all genders will care for patients.
- If personal assistance is required (e.g., hoist or adapted bath) then patients may be taken to a "unisex" bathroom used by people of all genders, but a member of staff will be with the patient, and other patients will not be in the bathroom at the same time.
- Patients who have undergone or are undergoing a process of gender transition (transgender) will be accommodated in the bay appropriate for the gender they are currently living in and there will be no requirement to show legal recognition in this gender.
- Where there is reason to believe that a transgender patient may be more comfortable being accommodated with patients of another gender or in a side room, this will be discussed with them privately and an agreement made between the patient and staff. Knowledge of a patient's history of transition will not automatically lead to this question being raised where there would otherwise be no question over where a patient should be accommodated.
- Patients who do not identify as male or as female will not necessarily be accommodated with other patients of the same gender or alone but will be accommodated with either male or female patients as based on agreement between the patient and staff.
- Where a patient is unable to contribute to the decision being made about their accommodation, the advice of family or carers will be sought where possible, and a decision made based on available indicators (name, manner of dress, etc.) where advice is not available, until such time as the patient can contribute to the decision being made.

3. STATEMENT OF ASSURANCE

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

3.2 The Board is committed to ongoing delivery of single gender accommodation.

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

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

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

3.6 Episodes of mixed gender accommodation breaches for non-clinical reasons will be reported to the NCL Integrated Care System through monthly performance reports and reviewed at the trust Quality Assurance Committee meeting.

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

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

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

3.10 There is an internal monitoring process to ensure the Trust does not misclassify any reports.

3.11 The trust will publish results within the Integrated Performance Report presented to the Trust Board

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

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

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

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

3.16 Issues of privacy/dignity and single gender accommodation are included in mandatory staff training and induction and the trust provides training to

support the elimination of mixed gender accommodation and to promote the protection of privacy and dignity.

3.17 The Trust will ensure all staff are aware of the guidance and how they manage requirements around recognising, reporting, and eliminating mixed gender breaches.

3.18 The Trust will ensure there are no exemptions from the need to provide high standards of privacy and dignity at all times.

4. RECOMMENDATIONS

4.1 The Board of Directors has agreed:

I. The statement of assurance is agreed by the Trust Board and then published onto the Trust Internet and Intranet.

II. Any monthly reporting of breaches is contained within the Trust Board Performance Report as reported to commissioners.

Meeting Title	**Trust Board – public meeting**	**Date:**	**24 May 2024**
Report Title	**Integrated Performance Report**	**Agenda Item:**	**9**
Executive lead	Jonathan Gardner, Chief Strategy, Digital and Improvement Officer		
Report Owners	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. The organisation has put considerable effort at every level to mitigate these issues where possible. **Emergency Care Flow** During April 2024, performance against the 4-hour access standard was 71.9%, which is improving and higher than the NCL average of 71.45%, but lower than the London average of 75.56% and the national average of 74.39%. There were 428 12-hour trolley breaches in April 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 74.6% in March 2024 against the standard of 75%. This is a worsening of 3.1% compared to 77.7% in February 2024. 62-day referral to treatment performance was at 65.9% for March 2024 against a target of 85%. This is an improvement of 0.3% compared to 65.6% in February 2024. At the end of March, the Trusts position against the 62-day backlog was 77 patients. **Referral to Treatment: 52+ Week Waits** Performance against 18-week standard for April 2024 was 63%, this is a worsening of 2.4% from March's performance of 65.4%. The Trust position against the 52-week performance has improved from 500 patients waiting more than 52-weeks for treatment in March 2024 to 454 in March 2024. The Trust had 9 patients over 78-weeks at the end of April 2024 against a target of 0. All providers are expected to have zero 78-week breach patients as of the 31st March 2024. **Workforce** Appraisal rates for April 2024 were at 78.5%, this is a worsening of 1.5% from March's performance of 80%. Work continues to support service areas to improve overall compliance.		

	Complaints Complaints Responded to Within 25 or 40 Working Days has improved from 60.7% in March 2024 to 71% in April 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
Board Assurance Framework	The following BAF entries are linked: Quality 1; Quality 2; People 1; and, People 2.
Report history	Trust Management Group
Appendix	1: Integrated Performance Report

Whittington Health NHS Trust

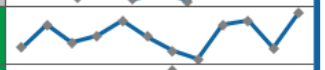
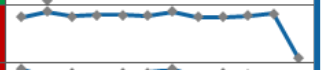
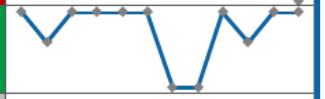
Performance Report

May 2024

Month 1 (2024-2025)

Community - Performance Dashboard

Whittington Health NHS Trust

Indicator	Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	2024-2025	Activity
IAPT Moving to Recovery	50%	50.0%	49.9%	44.5%	43.8%	46.8%	45.5%	45.2%	52.5%	48.1%	51.9%	54.9%			
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	95.9%	94.4%	90.9%	93.1%	90.7%	91.9%	90.4%	96.6%	91.9%	93.8%	93.0%			
% of MSK pts with a significant improvement in function (PSFS)	>75%	75.8%	83.3%	77.5%	79.8%	84.7%	79.5%	74.8%	72.0%	83.3%	84.7%	75.6%	87.4%	87.4%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	75.0%	61.8%	78.3%	81.8%	66.7%	81.8%	94.1%	83.3%	76.1%	88.2%	85.4%	84.2%	84.2%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	70.4%	74.3%	70.9%	71.6%	72.0%	71.2%	73.9%	70.4%	70.3%	71.3%	72.8%	43.8%	43.8%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	94.7%	89.1%	91.1%	89.7%	91.7%	91.7%	95.3%	88.9%	91.5%	90.3%	83.1%	53.6%	53.6%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	50.0%	50.0%	100.0%	80.0%	100.0%	100.0%	100.0%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 weeks	>45%		51.9%			54.1%			56.1%			54.5%			

Community Performance Dashboard

IAPT: Recovery – target 50% of patients seen for 2+ appointments have recovered on depression and anxiety. A drop in January 2024 continues due to national changes in guidance, where IAPT accept higher severity. Away day in January focused on patient feedback, data and how to improve patient experience and some improvement noted. It has been over 50% for both February and March with April their best month at 54.9% . Year to date is now improved and there are plans for the improvement to continue.

Waiting for first appointment (assessment) – this is above target.

MSK: Improvements within the delivery of MSK services continues and the overall backlog is reducing at a steady rate. Improvement in function remains consistently above standard.

ICTT: Previously this was a combination for Haringey urgent response and locality. This month it is split to show locality only (urgent response will be reported on separately in the future). This currently appears to be a data validation issue with a smaller cohort. The ops lead is preforming a deep dive into these discharges and outcomes.

ICARE EQUITY

Adult Community - Waiting Times

Whittington Health NHS Trust

Indicator (Routine Appointments)	Target	Target Weeks	Feb-24	Mar-24	Apr-24	Average Wait (Latest Month)	No. of Patients Seen
Community Matron	>95%	6	100.0%	100.0%	100.0%	0.9	26
Adult Wheelchair Service	>95%	8	98.3%	100.0%	100.0%	2.8	53
Community Rehabilitation (CRT)	>95%	12	71.1%	77.4%	65.4%	12.6	78
ICTT - Other	>95%	12	99.3%	100.0%	100.0%	2.6	157
ICTT - Stroke and Neuro	>95%	12	14.3%	40.0%	22.2%	16.0	9
Home-based Intermediate Care Service	>95%		88.9%	96.4%	89.5%	3.8	38
Paediatric Wheelchair Service	>95%	8	60.0%	100.0%	100.0%	5.3	7
Bladder and Bowel - Adult	>95%	12	41.1%	34.9%	45.1%	14.0	164
Musculoskeletal Service - CATS	>95%	6	32.0%	17.2%	30.6%	11.4	529
Musculoskeletal Service - Routine	>95%	6	28.9%	25.3%	37.3%	16.5	1494
Nutrition and Dietetics	>95%	6	96.8%	98.5%	96.2%	2.7	131
Podiatry (Foot Health)	>95%	6	42.2%	36.3%	22.2%	11.8	450
Lymphodema Care	>95%	6	53.8%	41.2%	36.4%	8.3	22
Tissue Viability	>95%	6	100.0%	100.0%	100.0%	1.4	59
Cardiology Service	>95%	6	95.9%	100.0%	95.0%	2.2	80
Diabetes Service	>95%	6	79.7%	68.3%	50.4%	6.0	135
Respiratory Service	>95%	6	57.6%	62.8%	60.7%	5.5	56
Spirometry Service	>95%	6	100.0%	100.0%	100.0%	3.7	67
Integrated MDT	>95%	6	94.1%	95.2%	94.2%	2.0	171
Self-Management	>95%	6	57.1%		32.1%	7.4	28
Covid	>95%	6	84.2%	87.5%	78.1%	5.7	32
Indicator (Urgent Appointments)							
Community Rehabilitation (CRT)	>95%	2	38.5%	71.4%	41.7%	10.4	24
ICTT - Other	>95%	2	14.3%	33.3%	0.0%	9.6	9
ICTT - Stroke and Neuro	>95%	2	66.7%	40.0%	11.1%	4.5	9
Home-based Intermediate Care Service	>95%	2	89.4%	98.0%	92.1%	1.0	114
Musculoskeletal Service - CATS	>95%	2	50.0%	60.0%	33.3%	6.3	6
Musculoskeletal Service - Routine	>95%	2	59.2%	48.0%	59.9%	2.2	137
Podiatry (Foot Health)	>95%	2	0.0%	100.0%	100.0%	1.1	1
Cardiology Service	>95%	2	100.0%	100.0%	100.0%	0.6	5
Integrated MDT	>95%	6	100.0%	100.0%	0.0%	9.1	2

Adult Community Waiting Times

Podiatry:
Number of patients seen in April reduced by 50 as a result of an increase in staff sickness. This is now resolved, and the service should see an increase in number of patients seen in the coming months to match the improving trajectory seen previously.

Islington Community Neuro-Rehabilitation (Formally CRT/ICTT):
The Community Rehab, backlog is in Speech and Language Therapy (SLT) and Occupational Therapy (OT), both professions have had long standing vacancies and long-term sickness. OT capacity is now managed by the recruitment of agency cover, with a primary focus of managing long waiters. Additional agency resource to support SLT service has been difficult to source. However, recruitment to permanent roles has been successful and will support the reduction of the waiting list.

Bladder and Bowel Service:
Bladder and Bowel remains a fragile service, however, recovery plans are underway. The service lead is on maternity leave, this will have an impact on capacity. Demand and capacity work in 2023 with Kingsgate showed best practice model would see a reduction in backlog once the service is fully staffed.

MSK Routine: The service continues to show significant downward trend that will continue, largely due to use of GetUBetter and being fully staffed. There has been a focus on data quality of the waiting list which has supported the management of the backlog for this service.

MSK CATS: There has been an improvement in overall backlog numbers and continues to be on a steady trajectory of improvement.

ICARE EQUITY

Children's Community – Waiting Times

Whittington Health NHS Trust

Indicator (Routine Appointments)	Target	Target Weeks	Feb-24	Mar-24	Apr-24	Average Wait (Latest Month)	No. of Patients Seen
CAMHS	>95%	4	50.6%	55.8%	43.5%	13.3	168
Community Children's Nursing	>95%	6	58.9%	78.8%	77.4%	3.6	62
Community Paediatrics - Haringey	>95%	18	91.9%	88.6%	47.7%	13.9	44
Community Paediatrics - Islington	>95%	18	92.3%	95.0%	85.7%	6.9	7
Haringey - SCT	>95%	20	0.0%	0.0%	0.0%	55.6	22
Islington SCT (0-5s)	>95%	20	3.8%	27.3%	22.7%	45.1	22
CLA Initial Assessments - Haringey	>95%	4	66.7%	92.9%	100.0%	1.3	7
CLA Initial Assessments - Islington	>95%	4	83.3%	100.0%	53.8%	4.3	13
Occupational Therapy - Barnet	>95%	18	100.0%	100.0%	97.0%	7.6	33
Occupational Therapy - Haringey	>95%	18	100.0%	100.0%	100.0%	8.6	19
Occupational Therapy - Islington	>95%	18	18.8%	64.3%	38.5%	21.5	13
Paediatrics Nutrition and Dietetics - Haringey	>95%	12	93.3%	100.0%	100.0%	4.5	14
Paediatrics Nutrition and Dietetics - Islington	>95%	12	100.0%	100.0%	100.0%	6.2	34
Physiotherapy - Barnet	>95%	18	97.5%	100.0%	100.0%	6.0	36
Physiotherapy - Haringey	>95%	18	98.2%	98.4%	97.2%	5.7	71
Physiotherapy - Islington	>95%	18	98.3%	97.1%	98.4%	3.3	63
PIPS	>95%	12	100.0%	100.0%	100.0%	3.2	12
SALT - Barnet	>95%	18	85.5%	50.0%	74.7%	14.3	154
SALT - Camden	>95%	6	46.8%	51.8%	51.4%	7.1	70
SALT - Haringey	>95%	13	27.5%	36.6%	63.5%	12.9	63
SALT - Islington	>95%	13	88.5%	87.0%	90.3%	4.8	31
SALT - MPC	>95%	18	100.0%	100.0%	96.2%	5.8	26
School Nursing - Haringey	>95%	12	97.0%	97.7%	89.0%	4.4	73
School Nursing - Islington	>95%	12	87.5%	90.7%	94.1%	3.3	34
Indicator (Urgent Appointments)							
CAMHS	>95%	2	100.0%	100.0%	71.4%	1.7	7
Community Children's Nursing	>95%	1	100.0%	100.0%	100.0%	0.0	4
SALT Barnet	>95%	6	100.0%	100.0%	100.0%	2.4	10
SALT Haringey	>95%	2	50.0%	50.0%			0

Indicator	Target	Current Month		Previous Month
Haringey New Birth Visits - % Seen Within 2 Weeks	>95%	Mar	91.1%	91.0%
Islington New Birth Visits - % Seen Within 2 Weeks	>95%	Mar	94.8%	97.8%

Children's Community Waits

Children Looked After:

Work is ongoing to consistently meet the 20-day target for initial health assessments in Haringey and Islington. Islington did not meet the target this month due to a gap in the administrative team, a reduction in clinic appointments due to annual leave and 5 young people requiring out of borough assessments. These challenges are being discussed and actions to strengthen provision across NCL will be considered at the NCL CYP Community Services Group in June.

Autism Assessments:

Sustained increased demand for assessments continues to have an impact on waiting times in Haringey and Islington. NCL providers have worked together to finalise a proposal for investment that supports a reduction in waiting times. This proposal will be considered for approval in June. Additional programme support is included in the proposal. This is key to ensure the approach to assessments is standardised and agreed changes are delivered. Without additional investment to reduce the back log and increase capacity it will not be possible to significantly reduce waiting times.

Therapy Services:

In Islington Occupational Therapy waiting times increased due to staffing gaps. The service continues to work with the local authority in progressing the roll out of the universal training offer to schools to help upskill schools to support children and young people with additional needs.
In Barnet the Physiotherapy and Occupational Therapy services continue to meet demand within current staffing resources linked to the 18-week target for first appointments. The SLT services does not have sufficient capacity to meet demand and there is a backlog of referrals to be seen. New referrals are directed to waiting well offer e.g. online virtual groups for parents/referrers. Additional non-recurrent funding that is expected in the next 2 months will help reduce waiting times.
The Camden SLT service is seeing approx. 50% of children within a 6-wait target. Similarly to other SLT services in NCL demand outstrips capacity. This challenge continues to be highlighted locally and across NCL.

ICARE EQUITY

Safe

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
HCAI C Difficile	<13	Apr	0	4	0		
Actual Falls	400	Apr	28	17	28		
Category 3 or 4 Pressure Ulcers	64	Apr	20	26	20		
Medication Errors Causing Serious Harm	0	Apr	0	0	0		
MRSA Bacteraemia Incidences	0	Apr	0	1	0		
Never Events	0	Apr	0	0	0		
Serious Incidents	N/A	Apr	0	0	0		
VTE Risk Assessment %	>95%	Apr	94.8%	94.8%	94.8%		
Mixed Sex Accomodation Breaches	0	Apr	14	10	14		
Summary Hospital Level Mortality Indicator (SHMI)	1.14	July 2022 - June 2023	0.94		0.93		

Category 3 or 4 Pressure Ulcers - *Target 0*

April Performance – 20 Pressure Ulcers on 11 patients

This is an improvement of 4 pressure ulcers compared to March 2024.

Category 3 = 16 (7 in hospital, 9 in the community) as per new NHSE 2023 categorisation guidance

Category 4 = 4 (in the community)

Issues: Implementation on new NHSE guidance on category 3 pressure ulcer reporting includes previously recorded unstageable pressure ulcers, therefore reported improvement is higher than documented.

Four category 4 pressure ulcers occurred on four patients in different District Nursing teams – all deterioration of previously reported pressure damage.

The seven category 3 hospital attributable pressure ulcers occurred on four patients in three clinical areas.

Shortage/delay in timely implementation of pressure relieving equipment in whole Trust due clinical pressures and a community IT critical incident.

Actions:

- Escalation and mitigatory action taken to address equipment issues.
- Incorporation of PSIRF into pressure ulcer investigations to support learning from pressure ulcer events.

MRSA Bacteraemia/C Difficile Incidents

MRSA April Performance – 0 This is an improvement of 1 compared to 1 in March 2024.

Hospital acquired MRSA Bacteraemia rates are greater in London than the rest of England. The London regional Infection Prevention and Control (IPC) network is seeking to understand the factors influencing this increase in hospital acquired MRSA Bacteraemia. The Trust had 2 cases of hospital acquired MRSA Bacteraemia reported in 2023/24. Extensive work around peripheral vascular devices known to be a common source of infection for MRSA bacteraemia is underway across the Trust.

C Difficile April Performance – 0 This is an improvement of 4 compared to 4 in March 2024.

Summit Talk Highlights: The probable rise of national colonisation of the population will have an effect of people coming into the hospital colonised. The Trust are testing more patients, and as a result there are more C Difficile infections. A 'back to basics' approach is fundamental across all disciplines, which includes visible of leadership. A Trust review of all C Difficile positive cases demonstrated antimicrobial length of treatment must be a focus for improvement post pandemic. Fidaxomicin which is a first line treatment for relapse nationally is used more frequently in other organisations, though is expensive, and NHS Trusts are looking to ICB for funding.

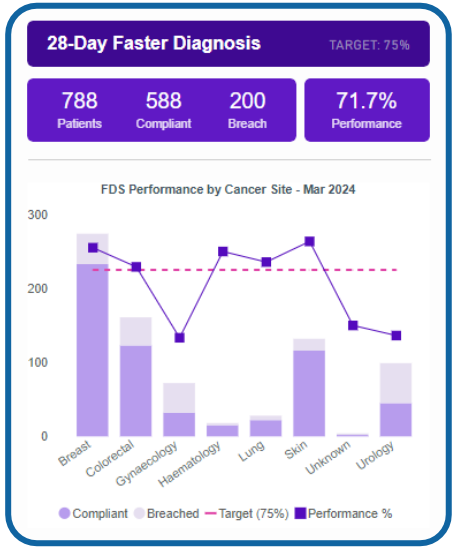
Responsive - Access

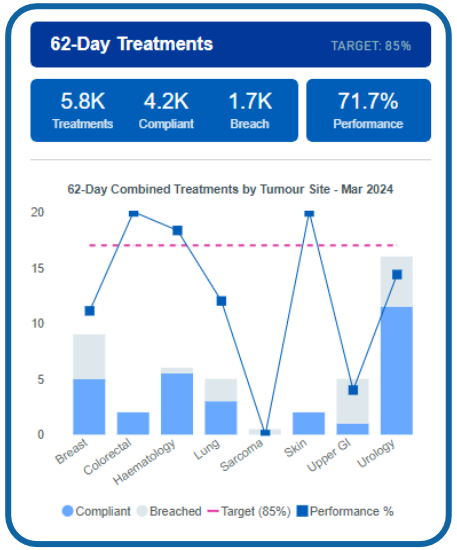
Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Cancer - 62 Days From Referral to Treatment	>85%	Mar	65.9%	65.6%			
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%	Mar	59.3%	61.4%			
Cancer ITT - % Of Pathways Sent Before 38 Days	>85%	Mar	18.2%	9.1%			
Cancer - % Pathways Received a Diagnosis Within 28 Days of Referral	>75%	Mar	74.6%	77.7%			
Cancer - 31 Days to First Treatment	>96%	Mar	88.1%	93.2%			
DM01 - Diagnostic Waits (<6 Weeks)	>99%	Apr	91.5%	94.0%	91.5%		
RTT - Incomplete % Waiting <18 Weeks	>92%	Apr	67.0%	65.4%	67.0%		
Referral to Treatment 18 Weeks - 52 Week Waits	0	Apr	452	500	452		
% Seen <=48 Hours of Referral to District Nursing Service	>95%	Apr	97.5%	89.7%	97.5%		
% Of Rapid Response Urgent Referrals Seen Within 2 Hours of Referral		Apr	66.9%	73.4%	66.9%		

What the Data Tells Us	Issues	Actions and Mitigations
Referral to Treatment Incomplete % Waiting <18 Week – *Target 92%* **April Performance – 67%** This is an improvement of 1.6% from March's performance of 65.4%.	• The Trust was 9 patients away from hitting the 78-week target of 0. This is a worsening of 6 from March's performance of 3. • 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 continues to remain consistent.	• Additional sessions to mitigate backlog increase continued throughout April 2024. • The Surgery and Cancer ICSU are in discussion with the Royal Free Hospital regarding the capacity management of the Vascular Surgery service. • 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* **April Performance – 452** This is an improvement of 48 from March's performance of 500. At the end of April there were 9 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.* **April Performance – 91.5%** This is a worsening of 2.5% from March's performance of 94%.	• Concerns still remain around the neurophysiology test service (25.31%) which relate to capacity constraints. • Cystoscopy compliance was 55.56%, this is currently being reviewed.	• 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. • NCL ICS is undertaking an additional review of Neurophysiology capacity across North Central London to help mitigate backlog issues.

Responsive - Access

What the Data Tells Us	Issues	Actions
Cancer: 28-Day Faster Diagnosis Standard (FDS) - *Target >75%* *% Pathways Received a Diagnosis within 28 Days of Referral.* **March Performance – 74.6%** This is a worsening of 3.1% compared to 77.7% in February 2024.	The trust performance declined by 3.1% missing the national standard of 75% by 0.4% Specialities contributing to not achieving the standard are: • Gynaecology performance decreased to 44.4% in March from 51.8% February • Upper GI performance at 50% for March • Urology performance improved to 45.5% in March from 33.6% in February	• Gynaecology performance was impacted by planned leave within the establishment. A business case for additional funding was approved by the Cancer Alliance however, there has been a delay in accessing the funds. The business case will address short-term issues and longer-term robustness of service. These roles include sonography/admin/CNS/consultant staffing. The business case has only been partially signed-off and the service is developing a succession plan to establish, which posts are a priority and best increase capacity towards meeting the demand. • Upper GI - There have been Endoscopic Ultrasound capacity issues at UCLH, who provide sector capacity, this has contributed to a number of patient breaches and has had a knock-on effect on the treatment (62-day) pathway. • Urology performance continues to be challenging due to capacity constraints within the workforce.
Cancer: 62-Day Performance - *Target >85%* *No. of pts receiving their first treatment for cancer within 62 days of GP referral.* **March Performance – 65.9%** This is an improvement of 0.3% compared to 65.6% in February 2024.	March's combined performance of 65.6% was driven by Breast, Haematology, Skin and the Urology tumour groups The Trust overall combined performance has continued to improve since October 2023 with a 0.3% improvement from February to March. The combined performance for March of 65.9% is in line with the trajectory plan for the Trust's 62-day combined performance for 2024/25.	All tumour groups continued to improve performance in March from February except for the Lung and Upper GI tumour groups. • Breast performance has continued to improve and has improved from 33.3% in February to 55.6% in March. Waiting list initiative weekends continued in March to reduce the wait time for the first appointment. • Endoscopic Ultrasound capacity at UCLH impacted the Upper GI performance. • The Lung pathway was impacted by PET scan capacity which has now been resolved by the 3rd PET scanner at UCLH coming online and UCLH offering protected slots for the Whittington. Additionally, there are historical delays in lung chemotherapy treatments, due to longer waits for molecular target therapy.

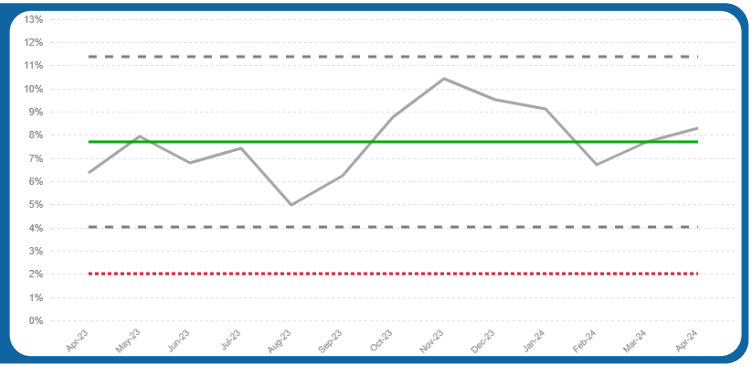




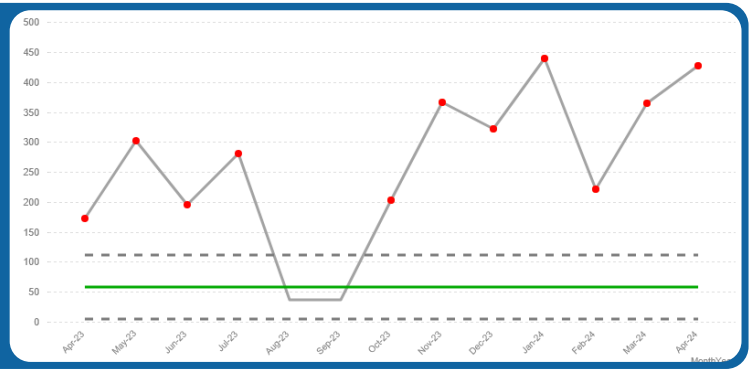
Responsive - Emergency Care

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Las Patient Handover Times - 30 Mins	0	Apr	135	95	135		
Las Patient Handover Times - 60 Mins	0	Apr	9	10	9		
% Streamed to an Onsite Service	>7.5%	Apr	4.2%	3.4%	4.2%		
Median Wait for Treatment (Minutes)	< 60 min	Apr	85 Mins	93 Mins	85 Mins		
% Of ED Attendance Seen by Clinician Within 60 Mins of Arrival		Apr	38.7%	35.6%	38.7%		
Median Time From Arrival to Decision to Admit		Apr	04:21	04:30	04:21		
12 Hour Trolley Waits in ED	0	Apr	428	364	428		
Total ED Attendances in Dept for More Than 12 Hours (Arrival to Dept)		Apr	743	560	743		
% Of ED Attendances Over 12 Hours From Arrival to Departure	<2%	Apr	8.3%	7.7%	8.3%		
ED Waits (4 Hrs Wait)	>95%	Apr	71.9%	73.1%	71.9%		
% Left ED Before Being Seen		Apr	8.4%	7.9%	8.4%		
% ED Re-Attendance Within 7 Days		Apr	10.5%	10.1%	10.5%		

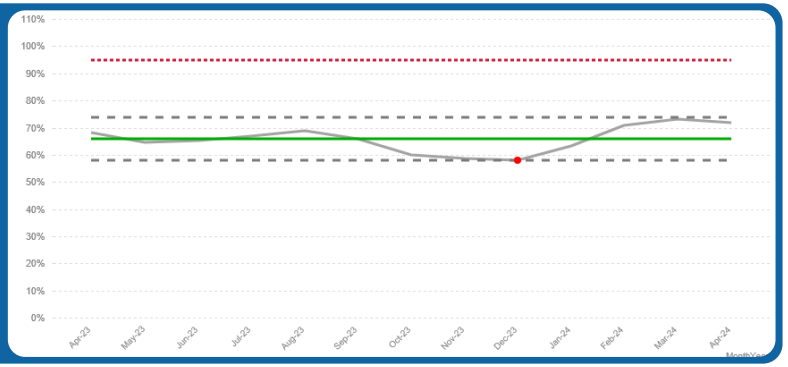
ED Attendances Over 12 Hours



12-Hour Trolley Waits in ED



ED 4-hour Waits



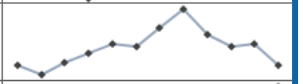
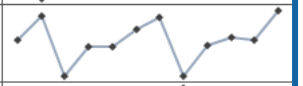
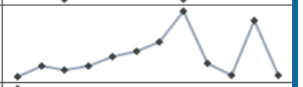
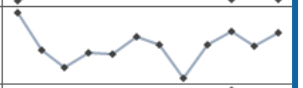
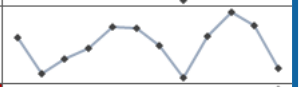
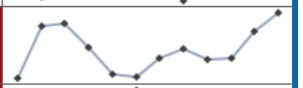
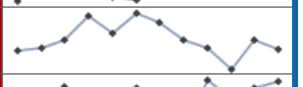
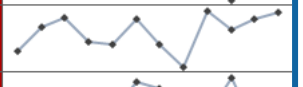
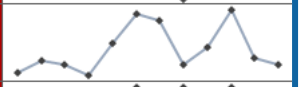
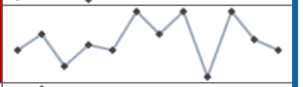
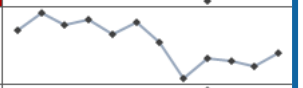
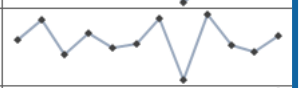
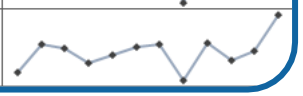
Responsive - Emergency Care

Whittington Health NHS Trust

What the Data Tells Us	Issues	Actions and Mitigations
% of ED Attendances Over 12 Hours - *Target <2%* **April Performance – 8.3%** This is a worsening of 0.6% from March's performance of 7.7% **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.* **April Performance – 428 (Average 14.3 per day)** This is a worsening of 64 from March's performance of 364 **Emergency Department Waits (4 hrs wait) - *Target >95%*** *No. of patients treated within 4 hours of arrival in ED.* **April Performance – 71.9%** This is a worsening of 1.2% from March's performance of 73.1% **LAS Handovers - *Target 0*** *Number of Ambulance Handover delays of greater than 30 minutes and 60 minutes.* **April Performance (30 mins) – 135** This is a worsening of 40 from March's performance of 95 **April Performance (60 mins) – 9** This is an improvement of 1 less from March's performance of 10 ***Median Wait for Treatment* - *Target <60*** *Time from arrival to seeing a doctor or nurse practitioner.* **April Performance – 85 minutes** This is an improvement of 8 minutes from March's performance of 93 minutes	• Continued NCL Sector pressures with North Middlesex University Hospital requesting regular LAS diverts informally and formally. • High number of out of borough conveyancing. • Discharge bottlenecks into the community which impact on wider hospital flow. **Whittington position and impact** • Attendances decreased in comparison to March however remain higher than previous months. • Increased acuity therefore resulting in longer length of stay on the wards. • Increased LOS In ED due to admitted flow, increased bedding in SDEC throughout April. • Increase out of borough conveyances impacting on ability to discharge from hospital.	**UEC improvement plan developed which focusses on Inflow, ED assessment and Outflow** ED improvement working group established. Focus on: • Improving streaming pathways to Urgent Treatment Centre (UTC) and Primary Care and working with GP liaison to engage with Primary Care partners. • Increased collaboration and streaming to Ambulatory Emergency Care (AEC) to improve pathways. • Paediatric focus on consistently achieving greater than 95% 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. • Working up a plan to get a CDU up and running to support non admitted flow/performance. Specialty review, discharge, flow and admission: • Focus on UTC and Paedatrics performance to consistently deliver >92%. • Working to get a CDU up and running to support non admitted flow. • Review of ED SDEC pilot underway • Embedding senior decision maker presence in UTC. • Improve specialty response times and escalations. • Flow manager of the day rota implemented. • 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. • LLOS meetings revamped with a focus on reducing criteria not met to 40. • Explore locations for a discharge lounge.

ICARE EQUITY

Activity

Indicator	Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Activity
ED Attendances		8823	9098	8609	8042	8426	8772	8592	8911	8704	8364	9562	8958	
ED Admission Rate %		9.6%	9.3%	9.7%	10.0%	10.3%	10.2%	10.8%	11.4%	10.6%	10.2%	10.3%	9.6%	
Elective and Daycase		2221	2418	1912	2167	2160	2307	2407	1908	2179	2245	2216	2467	
Emergency Inpatients		1551	1588	1576	1589	1622	1638	1674	1777	1598	1558	1746	1558	
GP Referrals to an Acute Service		10044	8082	7129	7911	7822	8752	8348	6516	8322	9059	8254	8959	
% Of GP Referrals Completed via eRS		72.1%	68.5%	69.9%	71.0%	73.2%	73.1%	71.3%	68.0%	72.2%	74.7%	73.4%	69.0%	
% e-Referral Service (e-RS) Slot Issues	<4%	65.7%	81.8%	82.5%	75.1%	67.1%	66.5%	72.1%	74.8%	71.5%	71.9%	80.3%	85.8%	
Maternity Births	320	226	228	237	263	245	266	256	237	229	206	237	227	
Maternity Bookings	377	263	291	302	274	271	300	271	245	310	288	301	308	
Outpatient DNA Rate % - New	<10%	11.3%	11.6%	11.5%	11.2%	12.1%	12.9%	12.7%	11.5%	12.0%	13.0%	11.7%	11.5%	
Outpatient DNA Rate % - FUp	<10%	10.2%	10.5%	9.9%	10.3%	10.2%	10.9%	10.5%	10.9%	9.7%	10.9%	10.4%	10.2%	
Outpatient New Attendances		12571	13698	12868	13292	12279	13075	11751	9294	10676	10458	10181	11062	
Outpatient FUp Attendances		17750	18662	17043	18013	17317	17550	18760	15789	18922	17449	17180	17891	
Outpatient Procedures		5734	6420	6313	5979	6172	6344	6409	5531	6437	6036	6249	7129	

GP Referrals

April Performance – 8,959

This is an increase of 705 compared to March's performance of 8,254.

It is an increase of 2,289 compared to 6,670 in April 2023.

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

April Performance – 82.7%

This is a worsening of 5.1% from March's performance of 77.6%.

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

Activity Highlights

Maternity Births April Performance – 227

This is a worsening of 10 from March's performance of 237, and an improvement of 35 from 192 in April 2023.

ED Attendances April Performance – 8,958 (Daily Average Attendance 299)

This is a reduction of 604 from March's performance of 9,562 (Daily average attendance 308) and an increase of 970 from 7,988 in April 2023.

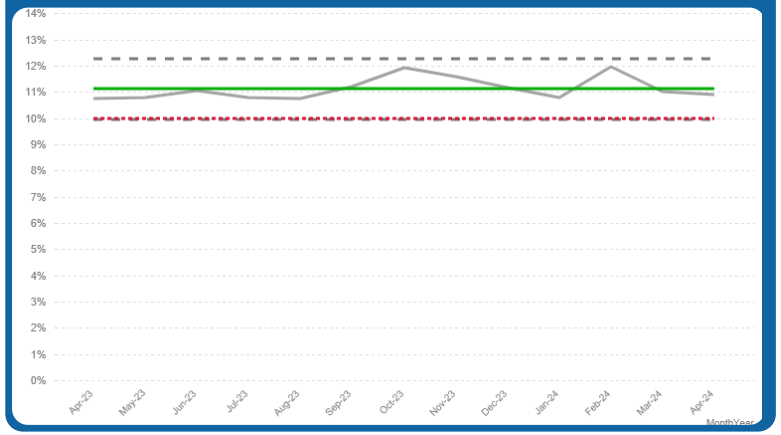
DNA Rates April 2024:

Acute DNA rate for April was 10.9%, this is an improvement of 0.1% from March's performance of 11%.

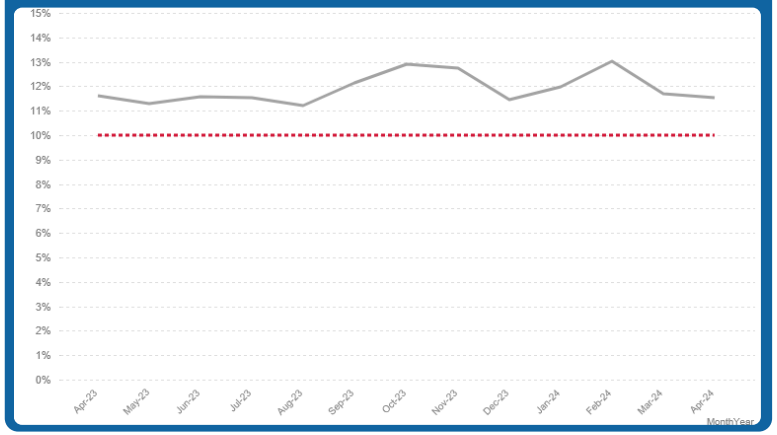
Outpatient DNA rate for new appointments was 11.5% for April, this is an improvement of 0.3% from March's performance of 11.8%.

Outpatient DNA rates for follow-up appointments was 10.2% for April, this is an improvement of 0.1% from March's performance of 10.3%.

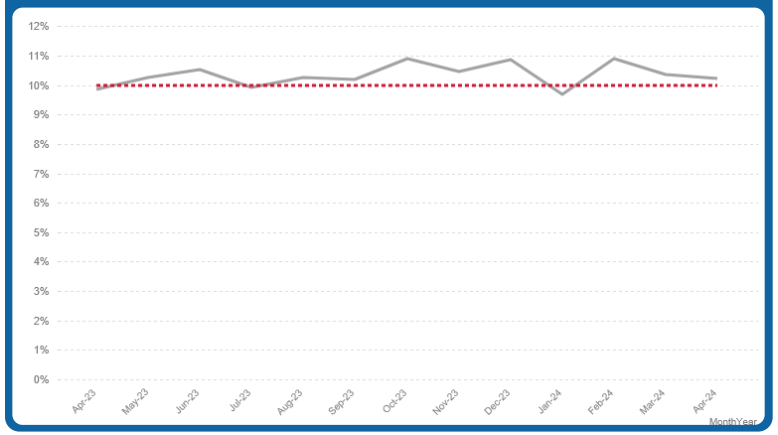
Acute DNA % Rate



Outpatient DNA % Rate - New



Outpatient DNA % Rate – Follow-Up



Activity – Activity and Forecasts

Activity Highlights

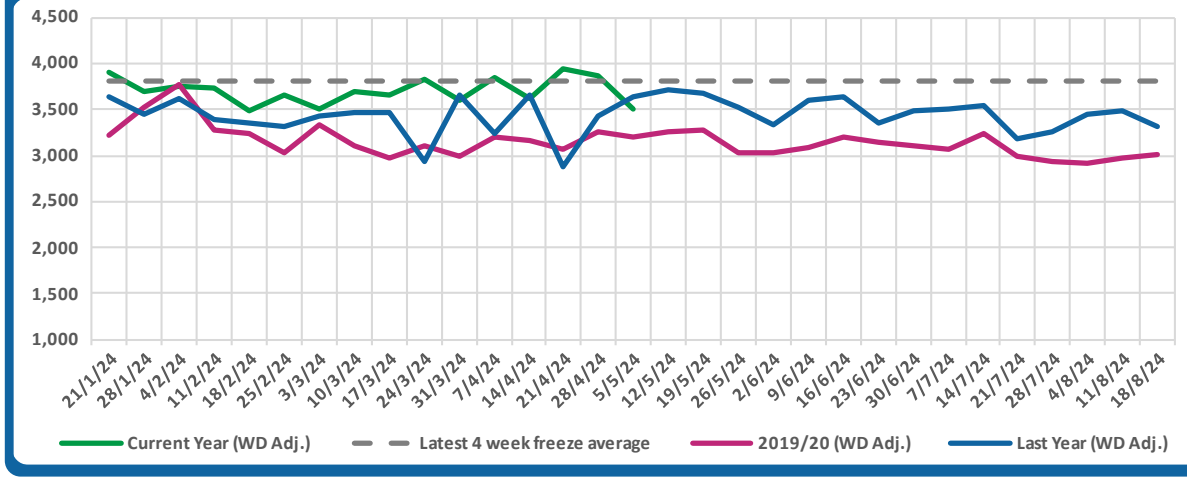
Outpatient First Appointments: There were 14,924 Firsts Appointments in the last 4 weeks of April 2024, this is 118% of 19/20 levels.

Outpatient Follow-up Appointments: There were 12,507 follow-up appointments in the last 4 weeks of April 2024, this is 92% of 19/20 levels.

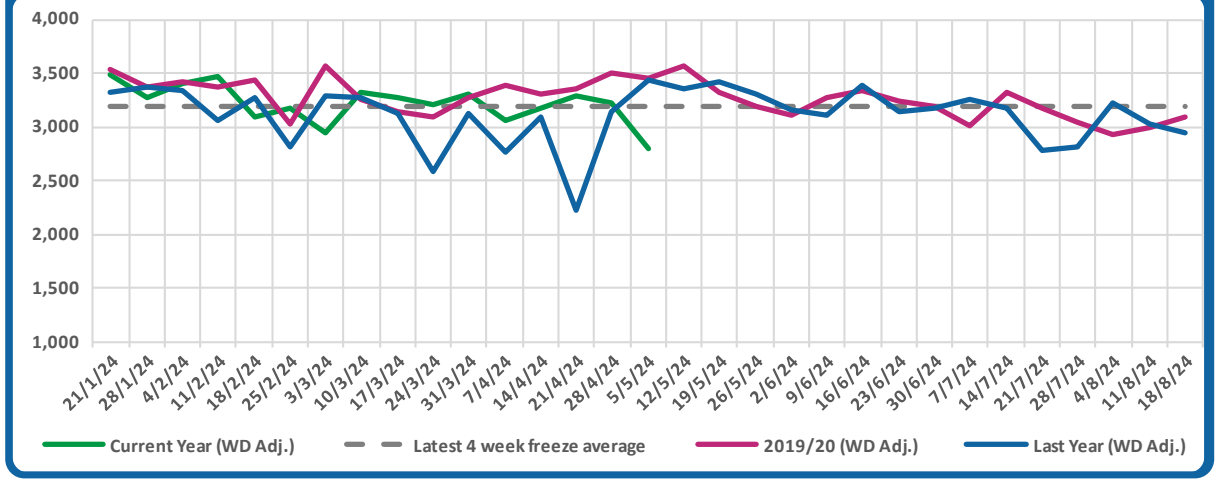
Follow-up activity is in line with productivity improvements.

Elective Activity: There were 2,362 cases in the last 4 weeks of April 2024, this is 113% of 19/20 levels. However, there is a variation in case mix where we have seen less inpatient activity and increased day cases.

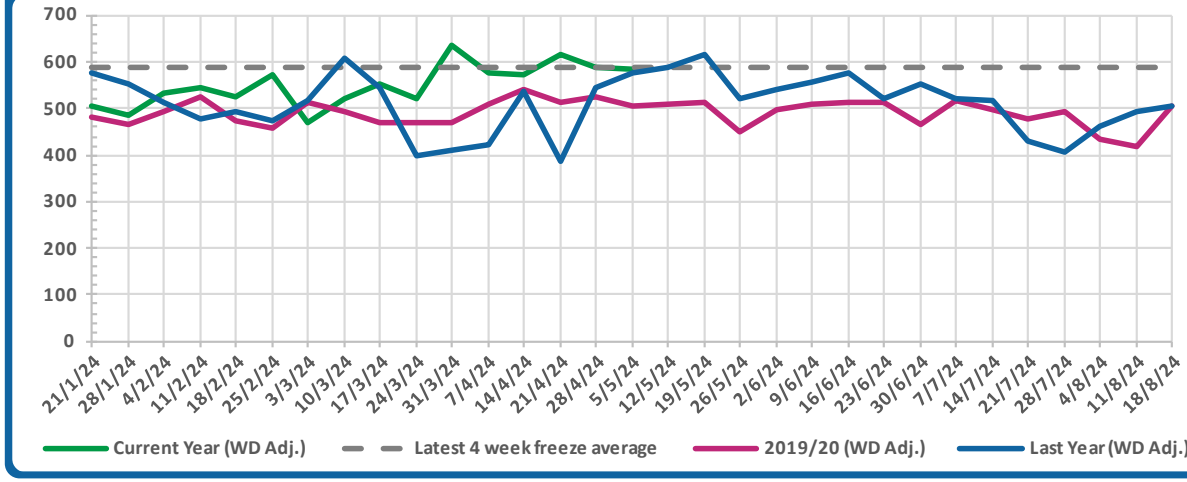
Weekly Outpatient First Attendances



Weekly Outpatient Follow-up Attendances



Weekly Elective Activity



Effective

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Cancelled Ops Not Rebooked <28 Days	0	Mar	4	2			F
Hospital Cancelled Operations	0	Mar	12	11			F
Theatre Utilisation	>85%	Apr	75.0%	71.9%	75.0%		F
Community DNA % Rate	<10%	Apr	7.3%	6.9%	7.3%		P
Acute DNA % Rate	<10%	Apr	10.9%	11.0%	10.9%		F
Outpatients New:Follow Up Ratio	2.3	Apr	1.59	1.71	1.59		P
Non Elective Re-Admissions Within 30 Days	<5.5%	Apr	4.3%	4.6%	4.3%		P
Rapid Response - % Of Referrals With an Improvement in Care		Apr	76.7%	73.7%	76.7%		

Theatre Utilisation - Target 85%

Percentage of available Theatre time used for elective procedure.

April Performance – 75%

This is an improvement of 3.1% from March's performance of 71.9%.

Issues:

- Data validation issues identified
- New digital POA implemented has decreased rate of booking
- Decrease in notice of appointment has exacerbated late notice patient choice cancellation

Actions:

- Daily review of utilisation data to identify and correct inaccuracies
- Temporary additional POA capacity to support booking process
- Support for patients in completing heath questionnaires and additional input into assisted digital pathway

Hospital Cancelled Operations - Target 0

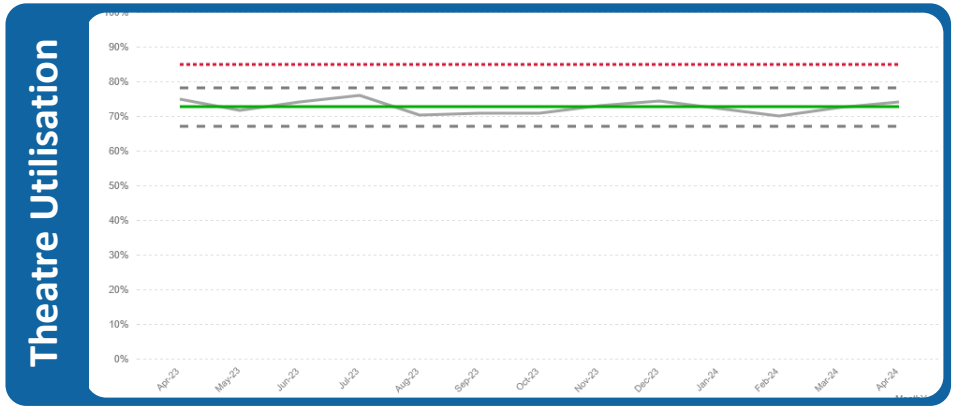
March Performance – 12

This is a worsening of 1 from February's performance of 11.

Issues:

- 7 of the cancellations were due to continual bed pressures and availability
- 2 cases cancelled to support prioritisation of emergency cases arriving via A&E

Actions: Theatre Utilisation and Hospital Cancelled Operations are being reviewed as part of the Elective Improvement Programme for 2024/25.



Caring

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
ED - FFT % Positive	>90%	Apr	83.8%	84.8%	83.8%		F
ED - FFT Response Rate	>15%	Apr	9.2%	9.8%	9.2%		F
Inpatients - FFT % Positive	>90%	Apr	94.6%	89.1%	94.6%	H	P
Inpatients - FFT Response Rate	>25%	Apr	14.2%	17.7%	14.2%		F
Maternity - FFT % Positive	>90%	Apr	98.5%	99.4%	98.5%		P
Maternity - FFT Response Rate	>15%	Apr	29.8%	18.5%	29.8%	H	F
Outpatients - FFT % Positive	>90%	Apr	92.7%	90.1%	92.7%	H	P
Outpatients - FFT Response Rate	400	Apr	382	304	382	L	P
Community - FFT % Positive	>90%	Apr	93.3%	94.7%	93.3%		P
Community - FFT Response Rate	1500	Apr	614	532	614		
Complaints Responded to Within 25 or 40 Working Days	>80%	Apr	71.0%	60.7%	71.0%		F
Complaints (Including Complaints Against Corporate Division)		Apr	31	28	31		

Friends and Family Test (FFT)

April Performance – Trust wide FFT for positive responses sits at 92%, this is above the 85% NHS benchmark and an increase of 2% on March. Negative FFT response rate was 5%.

Work continues to support maternity, imaging and outpatients with FFT collections. Additional iPads are being sourced currently awaiting activation, which will be used to obtain feedback with one being loaned to Maternity. During April, 16 new volunteers have been recruited, 9 as ward befrienders whose role consists of supporting inpatient wards collect feedback and 1 specifically for FFT collection.

Three areas of focus: Maternity 98% positive, ED 84% and Outpatients 92% an increase of 4% on March. Negative response rates for ED 12% a decrease of 2% on March, Outpatients 5%, a decrease of 3% and Maternity 1%.

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

April Performance – 71%

This is an improvement of 10.3% from March's performance of 60.7%.

The Complaints Team continue to work closely with the ICSUs to support with the completion of these and all complaint investigations. In the meantime, all urgent issues identified in complaints have been actioned.

The 31 complaints due a response in April 2024 were allocated to E&IM 36% (11), S&C 32% (10), ACW 16% (5), ACS 10% (3), and CYPS 6% (2)

Severity of Complaints: 48% (15) were designated 'low' risk, 48% (15) were designated as 'moderate' risk, & 4% (1) was designated as 'high' risk.

Themes: A review of the complaints due a response in April 2024 shows that 'Medical Care' 39% (12), 'Communication' 26% (8), & 'Delay' 13% (4) were the main issues for complainants.

Of the 22 complaints that have closed, 6 (27%) were 'upheld', 12 (55%) were 'partially upheld', and 4 (18%) were 'not upheld', meaning that 82% of the closed complaints in April 2024 were upheld in one form or another.

Well Led

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Appraisals % Rate	>85%	Apr	78.5%	80.0%	78.5%	H	F
Mandatory Training % Rate	>85%	Apr	86.5%	88.0%	86.5%	H	P
Permanent Staffing WTEs Utilised	>90%	Apr	92.6%	90.9%	92.6%		P
Staff Sickness Abscence %	<3.5%	Mar	3.5%	3.0%			F
Staff Turnover %	<13%	Apr	11.5%	12.6%	11.5%		P
Vacancy % Rate Against Establishment	<10%	Apr	7.4%	9.1%	7.4%		P
Average Time to Hire	<=63	Apr	60	54	60		P
Safe Staffing Alerts - Number of Red Shifts		Apr	0	3	0	L	
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		Apr	9.5	9.9	9.5		

Appraisals % Rate - *Target >85%*

April Performance – 78.5%

This is a worsening of 1.5% from March's performance of 80%

Issue: Due to the anniversary of TUPE transfers a large number of staff were due their appraisal in the estates team, which has slowed down progress.

Actions: We are actively working with the service to support completions of appraisals.

Staff Turnover % - *Target <13%*

April Performance – 11.5%

Staff turnover continues to reduce, and the Trust has seen an improvement of 1.1% from March's performance of 12.6%

Actions: Implementation of the Trust Workforce strategy to support the development and retention of staff.

Vacancy % Rate - *Target <10%*

April Performance – 7.4%

This is an improvement of 1.7% from March's performance of 9.1%

Issue: Continue to review vacancies in hard to recruit professions.

Actions: The Trust is reviewing alternatives such as development/run through posts, skill mix assessments and apprenticeships.

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2024**
Report title	Finance Report April (Month 1) 2024/25	**Agenda item: 10**
Executive director lead	Terry Whittle, Chief Finance Officer	
Report author	Finance Team	
Executive summary	The Trust is reporting a deficit of £3.3m at the end of April which is £1.7m worse than plan. Capital expenditure in April was £0.3m against in-month plan of £0.3m. Capital plan for 2024-25 is £10.2m. The Trust's cash balance at 30th April was £81.3m, which is £18.7m favourable to Plan. Trust will be submitting a revised financial plan of £10.9m deficit for 2024-25.	
Purpose:	To discuss M1 financial performance.	
Recommendation(s)	To note the financial performance for April	
Risk Register or Board Assurance Framework	BAF risks S1 and S2	
Report history	Monthly report to Board	
Appendices	1: Finance report	

CFO Message **Finance Report M1**

Trust is reporting a deficit of £3.3m for April 2024-25. This is £1.7m worse than plan.

The Trust is reporting a deficit of £3.3m at the end of April which is £1.7m worse than plan.

Key headlines for April financial performance are.

- Trust delivered £0.4m of savings against a target of £1.4m for April. Trust CIP target for 2024-25 is £16.6m.
- Pay overspends relating to enhanced care (0.4m), staffing pressures within ED (£0.1m), Endoscopy 4th room and other expenditure overspends being reviewed as part of cost pressures review.
- The Trust spent £0.5m on additional bed capacity that was opened during winter.
- Underperformance in ERF income of £0.1m for April.
- The Trust spent £1.6m on agency staff in April. This is 5.9% of total pay costs and £0.35m above the agency cap.

There is no external reporting requirement on April's performance.

Cash of £81.3m as at end of April

The Trust's cash balance at 30th April was £81.3m, which is £18.7m favourable to Plan.

Capital expenditure allocation for 2024-25 is £10.2m

Capital expenditure in April was £0.3m against in-month plan of £0.3m. Capital plan for 2024-25 is £10.2m.

Better Payment Practice Performance – 98.6% for non-NHS by value

The Trust is signed up to the NHS commitment to improve its Better Payment Practice Code (BPPC) whereby the target is to pay 95% of all invoices within the standard credit terms. Overall, the Trust's BPPC is 97.4% by volume and 97.9% by value. The BPPC for non-NHS invoices is 98.7% by volume and 98.6% by value.

Financial Plan for 2024-25

The Trust submitted a deficit income and expenditure plan of £12.9m for 2024-25. The deficit plan includes a CIP target of £16.6m. Following further discussions withing the ICS, the Trust will be submitting a revised financial plan of £10.9m deficit for 2024-25.

1. Summary of Income & Expenditure Position – Month 1

	In Month			Year to Date			
	Plan	Actual	Variance	Plan	Actual	Variance	Annual Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income							
NHS Clinical Income	26,268	26,391	123	26,268	26,391	123	315,099
High Cost Drugs - Income	939	1,001	62	939	1,001	62	11,386
Non-NHS Clinical Income	1,657	1,774	116	1,657	1,774	116	19,888
Other Non-Patient Income	2,177	2,324	147	2,177	2,324	147	26,126
Elective Recovery Fund	5,035	4,898	(137)	5,035	4,898	(137)	59,463
	36,077	**36,387**	**310**	**36,077**	**36,387**	**310**	**431,962**
Pay							
Agency	(163)	(1,621)	(1,457)	(163)	(1,621)	(1,457)	(163)
Bank	(419)	(2,450)	(2,031)	(419)	(2,450)	(2,031)	(2,564)
Substantive	(26,303)	(24,018)	2,285	(26,303)	(24,018)	2,285	(319,898)
	(26,885)	**(28,089)**	**(1,203)**	**(26,885)**	**(28,089)**	**(1,203)**	**(322,625)**
Non Pay							
Non-Pay	(8,020)	(8,836)	(817)	(8,020)	(8,836)	(817)	(89,313)
High Cost Drugs - Exp	(883)	(963)	(79)	(883)	(963)	(79)	(10,602)
	(8,903)	**(9,799)**	**(896)**	**(8,903)**	**(9,799)**	**(896)**	**(99,915)**
EBITDA	**288**	**(1,501)**	**(1,789)**	**288**	**(1,501)**	**(1,789)**	**9,421**
Post EBITDA							
Depreciation	(1,554)	(1,614)	(60)	(1,554)	(1,614)	(60)	(17,531)
Interest Payable	(69)	(64)	6	(69)	(64)	6	(830)
Interest Receivable	177	352	175	177	352	175	2,125
Dividends Payable	(506)	(506)	0	(506)	(506)	0	(6,068)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(1,952)	**(1,832)**	**120**	**(1,952)**	**(1,832)**	**120**	**(22,304)**
Reported Surplus/(Deficit)	**(1,664)**	**(3,333)**	**(1,669)**	**(1,664)**	**(3,333)**	**(1,669)**	**(12,882)**
Impairments	0	0	0	0	0	0	0
IFRS & Donated	(5)	(4)	1	(5)	(4)	1	(60)
Reported Surplus/(Deficit) after Impairments and IFRIC12	**(1,669)**	**(3,338)**	**(1,669)**	**(1,669)**	**(3,338)**	**(1,669)**	**(12,942)**

- The Trust is reporting a deficit of £3.3m (excluding donated asset depreciation and impairments) against a planned deficit of £1.6m. This is £1.7m worse than plan.
- The main driver for this position is unachieved CIP of £1m and other expenditure overspends being reviewed.

2.0 Income and Activity Performance

2.1 Income Performance – April

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	1,674	1,862	187	1,674	1,862	187
Elective	2,301	2,291	(10)	2,301	2,291	(10)
Non-Elective	4,788	4,917	129	4,788	4,917	129
Critical care	451	482	31	451	482	31
Outpatients	5,440	5,019	(421)	5,440	5,019	(421)
Direct access	1,442	1,754	312	1,442	1,754	312
Community	6,538	6,538	0	6,538	6,538	0
Other clinical income NHS	4,573	4,530	(44)	4,573	4,530	(44)
NHS Clinical Income	**27,207**	**27,392**	**185**	**27,207**	**27,392**	**185**
Non NHS clinical income	1,657	1,774	116	1,657	1,774	116
Elective recovery fund (ERF)	5,035	4,898	(137)	5,035	4,898	(137)
Income From Patient Care Activities	**33,900**	**34,063**	**164**	**33,900**	**34,063**	**164**
Other Operating Income	**2,177**	**2,324**	**147**	**2,177**	**2,324**	**147**
Total	36,077	36,387	310	36,077	36,387	310

- Income was £0.3m over plan. £0.2m NHS clinical income, £0.1m non-NHS clinical income, £0.1m other operating income offset by £0.1m ERF underperformance.
- £0.3m NHS clinical income is driven mainly by £0.1m drugs overperformance, £0.1m foundation trust income.
- £0.1m non-NHS clinical income is driven by local authority income in CYP services, such as Barnet universal services (offset by additional expenditure).
- £0.1m other operating income is driven by education & training income in corporate services (offset by additional expenditure).

2.2 Elective recovery fund (ERF) – April

- Trust underperformed by £0.1m against an estimated elective income target of 104% of 2019/20 performance. Its driven mainly by outpatient performance and surgery & cancer ICSU. The position is based on early data and an adjustment for outpatient un-outcome estimate.

ERF Income by ICSU

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	6,475	548	613	64	548	613	64
CYP	6,148	521	561	41	521	561	41
EIM	19,813	1,678	1,651	(27)	1,678	1,651	(27)
S&C	27,028	2,289	2,073	(216)	2,289	2,073	(216)
Grand Total	59,464	5,035	4,898	(137)	5,035	4,898	(137)

ERF Income by POD

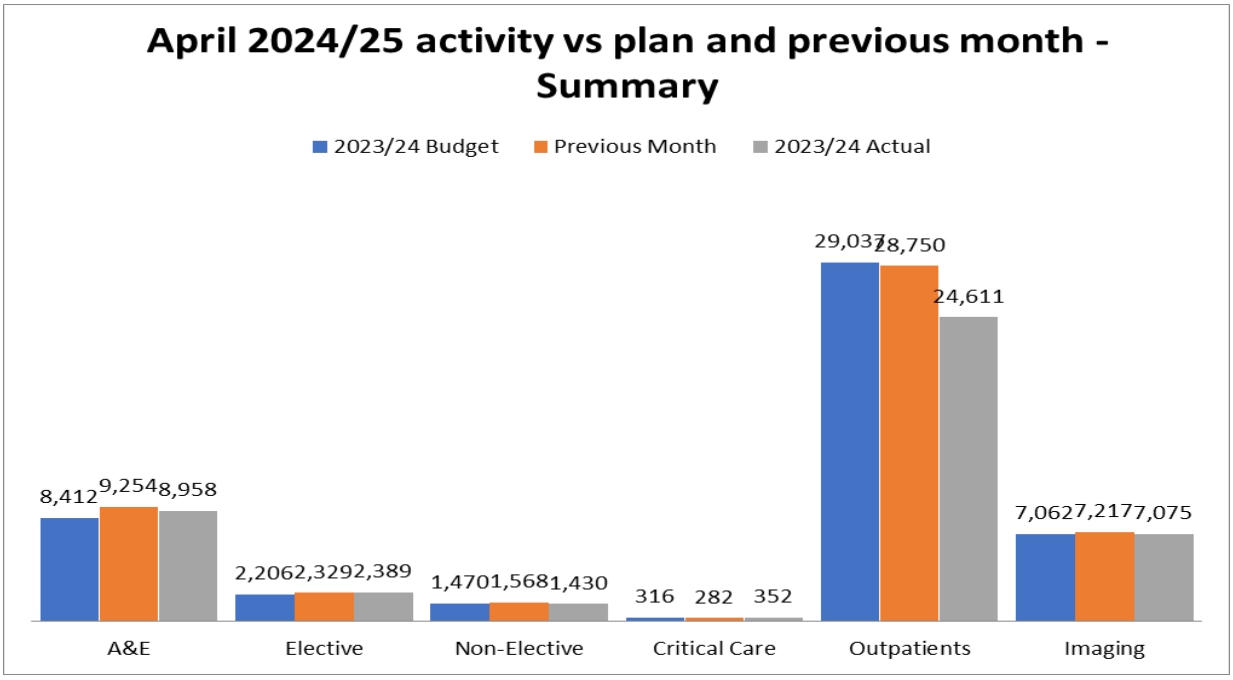
POD	Annual Plan £000's	In Month Income Plan £000's	In Month Income Actual £000's	In Month Income Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Income Variance £000's
DC	19,072	1,615	1,643	28	1,615	1,643	28
EL	7,785	659	611	(48)	659	611	(48)
OP First	23,493	1,989	1,929	(61)	1,989	1,929	(61)
OP Procedure	9,113	772	715	(57)	772	715	(57)
Grand Total	59,463	5,035	4,898	(137)	5,035	4,898	(137)

2.3 Activity Performance – April

- Activity overperformed against plan in A&E, elective, critical care and direct access (mainly due to pathology). Underperformance in non-elective inpatients and outpatients.

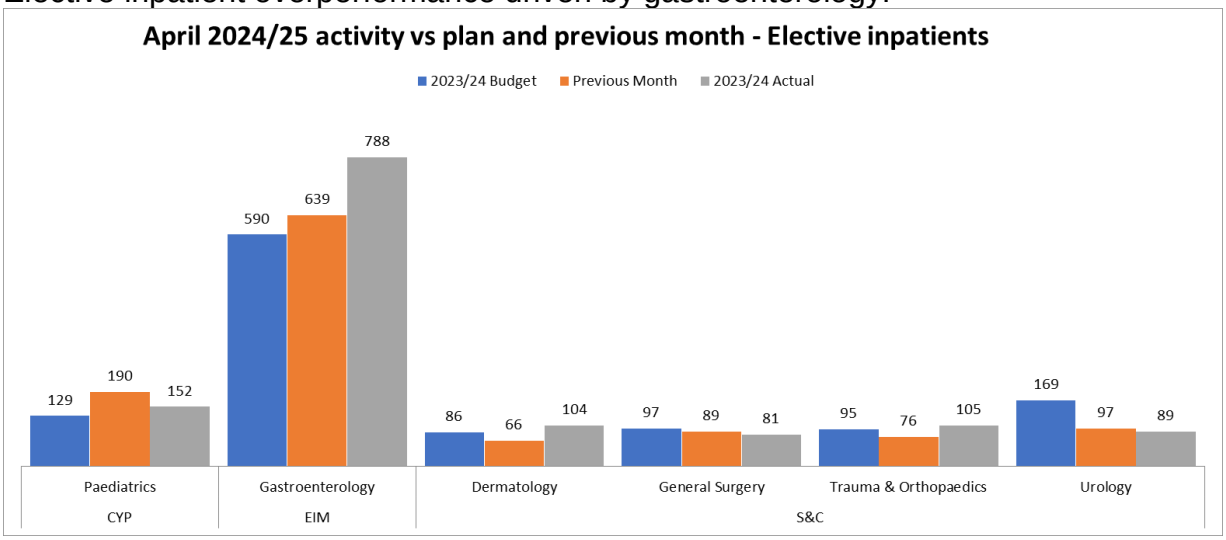
Activity	In Month Activity Plan	In Month Activity Actual	In Month Variance	In month Activity Diff%	YTD Activity Plan	YTD Activity Actual	Activity Diff	YTD Activity Diff%
A&E	8,412	8,958	546	6%	8,412	8,958	546	6%
Elective	2,206	2,389	183	8%	2,206	2,389	183	8%
Non-Elective	1,470	1,430	(40)	(3%)	1,470	1,430	(40)	(3%)
Critical care	316	352	36	11%	316	352	36	11%
Outpatients	29,037	24,611	(3,724)	(15%)	29,037	24,611	(3,724)	(15%)
Imaging	7,062	7,075	360	0%	7,062	7,075	360	0%
Direct Access	122,117	135,349	13,232	11%	122,117	135,349	13,232	11%

- Activity is slightly higher than March (adjusted for working/calendar days) across all points of delivery, except for A&E and non-elective.

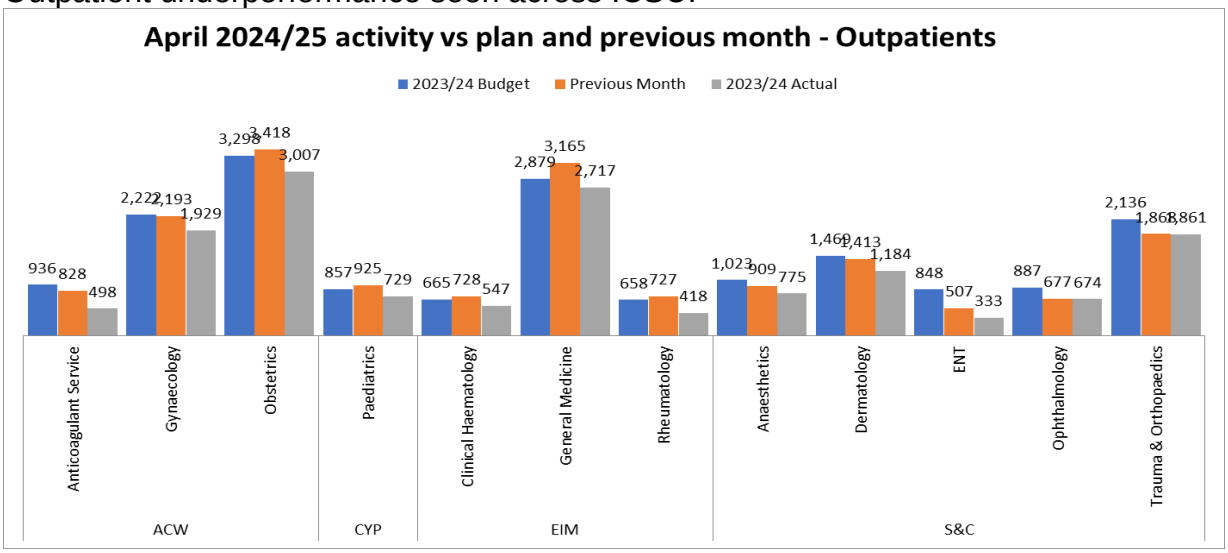


- ERF inpatient activity is slightly over plan, with significant underperformance in outpatients. Although outpatient procedures are under plan, there has been significant increase compared to previous month.

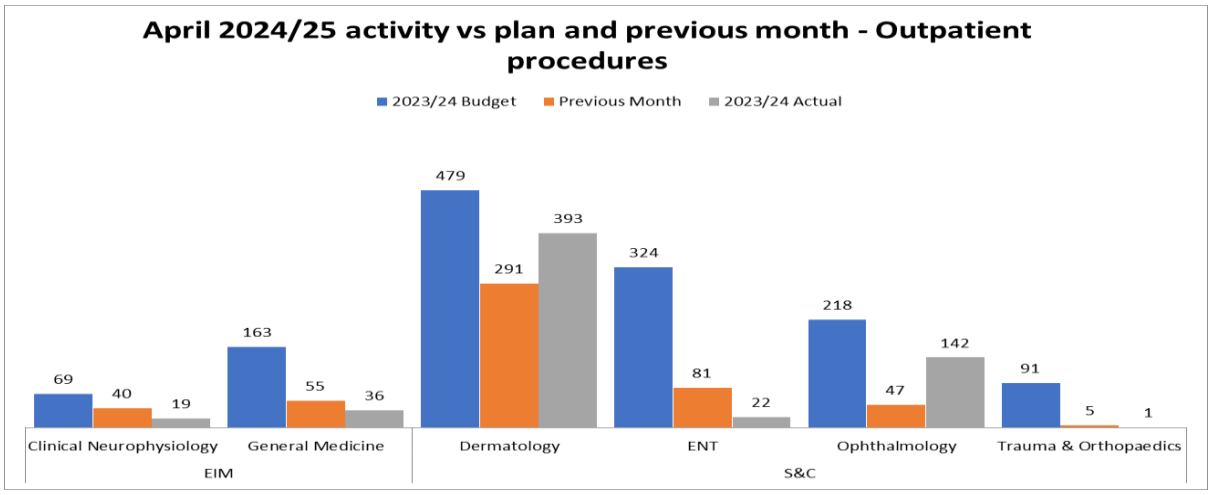
- Elective inpatient overperformance driven by gastroenterology.



- Outpatient underperformance seen across ICSU.



- Outpatient underperformance in outpatient procedures.



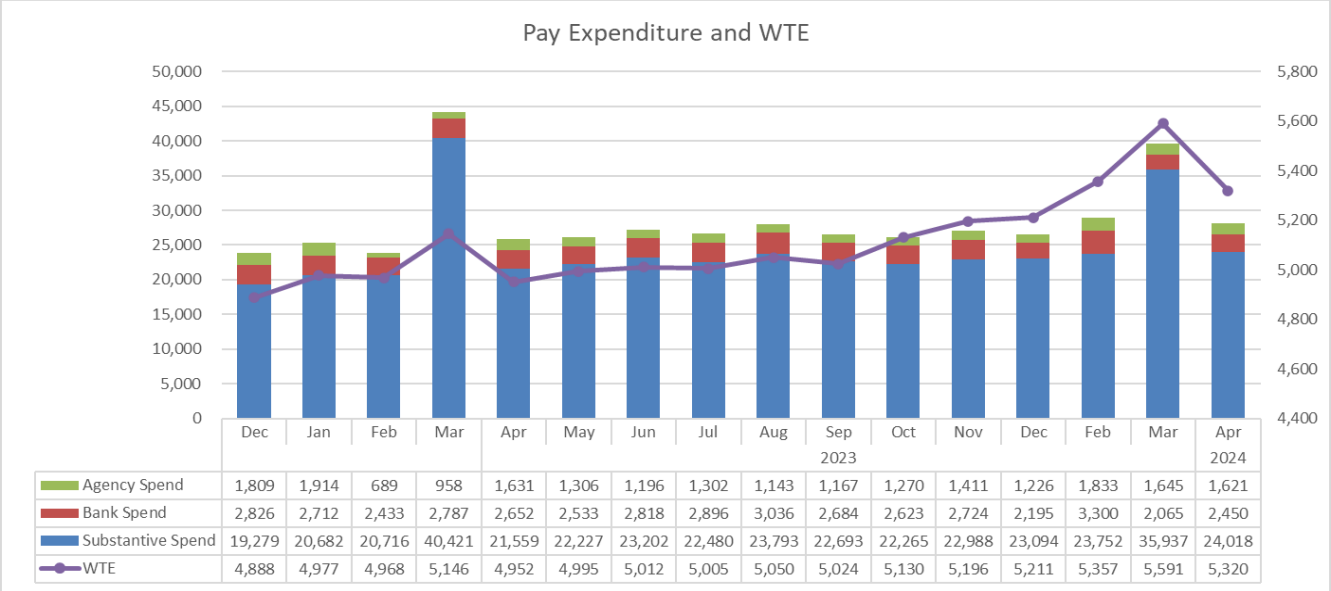
3. Expenditure – Pay & Non-pay

3.1 Pay Expenditure

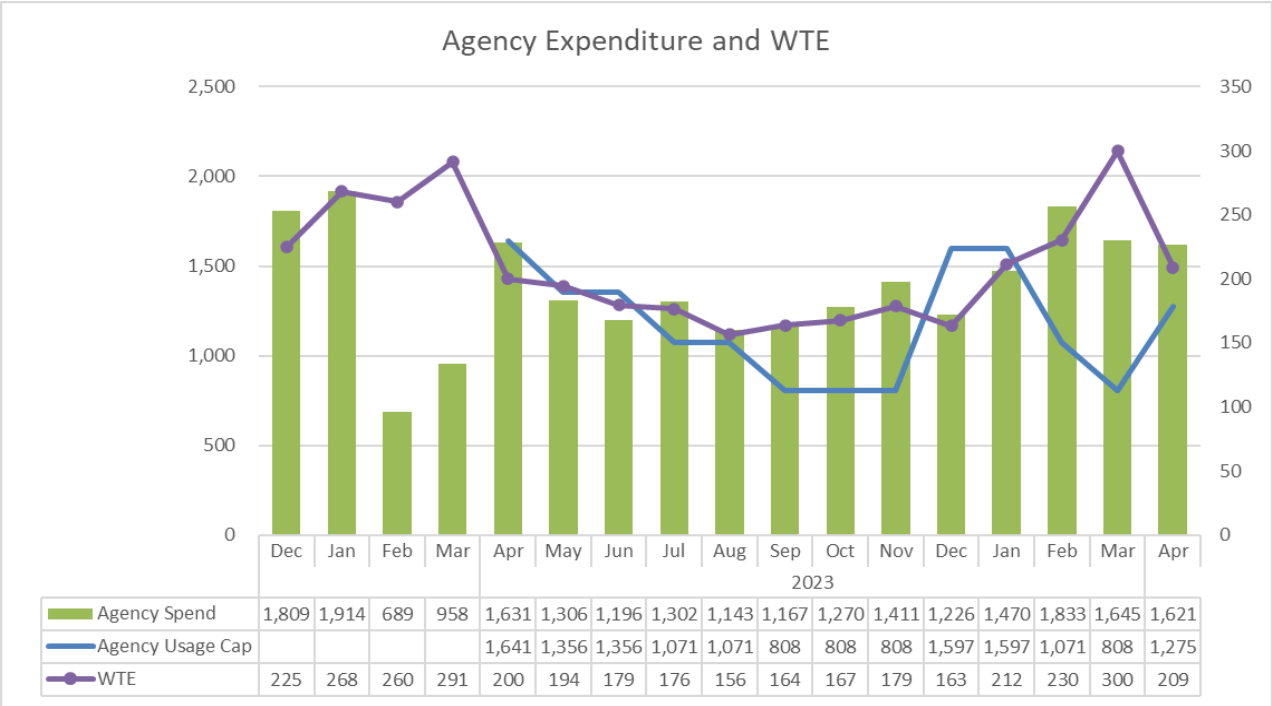
Pay expenditure for April was £28m, a decrease of £11.5m from the March position. The decrease is due to

- Additional pay expenditure relating to centrally funded pension contributions of £11.9m in March.
- Trust spent £0.5m (91.14wte) on additional bed capacity that was opened for winter.
- Reduction in substantive costs of £0.9m mainly due to consultant backdated pay accrued in March.

	2023-24			2024-25	
	Jan	Feb	Mar	Apr	Mov^t
Agency	1,470	1,833	1,883	1,581	302
Bank	3,079	3,308	2,039	2,442	(403)
Substantive	23,906	23,844	24,353	23,407	945
Total Operational Pay	**28,456**	**28,985**	**28,275**	**27,430**	**844**
Non Operational Pay Costs	74	(100)	11,372	658	10,714
Total Pay Costs	**28,530**	**28,885**	**39,647**	**28,089**	**11,558**



	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Feb	Mar	Apr
										2023						2024
Agency Spend	1,809	1,914	689	958	1,631	1,306	1,196	1,302	1,143	1,167	1,270	1,411	1,226	1,833	1,645	1,621
Bank Spend	2,826	2,712	2,433	2,787	2,652	2,533	2,818	2,896	3,036	2,684	2,623	2,724	2,195	3,300	2,065	2,450
Substantive Spend	19,279	20,682	20,716	40,421	21,559	22,227	23,202	22,480	23,793	22,693	22,265	22,988	23,094	23,752	35,937	24,018
WTE	4,888	4,977	4,968	5,146	4,952	4,995	5,012	5,005	5,050	5,024	5,130	5,196	5,211	5,357	5,591	5,320



	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
					2023												
Agency Spend	1,809	1,914	689	958	1,631	1,306	1,196	1,302	1,143	1,167	1,270	1,411	1,226	1,470	1,833	1,645	1,621
Agency Usage Cap					1,641	1,356	1,356	1,071	1,071	808	808	808	1,597	1,597	1,071	808	1,275
WTE	225	268	260	291	200	194	179	176	156	164	167	179	163	212	230	300	209

3.2 Non-pay Expenditure

Non-pay spend for April was £8.8m, a £3.4m increase from March spend. Expenditure in March was impacted by release of non-recurrent benefits.

	2023-24												2024-25	
Non-Pay Costs	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**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	4,860	4,096	764
Supplies & Servs - Gen	333	376	442	310	440	341	391	332	456	585	294	356	394	(38)
Establishment	263	240	284	237	273	324	320	334	293	517	278	(6)	291	(297)
Healthcare From Non Nhs	95	79	85	76	80	75	75	56	75	78	45	(85)	82	(167)
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	2,778	2,164	614
Ext Cont Staffing & Cons	193	388	265	13	169	218	127	16	152	114	146	117	140	(23)
Miscellaneous	1,821	1,836	1,295	1,942	669	1,255	1,868	1,732	1,997	1,968	1,765	(2,598)	1,660	(4,258)
Chairman & Non-Executives	9	9	9	9	9	9	9	11	11	11	11	11	11	0
Non-Pay Reserve	42	388	(251)	(178)	(5)	5	0	0	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**	**5,432**	**8,836**	**(3,404)**

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												2024-25	
Miscellaneous Breakdown	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Mov^t**
Ambulance Contract	175	206	185	172	199	139	207	137	174	186	178	177	190	(13)
Other Expenditure	155	85	166	100	(483)	66	92	60	120	288	146	(7,279)	125	(7,403)
Audit Fees	15	12	(17)	11	13	11	11	11	11	11	11	15	9	6
Provision For Bad Debts	65	94	(238)	250	(596)	(212)	57	(34)	34	(55)	(115)	2,097	(54)	2,150
Cnst Premium	821	821	821	821	821	577	780	778	765	761	741	406	765	(359)
Fire Security Equip & Maint	5	5	6	10	7	13	4	47	2	7	4	34	9	25
Interpretation/Translation	27	8	31	21	14	21	10	102	36	20	(5)	56	42	15
Membership Subscriptions	125	159	117	161	135	146	146	149	61	127	154	74	141	(67)
Professional Services	355	354	115	288	495	399	387	389	374	450	518	700	354	346
Research & Development Exp	(1)	(1)	(1)	4	12	(1)	8	6	286	(13)	3	169	3	166
Security Internal Recharge	10	11	14	13	(0)	12	10	7	10	10	9	10	10	0
Teaching/Training Expenditure	66	77	92	89	49	84	152	73	124	173	116	939	62	877
Travel & Subs-Patients	2	4	4	1	4	0	5	7	0	3	3	3	3	1
Work Permits	0	0	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	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**	**(2,598)**	**1,660**	**(4,258)**

3.3 Cost Improvement Programme (CIP)

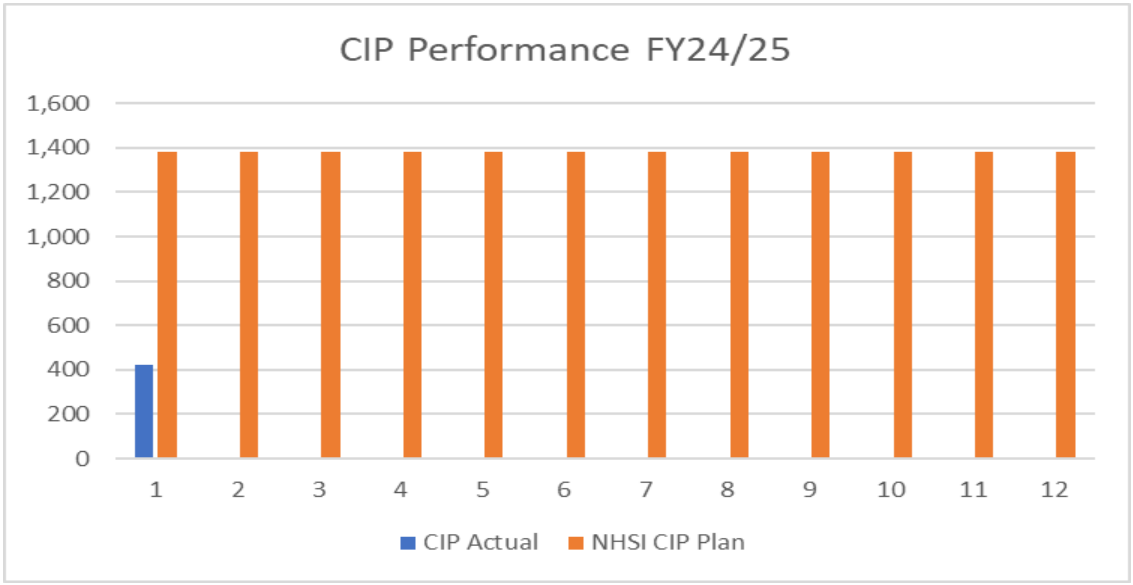
The CIP target for 2024-25 is £16.6m. The targets have been allocated to ICSU and corporate divisions as part of 2024-25 budgets.

ICSU	24/25 CIP Target Allocated £'000
ADULT COMMUNITY	2,086
CHILDREN & YOUNG PEOPLE	3,073
EMERGENCY & INTEGRATED MEDICINE	2,729
SURGERY & CANCER	2,565
ACW	2,928
ICSU TOTAL	**13,381**
CORPORATE SERVICES TOTAL	3,218
CIP GRAND TOTAL	**16,599**

CORPORATE DIRECTORATES	24/25 CIP Target Allocated £'000
CHIEF OPERATION OFFICER	87
ESTASTES & FACILITIES	1,547
FINANCE	270
ICT	426
MEDICAL DIRECTOR	119
NURSING & PATIENT EXPERIENCE	295
TRUST SECRETARIAT	166
WORKFORCE	308
PROCUREMENT	-
CIP GRAND TOTAL	**3,218**

Trust is reporting actual delivery of £0.4m of CIP against a target of £16.6m (30% of the YTD plan) for 2024-25.

ICSU	24/25 CIP Target Allocated	YTD Plan £'000	YTD Actuals £'000	YTD Variance £'000	YTD Actual vs Plan % Variance
ADULT COMMUNITY	2,086	174	0	(174)	0%
CHILDREN & YOUNG PEOPL	3,073	256	6	(250)	2%
EMERGENCY & INTEGRATED	2,729	227	0	(227)	0%
SURGERY & CANCER	2,565	214	0	(214)	0%
ACW	2,928	244	6	(238)	3%
ICSU TOTAL	**13,381**	**1,115**	**13**	**(1,103)**	**1%**
CORPORATE SERVICES	1,671	139	192	52	138%
ESTATES & FACILITIES	1,547	129	46	(83)	36%
CENTRAL	0	0	170	170	0%
CIP GRAND TOTAL	**16,599**	**1,383**	**420**	**(963)**	**30%**



4.0 Statement of Financial Position (SoFP)

The net Statement of Final Position as of 30th April 2024 is £233.19m, £3.34m lower than March 2024, as shown in the table below

Statement of Financial Position as at 30th April 2024	2023/24 M12 Balance	2024/25 M01 Balance	Movement in Month
	£000	£000	£000
NON-CURRENT ASSETS:			
Property, Plant And Equipment	219,465	218,391	(1,074)
Intangible Assets	5,701	5,495	(206)
Right of Use Assets	43,136	42,796	(340)
Assets Under Construction	40,916	41,228	312
Trade & Other Rec -Non-Current	561	534	(27)
TOTAL NON-CURRENT ASSETS	**309,779**	**308,445**	**(1,334)**
CURRENT ASSETS:			
Inventories	1,090	1,088	(2)
Trade And Other Receivables	27,135	13,771	(13,364)
Cash And Cash Equivalents	68,549	81,286	12,736
TOTAL CURRENT ASSETS	**96,774**	**96,144**	**(630)**
CURRENT LIABILITIES			
Trade And Other Payables	(92,997)	(91,152)	1,845
Borrowings: Finance Leases	235	321	86
Borrowings: Right of Use Assets	(4,370)	(4,370)	0
Borrowings: Dh Revenue and Capital Loan - Current	(116)	(116)	0
Provisions for Liabilities and Charges	(661)	(650)	11
Other Liabilities	(5,470)	(9,142)	(3,671)
TOTAL CURRENT LIABILITIES	**(103,379)**	**(105,109)**	**(1,730)**
NET CURRENT ASSETS / (LIABILITIES)	**(6,605)**	**(8,965)**	**(2,359)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**303,174**	**299,480**	**(3,694)**
NON-CURRENT LIABILITIES			
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,508)	(1,508)	0
Borrowings: Finance Leases	(3,498)	(3,498)	0
Borrowings: Right of Use Assets	(38,824)	(38,457)	367
Provisions for Liabilities & Charges	(22,827)	(22,838)	(11)
TOTAL NON-CURRENT LIABILITIES	**(66,657)**	**(66,302)**	**356**
TOTAL ASSETS EMPLOYED	**236,516**	**233,178**	**(3,338)**
FINANCED BY TAXPAYERS EQUITY			
Public Dividend Capital	137,948	137,948	0
Retained Earnings	16,743	13,405	(3,338)
Revaluation Reserve	81,826	81,826	0
TOTAL TAXPAYERS EQUITY	**236,516**	**233,178**	**(3,338)**

The most significant movements in the month to 30th April 2024 were as follows:

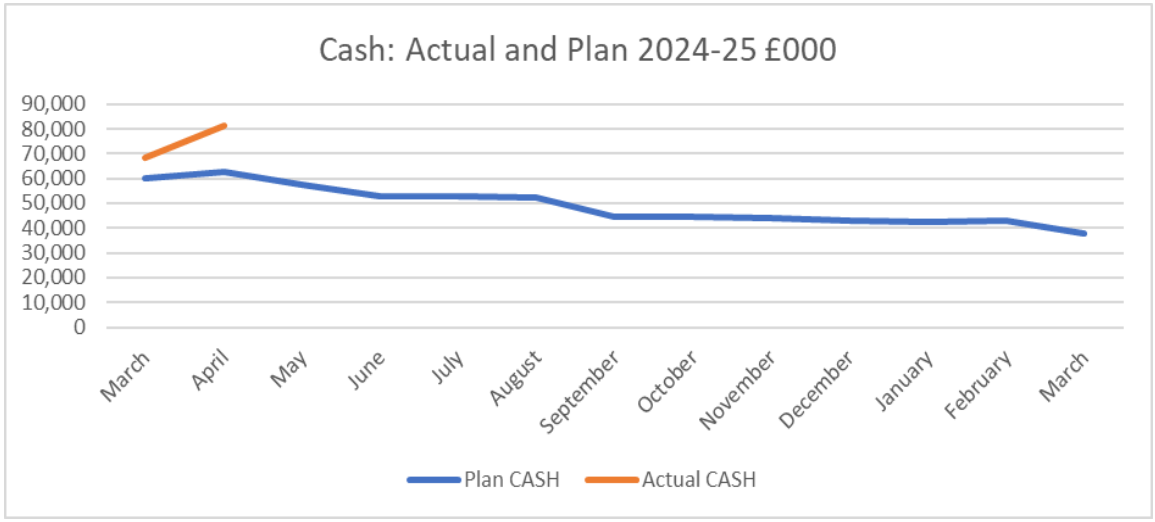
NON-CURRENT ASSETS

Non -Current assets closed at £308.44m in April 2024, a net decrease of £1.33m from previous month due to the monthly depreciation exceeding the month 1 asset addition of £0.31m.

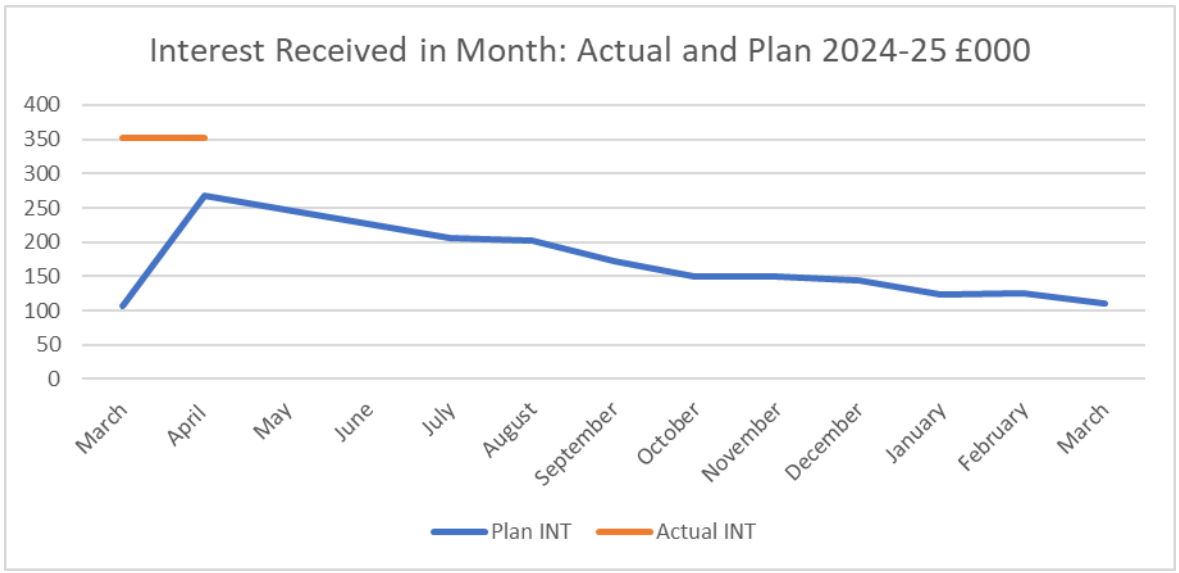
CURRENT ASSETS
Current assets closed at £96.14m in April 2024, a net decrease of £0.63m from the previous month. Principal movements comprised Trade and other receivables (reduced by £13.36m) and Cash (increased by 12.74m).

CURRENT LIABILITIES
Current liabilities increased by £1.73m in month. Trade and other payables decreased by £1.84m in month and other liabilities increased by £3.67m in month: education funding received in relation to future months of £2.9m was deferred.

CASH
The Trust's cash balance at 30th April was £81.29m, which is £18.71m favourable to Plan.



Interest Received
Year-to-date interest received is £0.35m which is favourable to Plan by £0.08m. The Plan was set with an anticipated peak to interest rates around Month 6-7 of the 2024-25 financial year.



5.0 Capital Expenditure

The core capital allocation for 2024-25 is £10.236m.The allocation to projects includes overprogramming.

Capital Expenditure 2024/25: 1 month to 30th April 2024		
	12M Budget 2425 £000	*01M Actuals £000*
Estates Capital 2425	3,800	108
Strategy Capital 2425	5,800	204
ICSUs 2425	200	
ICT 2425	400	
Equipment 2425	400	
Contingency 2425	500	
Total	***11,100***	***312***

The current year to date expenditure at M01 is £0.31m against in-month plan of £0.30m, and is comprised of Estates £0.1m, and Strategic Projects £0.2m.

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2024**
Report title	**Workforce Assurance Committee Chair's report**	**Agenda item: 11**
Committee Chair	Rob Vincent, Non-Executive Director	
Executive lead	Liz O, Hara, Chief People Officer	
Report authors	Swarnjit Singh, Trust Company Secretary	
Executive summary	Trust Board members are presented with the Workforce Assurance Committee Chair's report for the meeting held on 20 May 2024. **Areas of good assurance:** • Staff story – Staff health and wellbeing • Director's report • Freedom to Speak Up Guardian report • Quarter four Staff wellbeing and engagement activities • Quarter three report from the Guardian of Safe Working • Annual workforce equality standard submissions • 2023 NHS Staff Survey outcomes • Quarter 3 workforce information report • Report on Medical and Dental Disciplinaries • Review of Committee Effectiveness and Terms of Reference • Q1 Board Assurance Framework – People entries • Trust Risk Register **Key areas to highlight to the Board:** 1. The findings from the 2023 Staff Survey and the areas of focus for actions 2. The annual report from the Freedom to Speak Up Guardian. 3. The annual workforce race and disability equality standard submissions for NHS England. 4. The opportunities for collaboration with University College London Hospitals NHS Foundation Trust and the learning to be had in both directions. 5. The quarterly report from the Guardian of Safe Working Hours.	
Purpose	Approve	
Recommendation(s)	Board members are invited to: i. note the Committee Chair's report for the meeting held on 20 May 2024, including the Guardian of Safe Working Hours report and the outcomes from the workforce equality standard submissions to NHS England; and ii. approve revised Committee terms of reference shown in appendix 1.	
BAF	People 1 and 2 entries	
Appendices	1. Workforce Assurance Committee terms of reference 2. Guardian of Safe Working Hours report	

Committee Chair's assurance report

Committee name	Workforce Assurance Committee
Date of meeting	24 May 2024
Summary of assurance:	

1. The Committee is reporting good assurance to the Board on the following items:

Staff story – staff health and wellbeing

The Committee welcomed a staff story item which highlighted the support provided to help with staff health and wellbeing. Committee members learnt from Kiran Sanger who set out her personal journey and highlighted the examples of support available such as post-natal support, bereavement counselling and support to carry out debriefs involving situations of trauma, by using a framework which provided a systematic approach.

Committee members supported the observations and suggestions made which included empowering staff by allowing then protected time and enabling them to take a more proactive approach to managing health and wellbeing and the inclusion of mindfulness training to support and grow compassionate leaders.

Chief People Officer's report

The Committee received a verbal update which included the following points to note:

- The Chief People Officer assumed her role at Whittington Health on 27 March and had received a really warm welcome from colleagues.
- The workforce team at University College London Hospitals NHS Foundation Trust had welcomed the opportunity to attend the Too Hot To Handle talk by Professor Joy Warmington, co-author.
- It was clear that there were good opportunities to work more collaboratively on inclusion work across both organisations which the Joint Directors were keen to help support.
- There was a backdrop of significant financial challenge in the NHS at a national, region and local level and there were areas of shared focus where it would be fruitful to work more together such as work on temporary staffing challenges to help meet the 2024/25 agency expenditure target.

The Committee noted the report and welcomed the mutuality and supplementary strengths that both organisations brought to the people function.

Freedom to Speak Up Guardian report

The Committee welcomed and took good assurance from the 2023/24 Freedom to Speak Up Guardian's annual report. Committee members were pleased to see that staff felt able to raise concerns without anonymity and that there were plans in place to recruit more than the current 45 Freedom to Speak Up Champions, in areas and professional groups where there were gaps. The Committee learnt that 59% of concerns had been raised by staff

from a minority ethnic background and that the priorities for the function were to:

- Increase the numbers of staff who received training.
- Build on the existing good culture of raising concerns.
- Ensure the Champions cohort was more visible.
- Building a culture of acting on the concerns raised within a specific timeframe.
- Benchmarking against other NHS providers, with the acknowledgement that not all providers reported in a consistent fashion.

The Committee noted the Freedom to Speak Up Guardian's 2023/24 annual report and commented that it was an area of strength to build on for both University College London Hospitals and Whittington Health.

Quarter four Staff Wellbeing and engagement activity

Committee members reviewed a presentation which set out the work of the staff health and wellbeing function since October 2023. They noted the strong visibility of the team and of the increased training offer being made available to the organisation. For the former, Committee members learnt of the programme of roadshows which would target community sites. In terms of the health and wellbeing support available, the Committee was informed that a tender had been issued for an external provider to deliver psychological interventions to support staff – this had been highlighted as an area in the recent webinar held on global conflicts to help uphold the organisation's values of compassion and behaviours which demonstrated care for one another.

The Committee also discussed the importance for staff health wellbeing from having quality food options which could be heated up safely and eaten in a suitable environment. This was particularly the case for staff who worked at nights or at the weekend.

The Committee noted the report and supported the areas of focus in 2024/25 by the health and wellbeing team.

Quarterly Guardian of Safe Working Hours report (GOSWH)

Angad Singh presented the report for quarter three 2023/24 and drew attention to the following:

- The report covered an ongoing period of intermittent industrial action by most junior doctors.
- This, coupled with high levels of acuity of patients has led to high levels of exception reporting this quarter.
- Nationally there are lower than previous numbers of junior doctors available to fill bank and agency shifts which leaves on-call teams very stretched.
- There continue to be high levels of fatigue and burnout amongst all staff across the NHS and this has affected the Trust's doctors and dentists in training.
- Junior doctors have decided to spend the fine money on lunch

provisions at teaching. This money has been transferred to the postgraduate department budget who are facilitating this.
- The GOSWH has continued to work with the postgraduate department, rota coordinators and the Junior Doctors' Forum during this period to support all the trainees to face the challenges before them whilst ensuring safe working throughout this period.

The Committee noted the number of exception reports from the Emergency and Integrated Medicine clinical division which was continued to experience considerable pressure on the urgent and emergency care pathway.

Workforce race and disability equality standard submission
The Committee noted the outcomes from the annual workforce race and disability workforce standard submissions to NHS England. The Committee noted the increase in ethnic minority representation in the workforce from 41% to 45% and the ethnicity non-disclosure rate of c.17%. The Committee welcomed the improvements made to indicators covering formal disciplinary processes and access to training and development opportunities. The Committee also noted the improved outcomes for indicators linked to the 2023 NHS Staff Survey. Committee members supported the areas identified or focus in 2024/25 including recruitment and career progression. In terms of outcomes from the disability workforce standard, the Committee noted the need to increase the numbers of staff who disclosed a disability as well as those with a nil return. Committee members received assurance that training was provided for managers on recruitment and selection and that, at least one member of a recruitment and selection panel had to have been trained.

The Committee noted the outcomes for both the race and disability submissions and gave strong support to the work taking place to continually improve outcomes. The Committee agreed that the new co-chairs of the staff disability network, WhitAbility, be invited to a future meeting. In addition, the Committee asked that a specific report be brought back on career progression.

2023 NHS Staff Survey outcomes
Committee members reviewed the outcomes from the 2023 NHS Staff Survey and the priority areas for action. They were informed of the fall in the response rate by 1% to 45% when compared with the previous year and of the continued improvement in the staff engagement score from 6.81 to 6.94. The Committee also noted that, for the nine areas of the NHS People Promise, when benchmarked against other providers in the acute and community group, Whittington Health was not ranked as 'worst' or 'best' in any of the themes. The Trust was slightly above average for the majority themes and was below average for three themes: *We are safe and healthy, We work flexibly, and Morale.* Furthermore, the Committee welcomed the fact that four out five of the areas of focus following the 2022 staff survey outcomes had shown improvements in the most recent survey. This included areas such as staff working less unpaid additional hours, making reasonable adjustments and having access to adequate materials for the job.

The Committee agreed that to support the following NHS People Promise themes and areas for focus this year to help morale, engagement, and support staff retention:

- We are safe and healthy, particularly the view that the organisation is not doing enough to support health and wellbeing.
- We work flexibly, particularly around having support for a better home and work life balance.
- Morale, particularly the reasons for staff thinking about leaving the organisation.
- Career progression and fairness

Quarter 4 workforce information report

The report was taken as read and Committee members noted the summary of performance metrics which showed the following:

- The Q4 cumulative sickness absence rate was 3.9%, down from 4.4% in Q3 but above the target of 3.2%.
- Vacancy rates saw a decrease to 9.1% from 10% in the last quarter.
- The turnover rate was down rose from 11.7% in December 2023 to 12.6% in March 2024.
- Mandatory training compliance was at 88% and the appraisal compliance rate was 80% with both indicators continuing to go in the right direction.
- The time taken to hire new recruits rose to an average of 68 days in January but fell to an average of 58 days in March 2024, under the 62-day target.
- The number of formal employee relations cases rose in Q4 to 21. The average time to resolve these cases was c.67 days, below the 90-day target.

Report on Medical and Dental Disciplinaries

Committee members discussed a report covering the period, June 2019 to May 2024where medical or dental practitioners were the subject of formal disciplinary processes, including maintaining high professional standards (MHPS) in the NHS. The Committee noted that:

- During the last five years, nine doctors had been investigated via formal processes.
- All Whittington Health Case Investigators and Case Managers conducting disciplinary processes within the Trust have undertaken training on the disciplinary process.
- There was an even spread of male and female doctors in disciplinary processes with no obvious trend for ethnicity.
- Cases commonly took longer to investigate than the prescribed duration in the Trust Policy, particularly when annual leave and sickness absence were taken into account. However, doctors are kept informed of delays in writing by from the case manager.
- It was important to maintain an experienced cohort of case managers and investigators and to help them develop through internal and external learning opportunities.
- All but one of the cases were conduct allegations rather than capability.

	• No appeals of the outcomes of disciplinary hearings had been submitted during this period. The Committee welcomed the report and agreed that an annual report on medical and dental practitioners and the disciplinary process would be included on the Committee's forward plan. **Review of committee effectiveness and terms of reference** The Committee reviewed its assessment of effectiveness and agreed to the small changes in its updated terms of reference. **Q1 Board Assurance Framework – People entries** The Committee discussed the potential for decreasing the total score for the people 1 entry but concluded that this be left unchanged at a 20 score to reflect concerns on recruitment and retention and career progression for the time being. **Trust Risk Register** The Committee reviewed the register and discussed the two entries which covered the Barnet 0-19 service and staffing levels in physiotherapy services impacting adversely on plans to tackle the backlog. Committee members noted the work taking place in the Children and Young people's clinical division to mitigate staffing gaps in the Barnet 0-19 service.
2.	**Present:** Rob Vincent, Non-Executive Director (Committee Chair) Junaid Bajwa, Non-Executive Director Clare Dollery, Acting Chief Executive Clarissa Murdoch, Acting Medical Director Liz O'Hara, Chief People Officer Chinyama Okunuga, Chief Operating Officer Glenys Thornton, Non-Executive Director Terry Whittle, Chief Finance Officer Sarah Wilding, Chief Nurse and Director of Allied Health Professionals **In attendance:** Deborah Choudhury, Business Manager & Executive Assistant, Chief People Officer Tina Jegede, Joint Director of Inclusion & Lead Nurse, Islington Care Homes Charlotte Pawsey, Deputy Director of Workforce Kiran Sanger, Associate Director of Nursing and Haringey Borough Lead Angad Singh, Registrar, Gastroenterology Service Swarnjit Singh, Joint Director of Inclusion & Trust Company Secretary Eva Tinka, Head of Staff Wellbeing and Engagement Rowena Welsford, Deputy Director of Workforce Astrid von Volckamer, Learning & Organisational Development Manager

Appendix 1: Committee terms of reference

Workforce Assurance Committee	
1. 1.1 1.2 1.3	**Authority** The Board of Directors hereby resolves to establish a Committee to be known as the Workforce Assurance Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference, subject to any amendment at future Board of Directors' meetings. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires for any employee, and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by the Board to obtain outside legal or other professional Advice, if it considers this necessary, via the Trust Secretary.
2. 2.1	**Role** The role of the Committee is to provide assurance to the Trust Board that: • there is an effective structure, process and system of control for the governance of workforce matters and the management of risks related to them; • human resources services are provided in line with national and local standards and policy guidance and is in line with the Trust's strategic and annual corporate objectives; • the Trust's People Workforce Strategy is successfully implemented; and • the Trust complies with its obligations under all workforce related legislation including eWorkforce, diversity and human rights legislation.
3. 3.1	**Membership** The membership of the Committee shall comprise: • At least two Non-Executive Directors (one of whom shall Chair this Committee) • Director of Workforce (lead executive director for the committee) • Chief Nurse and Director of Allied Health Professionals • Medical Director • Chief Operating Officer • Chief Finance Officer • Director/s of Inclusion • Associate Director of Workforce • Deputy Director of Workforce • Assistant Director of OD and Learning

4.	**Quorum and attendance**
4.1	The Committee shall be deemed to be quorate if attended by any two Non-Executive Directors (NEDs) of the Trust (to include the Chair or designated alternate) and two executive directors. All NEDs can act as substitutes on all Board Committees.
4.2	In the event that an executive director member of the Committee is unable to attend a meeting, they are required to send a deputy director from their directorate in their stead.
4.3	The following members of staff will be in attendance at Committee meetings: • Integrated Clinical Service Unit 'Directors of Operations (will be invited) • Chief Allied Health Professional • Guardian of Safe Working Hours • Head of Organisational Development
4.4	The Secretary of the Committee will be the Personal Assistant to the Director of Workforce and they will keep a register of attendance for inclusion in the Trust's Annual Report.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. The Committee shall meet at least six times a year. The Committee Chair is able to call special meetings, if required.
6.	**Agenda and papers**
6.1	Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
6.2	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least one full week before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

7.	**Duties**
7.1	The Committee will carry out the following duties for the Trust Board: i. Keep under review the development and delivery of the Trust's People Workforce Strategy in response to the national People Plan to ensure performance management is aligned to strategy implementation. The Committee will ensure that the workforce is agile and adaptable so that the Trust can respond swiftly to changes in the external environment; ii. Receive details of workforce planning priorities that arise from annual business planning processes and to receive exception reports on any significant risks or issues; iii. Ensure that effective workforce enablers are put in place to drive high performance and Workforce improvement; iv. Review performance scorecard indicators for workforce–related matters; v. Monitor and evaluate Trust compliance with its statutory duty to produce an annual public sector eWorkforce duty report; vi. Review annual performance against the national workforce eWorkforce standards for race and disability and any other workforce standards established; vii. Review annual performance against the workforce domains of the NHS eWorkforce Delivery System viii. Monitor delivery of the workforce culture improvement plan; ix. Advise the Board on key strategic risks relating to workforce and employment practice and review their effective mitigation; x. Receive and review regular reports on human capital management including leadership capability, workforce planning, cost management, regulation of the workforce and their health and wellbeing; xi. Receive and review reports on the staff survey and ensure that action plans support improvement in staff experience and services to patients; and xii. Annually review and approve the terms of reference and membership of its key reporting forum, the Quality Governance Committee.
7.2	Non-Executive Director Committee members are asked to: i. Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision; ii. Review data on workforce on a regular basis and hold Executive Directors to account for ensuring that the right staff are in place to provide high Workforce care to patients; iii. Ensure that decisions taken at a Board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key Workforce and outcome measures; and iv. Understand the principles which should be followed in workforce planning and seek assurance that these are being followed in the organisation.

8.	**Reporting**
8.1	Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.
8.2	The draft minutes of Committee meetings shall be formally recorded and a Chair's assurance report presented at the next meeting of the Trust Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure, or executive action.
8.3	The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.
8.4	The Committee shall receive reports from the following Trust fora: • People Committee • Trust Partnership Group • Multidisciplinary team Recruitment & Retention Group • Health & Wellbeing Group • Junior doctor forum • Education Committee • Staff eWorkforce networks • Medical Staff Negotiating Committee (MNSC) • #Caringforthosewhocare programme
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.
9.3	These terms of reference were approved by the Board of Directors in May 2024 and will be reviewed, at least annually.

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2024**
Report title	**Freedom To Speak Up Guardian Report (April 2023 - March 2024)**	**Agenda item: 12**
Executive lead	Liz O'Hara, Chief People Officer	
Report author	Ruben Ferreira, Freedom to Speak Up Guardian	
Executive summary	This paper provides: • A brief overview of the work of the Freedom To Speak Up Guardian (FTSUG) from April 2023 to March 2024 and Q1, Q2, Q3 and Q4 Data • Updates and summaries on the National Guardian Office (NGO) Listening to Guardians Report (April 2023) and Annual Data Report (April 2022 to March 2023)	
Purpose	The report provides information about Freedom to Speak Up across Whittington Health with information covering the period April 2023 to September 2023	
Recommendation(s)	The Trust Board is asked to: i. encourage and promote with managers and senior leaders to engage with Freedom to Speak Up; ii. support the implementation of Freedom to Speak Up training to all staff; iii. support the recruitment of Speak Up Champions specially in services where they are not present; and iv. build a culture of safety and encouragement regarding raising concerns of any kind.	
Risk Register or Board Assurance Framework	BAF entry 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.	
Report history	Six monthly report presented to Whittington Health Trust Board	
Appendices	1: FTSU Guardian Survey (April 2023) 2023-FTSU-Guardian-Survey.pdf (nationalguardian.org.uk) 2: Annual Data Report (April 2022 to March 2023) 202223-Annual-Data-Report.pdf (nationalguardian.org.uk)	

1. Introduction

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

1.2. The National Guardian Office (NGO) works to make speaking up become business as usual in health. The office leads, trains and supports a network of Freedom to Speak Up Guardians in England and provides learning and challenges on speaking up matters to the healthcare system. Since the establishment of the NHS National Guardian's Office in 2016 following the recommendation of the Francis Review, there is now a wide-ranging network of more than 900 Freedom to Speak Up Guardians in England supporting workers in 514 organisations in primary and secondary care, the independent sector and national bodies.

2. Brief National overview / National Guardian Office reports

2.1 The **Listening to Guardians Report** (April 2023) from the National Guardian Office comprehensively analyses the experiences of Freedom to Speak Up (FTSU) guardians in the healthcare sector. The report's primary objective is to evaluate the existing speaking-up culture within organisations, as perceived by FTSU guardians, who play a pivotal role in listening to workers and addressing their concerns. An overall perception indicates that while most FTSU guardians expressed positivity about the speaking-up culture within their organisations, the report signals the need for further action to fortify and enhance the existing frameworks. The report highlighted positive aspects, including 84% of respondents acknowledging that their organisations actively address barriers to speaking up—an increase of nine percentage points from the previous survey. Additionally, three-quarters of respondents noted that their organisations do not tolerate detriment for speaking up. However, the report also uncovers concerns regarding FTSU. Notably, 66% of respondents identified the fear that nothing would be done as a significant barrier to workers speaking up, marking an 8-percentage point increase from the previous year. This places feelings of futility on par with the fear of detriment as a primary obstacle to speaking up.

2.2 Some of the Key Findings can be seen in more detail on appendix 1. The report also sheds light on the crucial role of leadership support for FTSU guardians and how it directly influences their effectiveness. Noteworthy points include: FTSU guardians must have access to senior leaders and decision-makers for effective performance. A lack of leadership support can undermine their ability to address barriers and escalate serious matters.

2.3 In conclusion, the report underscores the need for continuous effort, collective commitment, and sustained leadership support to foster a robust speaking-up culture in healthcare. It emphasises that the transformation of the speaking-up culture is a collective responsibility that requires urgent action to focus on the well-being of the healthcare workforce. The report serves as a call to action for all stakeholders to

prioritise and promote an environment where speaking up is encouraged and valued for the benefit of patients and workers.

2.4 The Annual Data Report from the NGO is comprehensive and covers cases reported to Freedom to Speak Up guardians from April 1, 2022, to March 31, 2023. The data, derived from non-identifiable information submitted by guardians to the National Guardian Office, reveals significant trends and insights. There was a notable 25% increase in reported cases, totalling 25,382 cases compared to the previous year.

3. Brief overview of the Whittington Health NHS Trust Freedom to Speak Up Guardian and Speak Up Network

3.1 The successful collaboration model between the Freedom to Speak Up Guardian and our Non-Executive Director (NED) for FTSU will serve as an example to future FTSU NEDs. Our collaborative work, characterised by continuous support, has positively impacted the Guardian´s well-being, safety, and overall work development and confidence. In response to a request from the National Guardian Office, our example will be utilised as a reference for the training of future FTSU NEDs. Our NED for FTSU is crucial in supporting the Guardian providing ongoing support and advice. In their role they are also responsible for addressing concerns with the Executive team. This collaborative model showcases the NED as a 'Guardian to the Guardian'.

3.2 The Guardian is taking proactive steps to enhance the effectiveness of the reporting system by engaging with the Datix team, Safeguarding, and PALS. This triangulation of information aims to provide senior leadership with a clearer picture for prompt action while also identifying areas of potential resistance to change. The Datix form has been updated to include the Guardian as a designated recipient for concerns.

3.3 Communication and visibility remain crucial, with the Guardian collaborating closely with the Communications Department to review media activity, ensuring broader outreach and clarification of roles.

3.4 Recognising the urgency of fostering a safe environment for employees to voice concerns, we have implemented a new and revised FTSU policy in alignment with national guidelines from NHS England and Education. This policy is designed to be accessible, user-friendly, and comprehensive, serving as a valuable tool for anyone seeking to raise concerns. It outlines various routes and key contacts available to assist individuals, ensuring a clear and supportive framework for addressing and resolving issues within our organisation.

3.5 The Guardian actively participates in key educational initiatives, including preceptorship study days, Newly Qualified Nurses Orientation Training, the Health Care Support Worker (HCSW) Development Programme, and medical education inductions. Through these engagements, the Guardian educates attendees on the safe and confidential means of raising concerns, elevating the visibility of FTSU. Additionally, the Guardian remains involved in the corporate induction day for new starters, and in instances of unavailability, Speak Up Advocates step in to provide coverage, further promoting their role and expanding their experience.

3.6 The FTSU Guardian and Human Resources (HR) Business Partners continue their close collaboration, listening and supporting colleagues in particular areas of concern.

3.7 The collaboration between the FTSUG, Head of Well-being and Staff Engagement and the Organisational Development (OD) team remains integral, fostering continuous learning and action on concerns received. This partnership enables the Trust to address cultural behaviours, bullying, harassment, and detriment in a serious, committed, and constructive manner, contributing to ongoing improvement in services and staff experience. The OD team actively participates in developing and training the Speak Up Advocates network. Additionally, the Freedom to Speak Up Guardian plays a key role in de-escalating conflicts, enhancing communication at both individual and team levels, and supporting the OD team in mediations, conflict resolutions and facilitated conversations.

3.8 The Guardian will resume the presentation of the FTSU report directly to the Trust Board and restart 121 meetings with the CEO.

4. Speak Up Champions' role and activity.

4.1 In order to align of Network with the national guideline we will be renaming the Speak Up Advocates to Speak up Champions. The terms Freedom to Speak Up 'Champion' should be used to describe the role which is designed to raise awareness and play a key part in making speaking up business as usual. The use of the term 'advocate' is no longer recommended as this can create confusion and a false expectation that there is a personal representative element to the role. Using 'champion' helps to create a clear distinction between this role and that of the Freedom to Speak up Guardian. From now, we will be referring the Speak Up Advocates as Champions.

4.2 Freedom to Speak Up Champions have a vital role in awareness raising, ensuring workers understand the importance of speaking up; listening up and following up.; signposting, discussing concerns with workers and providing details of speaking up routes as stated in their organisation's Freedom to Speak Up Policy; promoting a positive speaking up culture by supporting their organisation to welcome and celebrate speaking up. The National Guardian's Office recommends a clear distinction between the roles of champion and guardian. Only Freedom to Speak Up guardians, having received National Guardian's Office training and registered on the NGO's public directory, should handle speaking up cases. This ensures quality and consistency in how workers are supported when speaking up

4.3 The Guardian provides supervision and support to strengthen the Network of Speak Up Champions, which currently comprises 45 Champions, with over half being from a black and minority ethnic background (BAME). New Champions are actively sought to ensure continuity when some leave the Trust.

4.4 The Guardian regularly holds Network and one-to-one meetings with FTSU Champions, offering support and collecting valuable feedback from various areas. Contrary to previous trends of staff disengagement in raising concerns, there is now a noticeable increase in engagement and a rise in concerns. To further encourage this positive trend, the Guardian collaborates with Champions to visit teams and services throughout the Trust, actively listening to individuals, identifying barriers, and promoting a safe culture for raising concerns, enhancing overall engagement, visibility, and awareness of FTSU.

4.5 Our dedicated Speak Up Network has played a pivotal role in elevating the profile of Freedom to Speak Up through a series of impactful initiatives, notably during Speak Up Month. Committed Champions within the Network took a proactive stance by championing 'Green Wednesday' to enhance awareness, and these efforts were further amplified through shared photos on our social media platforms. The Speak Up Network stands as a driving force, emphasising the importance of promotion, visibility, education, and encouragement in cultivating a robust FTSU culture within our organisation. Their unwavering commitment contributes significantly to fostering an environment where every individual feels empowered to voice concerns safely.

4.6 We have successfully expanded our Speak Up Network by recruiting and training five additional Champions, each representing diverse services, professions, and cultural backgrounds. This ongoing recruitment and training initiative is pivotal in supporting areas lacking representation within the Network. Active and strategic recruitment increases awareness and knowledge about Freedom to Speak Up. It contributes to a cultural shift, fostering an environment where Speaking up is business as usual. Our continued priority is to ensure at least one Champion per ward, reinforcing our commitment to a widespread and representative FTSU culture.

4.7 We aim to recruit more Champions for the Community, raising the profile of FTSU and the role, in the upcoming community sites roadshow initiative in collaboration with the Head of Wellbeing and staff engagement. Speak Up champions should be appointed in a fair and open way to ensure confidence of workers within their organisation. Speak up Champions should have agreement from their line manager to undertake the role who should also be aware of the role expectations and the potential time commitment to carry it out. Local processes must offer assurance that there are no real or perceived barriers to anyone applying for or being appointed to the champion role. We aim to encourage applications from groups who may face additional barriers to speaking up. Examples include workers with a disability, those from minority ethnic backgrounds, agency or temporary workers, junior doctors and trainees.

5. Local concerns raised Q1 to Q4 (April 2023 to March 2024)

5.1. In the current reporting period (April 2023 to March 2024 - quarters one to four), the Freedom to Speak Up Guardian received 76 initial concerns that required action. Quarter 1 and 2 had 38 concerns and the same amount for Quarter 3 and 4 with 38 concerns. Notably, all of them were raised without anonymity. This absence of anonymous concerns underscores a noteworthy level of Trust in the FTSU as a secure and confidential channel for expressing concerns. While there is a slight increase in the number of concerns in Q4, it shows less concerns if compared to the preceding year (April 2022 to March 2023) when 84 initial cases were reported. The ongoing upward trend in concerns suggests a potential return to previous patterns, indicating a need for continued attention and analysis. For the first time, Q3 and Q4 shown a significant decrease of concerns being raised by register nurses and midwives. This professional group has been consistent in raising high numbers of concerns. This aspect requires further reflection and engagement with Senior nursing leaders to promote FTSU visibility and learning. On the other hand, it is noticeable an Increase of concerns raised by Administrative and clerical staff and Additional Clinical services. During this reporting period there were also concerns regarding senior leadership. The Guardian is worked with the support of the Non-Executive for FTSU and the CEO to address these concerns.

5.2. Table one shows cases received in Q1 and Q2 by Integrated Clinical Service Units (ICSU) and Corporate Directorates.

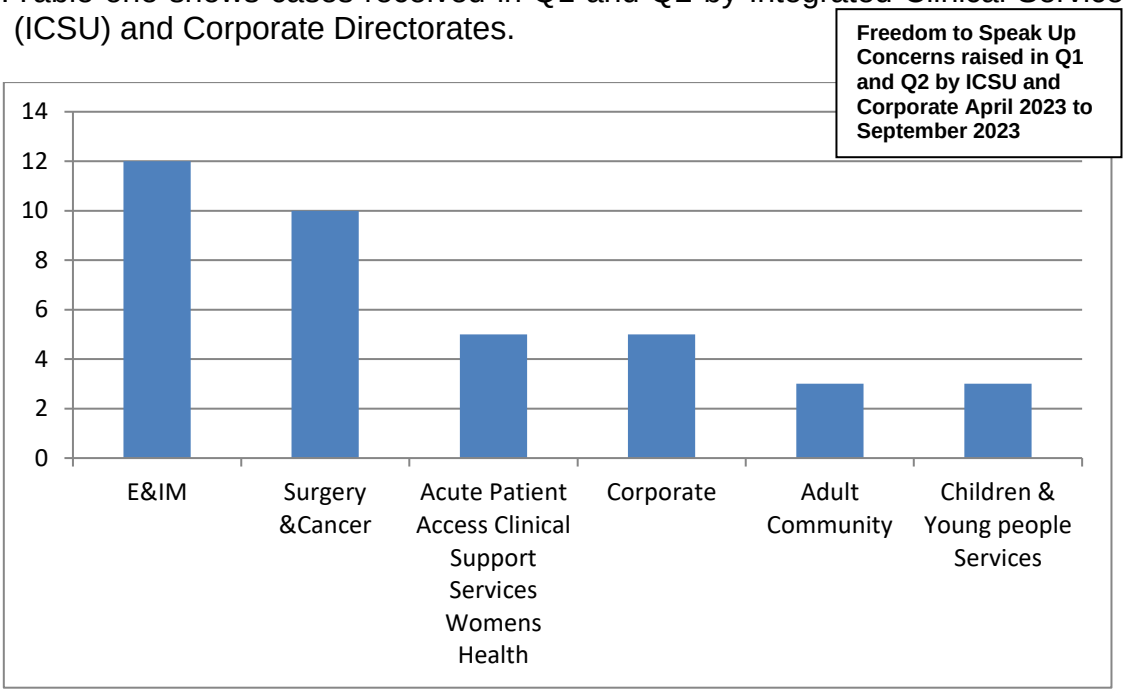


Table one: Freedom to Speak Up Concerns raised in Q1 and Q2 by ICSU and Corporate in April 2023 to September 2023

5.3. Table two shows cases received in Q3 and Q4 by Integrated Clinical Service Units (ICSU) and Corporate Directorates. We can notice a drop on concerns raised in E&IM and minor decrease in Adult Community and an increase in all the other ICSU mainly in Surgery and Cancer.

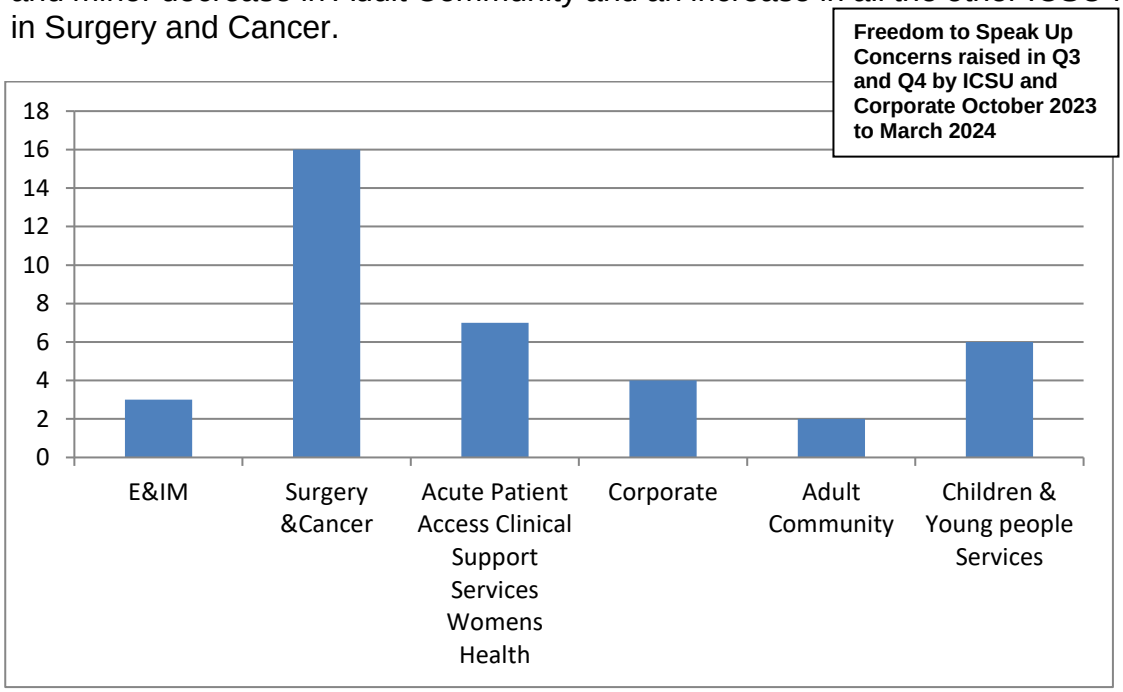


Table one: Freedom to Speak Up Concerns raised in Q3 and Q4 by ICSU and Corporate in October 2023 to March 2024

5.4. Table Three provides an overview of the themes raised during Q1 to Q4. Aligning with the guidelines set forth by the National Guardians Office, a new category was added: 'Workers Safety and Wellbeing'. This category entails any case that includes an element that may indicate a risk of adverse impact on worker safety or wellbeing. This

can be a current or past matter and may identify risks or actual events. Examples of worker safety or wellbeing could include Lone working arrangements, especially at night, Insufficient access to personal protective equipment, Stress at work, Unsuitable or insufficient risk assessment. The 'Attitudes and Behaviours' category has been replaced to enhance clarity. Also aligning with the guidelines set forth by the National Guardians Office, this category has now been divided into two distinct classifications: 'Bullying and Harassment' and 'Elements of Inappropriate Attitudes or Behaviours.' This reclassification aims to provide a more nuanced understanding of the nature of reported behaviours, offering improved categorisation for a comprehensive analysis. In the Q3 and Q4 we saw an increase of concerns raised regarding racism and discrimination, encompassed in the 'Bullying and Harassment' category. The Guardian is working with senior leaders, HR Business partners, See me First ambassadors and EDI lead to address and tackle these behaviours.

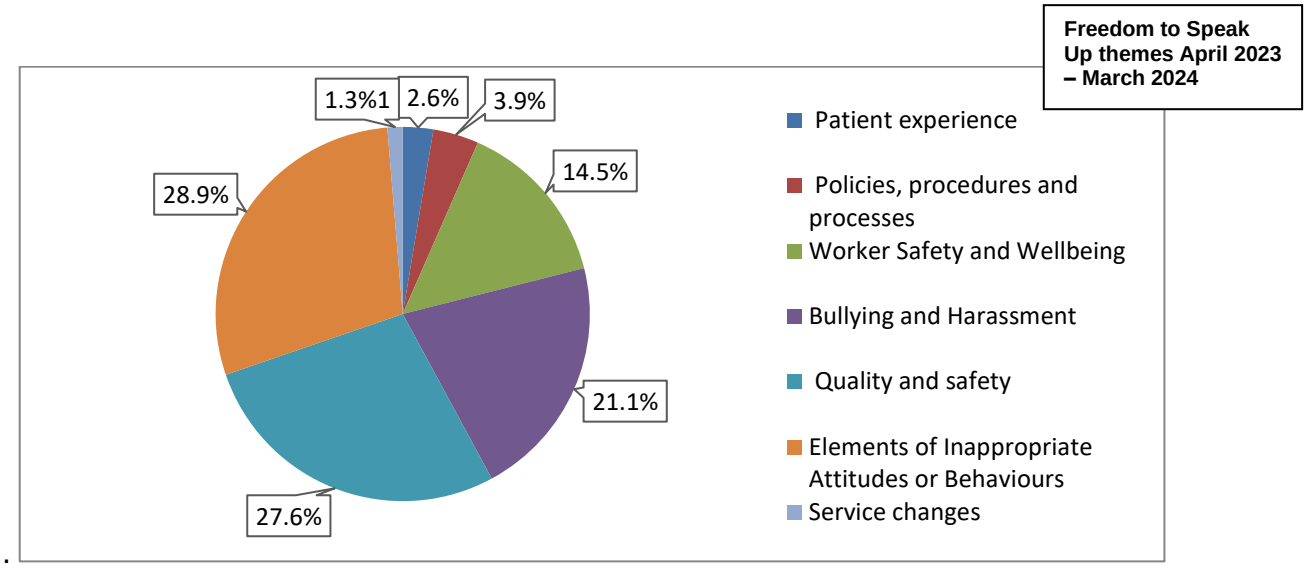


Table three: Freedom to Speak Up themes April 2023 – March 2024

5.5. Table four overleaf presents the ethnic background of staff raising concerns from April 2023 to March 2024. An important observation is that 57.9% of individuals raising concerns identify as Black and Asian Minority Ethnic (BAME). This notable increase highlights the significance of addressing BAME colleague's potential barriers to speaking up. The FTSU Guardian, in collaboration with the Joint Directors for Race, Equality, Diversity & Inclusion, See me First ambassadors and Staff Networks, is committed to reflecting on and learning from these known barriers. The ongoing efforts include increasing visibility and knowledge about FTSU and promoting the recruitment of Speak Up Advocates. Furthermore, 19.7% of concerns were raised by individuals identifying as White British, while 22.4% were from different White backgrounds.

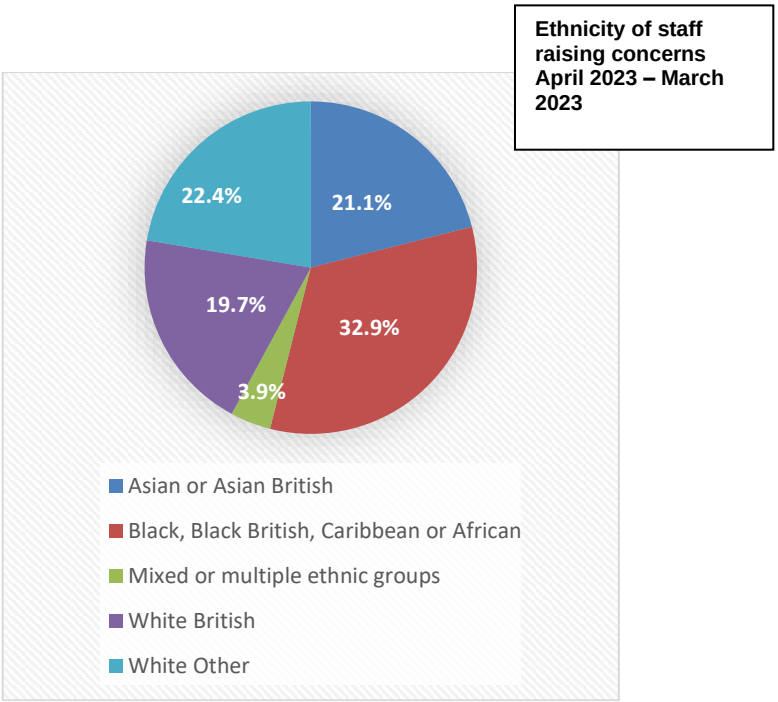


Table four: Ethnicity of staff raising concerns April 2023 – March 2024

5.6. Table five and six shows the number of cases raised by professional groups in Q1and Q2. These new professional/worker group categories are informed by Freedom to Speak Up Guardians feedback and based on NHS Digital's National Workforce data set. There is a noticeable positive increase in the number of concerns being raised by dental and medical professional groups. In table six showing Q3 and Q4, we see a significant drop on concerns raised by Register nurses and midwifes and a significant increase in professional groups such as Administrative and Clerical and Additional Clinical services.

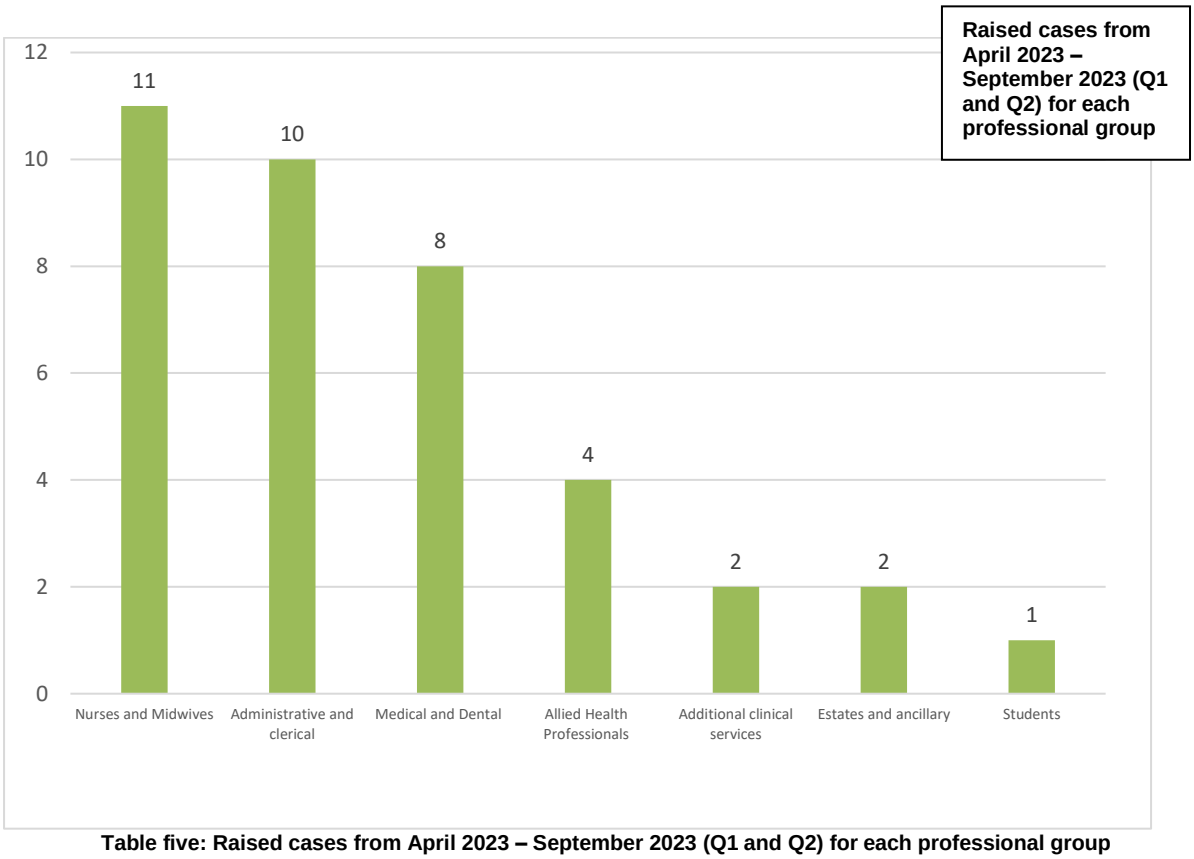


Table five: Raised cases from April 2023 – September 2023 (Q1 and Q2) for each professional group

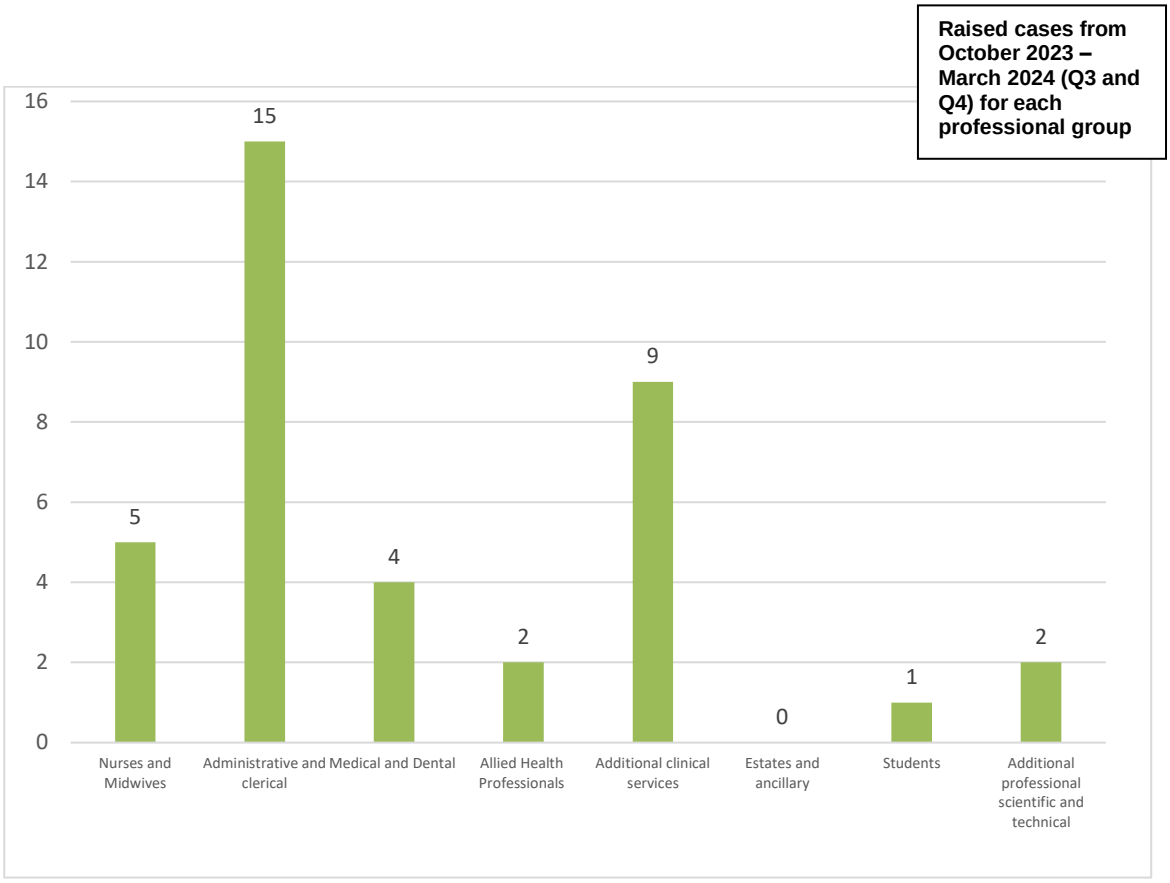


Table six: Raised cases from October 2023 – March 2024 (Q3 and Q4) for each professional group

6. Priorities for the next six months

6.1 The Guardian has identified several priorities for the next six months to re-enable staff engagement regarding raising concerns, and they include:

- In light of the identified challenges and opportunities for improvement in the speaking-up culture within the NHS, it is imperative to prioritise the implementation of Freedom to Speak Up in Health Care in England Programme training for all staff. For the next 6 months, we aim to make the **Speak Up** - Core FTSU training for all workers including volunteers, students and those in training, available on our FTSU intranet page and sent to all staff via Learning and Development. And, integrate the **Listen Up** – FTSU training for all line and middle managers in their training program. Finally, until the end of next financial year, we aim to implement the **Follow Up –** FTSU training for all senior leaders including executive board members and Non-Executive Directors.
- Continue regular weekly visits to community and hospital sites to maintain ongoing visibility of Freedom to Speak Up. Ensure that the FTSU Guardian is accessible and approachable during these visits to foster a culture of Trust and openness. The Guardian will participate in the Community Roadshow to enhance visibility and proximity.
- Continue supporting the recruitment of Speak Up Champions, focusing on areas not yet covered by the Network, being our main goal by the end of financial year, to recruit at least one Speak Up Champion per Clinical Ward, Finance and IT.
- Provide support and raise the FTSU profile in all the Staff Networks.

7. Recommendations

- Encourage prompt engagement from senior staff members, including executives and Senior managers, in addressing concerns raised through the FTSU. Engagement with the Guardian should occur within five working days and follow up to the person raising

concerns, no longer than 15 days after initial contact. Timely responses are significant in de-escalating problems, improving the quality of care, and enhancing the overall well-being of staff members.

- Foster a culture where senior leaders prioritise listening to and addressing concerns raised by staff, reinforcing the message that every voice matters. This proactive engagement sets a positive tone for the entire organisation, signalling a commitment to continuous learning, improvement, and prioritising the well-being of both staff and patients.
- Support the recruitment of Speak Up Champions until the end of financial year, and acknowledge the importance of providing protected time (within job roles) for the Advocates to support their colleagues.

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2024**
Report title	**Staff Survey 2023 Results**	**Agenda item: 13**
Executive lead	Liz O'Hara, Chief People Officer	
Report author	Mala Shaunak, Head of Organisational Development	
Executive summary	Every year NHS England commission a national NHS staff survey to be run in every NHS organisation. This is the thirteenth year for Whittington Health as an integrated care organisation (ICO), and the sixth in which all staff have been invited to respond. To ensure confidentiality, NHS England require that an approved, independent company manages the survey process and data. Whittington Health used Picker to run the 2023 staff survey, to protect confidentiality Picker do not release results where the response group received less than ten responses. The Trust, along with other Integrated Care Organisations (ICOs), is benchmarked with 'acute and acute and community' trusts. The results are organised into themes aligned to the People Promise. However, this year, the data under the People Promise theme of 'We are safe and healthy', needs to be treated with caution as nationally there was an issue with the data quality, which means not all respondents may have provided an answer to some of the questions under this theme. This report provides a detailed summary of the results and compares them under the People Promise theme headings with results from previous years, where available. It provides details of proposed steps for developing action plans. It will also compare the Staff Survey 2022 results and discuss the improvements that have been made and activities undertaken based on the People Promise themes to support staff engagement.	
Purpose:	This paper is for information, discussion, and decision	
Recommendation(s)	Board members are asked to: - Note the content of this report following the results of the 2023 NHS Staff Survey - Agree the Trust-wide priorities for 2023/24 which will increase morale, engagement, and support staff retention. These priorities will be the themes for Trust-wide listening events. - The People Promise themes and area of focus include: • We are safe and healthy, particularly the view that the organisation is not doing enough to support health and wellbeing. • We work flexibly, particularly around having support for better home and work life balance.	

	• Morale, particularly the reasons for staff thinking about leaving the organisation.
BAF entries	• People 1 - staff recruitment and retention • People 2 - staff wellbeing, engagement and equity, diversity and inclusion
Report history	Staff Survey result reports are provided annually
Appendices	Appendix 1 – Response Rate Appendix 2 – Respondent Details Appendix 3 – OD Leadership Offer Appendix 4 – Communications Plan Appendix 5 - Four step guide and templates for Managers

Staff Survey 2023 Results

1.0 Introduction

1.1 This is the thirteenth year in which Whittington Health as an Integrated Care Organisation (ICO) has conducted the national staff survey and the sixth year in which the Trust opted to invite all eligible staff to complete it. It is the third year Whittington Health has opted to run the survey online only, which meant everyone received an online questionnaire via a personal link sent by email. This paper summarises the results of the survey, draws out key comparative data and provides details of the proposed steps for updating staff and developing action plans.

1.2 The 2023 NHS England-commissioned survey was sent to all staff in 122 NHS organisations. In 2023, 477, 643 staff nationally responded with a median response rate of 45%.

1.3 The findings from this NHS survey will be considered alongside the progress made on the five Trust-wide improvement areas from the 2022 Staff Survey. The analysis of these results will be discussed with the Trust Management Group (TMG) to agree priorities and the overall approach to the development of a staff survey action plan.

1.4 The Trust commissions the Picker Institute to run its survey, as do a further 62 other Acute and Acute & Community Trusts. In addition to the national comparisons, we have access to reports at ICSU, directorate and individual service levels for a more detailed and local analysis. Nationally, Whittington Health was benchmarked against a total 122 similar Trusts.

1.5 This is the third year the survey results are aligned to the People Promise. There are seven People Promise elements. A total of 118 questions were asked in the 2023 survey, of these, 113 can be compared to 2022 and 100 can be positively scored. The results include every question where Whittington Health received at least ten responses, which is the minimum required.

1.6 This year, the data under the People Promise of 'We are safe and healthy', needs to be treated with caution as there was a national issue with the data quality. Results for questions 13a-d are absent. These questions ask about the experience of physical violence at work. This is currently under investigation by the Survey Coordination Centre and NHS England, and they will produce results at an organisational and aggregated level at the earliest opportunity. For Whittington Health, Picker estimates that approximately 129 respondents (6% of our total) may not have provided an answer to Q13a-d, because of this issue.

1.7 The 2023 survey asked three new questions which included the following themes: experience of unwanted sexual behaviour, availability of nutritious and affordable food, and frequency of home working. The COVID19 questions were removed from the 2023 staff survey.

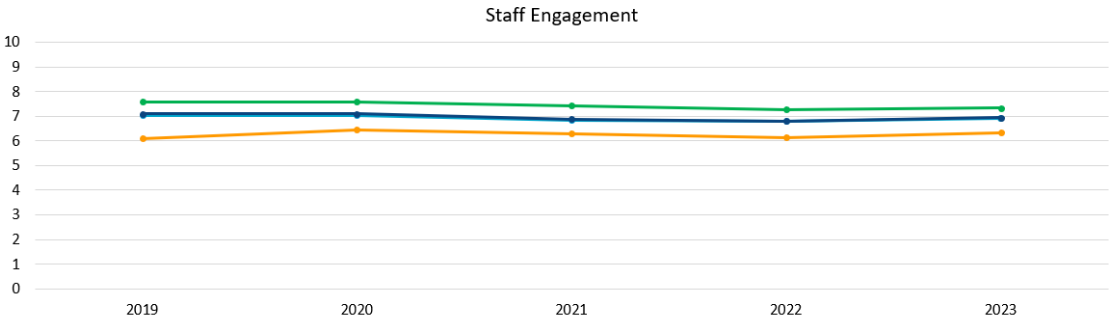
2.0 Response and Respondent Details

2.1 A total of 2123 staff out of Whittington Health's (WH) 4865 eligible staff completed the survey. This equals a response rate of 44**%**, this is 2% below the Picker average of 46% for Acute and Acute & Community trusts. Despite an additional 104 staff completing the survey in 2023 compared to 2022, the actual response rate was down by 1% due to the increased number of eligible staff (**appendix one**).

2.2 Details on the respondents' demographics and occupational groups can be found in **appendix two**.

3.0 Staff Engagement Indicator

3.1 Whittington Health's staff engagement score is 6.94, which is slightly higher than the Picker average of 6.91. This has also been an improvement since the previous two years, which was 6.89 in 2021 and 6.81 in 2022.



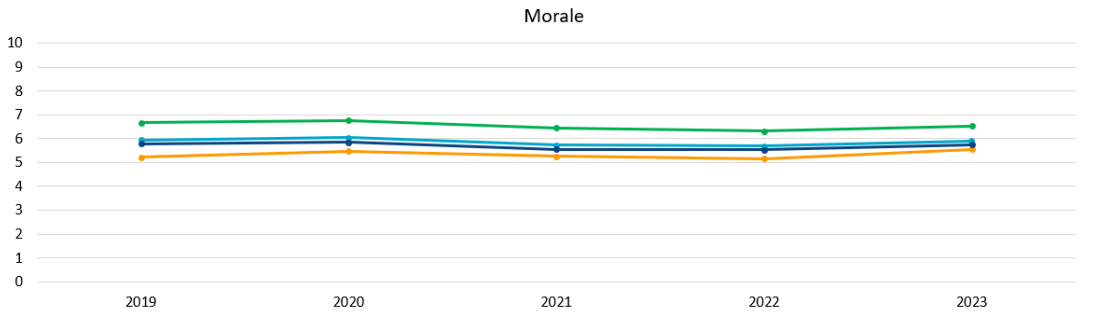
	2019	2020	2021	2022	2023
Your org	7.10	7.10	6.89	6.81	6.94
Best result	7.58	7.59	7.44	7.28	7.32
Average result	7.04	7.03	6.84	6.80	6.91
Worst result	6.10	6.45	6.30	6.13	6.34
Responses	2334	2164	2265	2018	2118

3.2 The three key findings that make up the Engagement score are:

- Advocacy: Staff recommendation of the trust as a place to work or receive treatment
- Motivation: Staff motivation at work
- Involvement: Staff ability to contribute towards improvements at work

3.3 Staff Morale Indicator

3.4 Whittington Health's score for staff morale is 5.74, slightly below the Picker average of 5.91. However, this result is an improvement from the morale score of the last two years, which was 5.56 in 2021 and 5.52 in 2022.



	2019	2020	2021	2022	2023
Your org	5.78	5.84	5.56	5.52	5.74
Best result	6.66	6.76	6.46	6.31	6.52
Average result	5.95	6.04	5.74	5.69	5.91
Worst result	5.23	5.47	5.26	5.17	5.54
Responses	2320	2151	2255	2017	2120

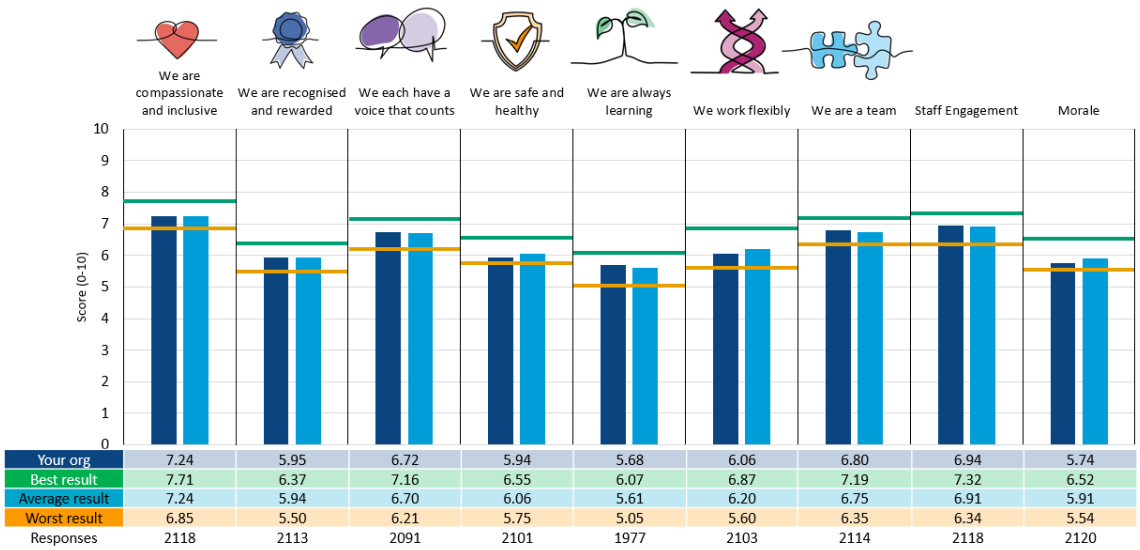
3.5 The key findings that make up the morale score are:

- Staff retention/turnover – thinking about leaving the organisation
- Work pressures
- Stressors

3.6 Ranking Scores for Acute and Acute & Community Trusts

The reporting shows Whittington Health results against the seven People Promise elements and against the themes of staff engagement and morale.
Results are presented in the context of the 'best', 'average' and 'worst' results for the total 122 Acute and Acute & Community Trusts.

3.7 Whittington Health – 2023 Overall People Promise Results



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.24	5.95	6.72	5.94	5.68	6.06	6.80	6.94	5.74
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	2118	2113	2091	2101	1977	2103	2114	2118	2120

3.8 In 2023 Whittington Health is not ranked as 'worst' or 'best' in any of the themes. The Trust is slightly above average for the themes of: We are recognised and rewarded, We each have a voice that counts, We are always learning, We are a team and Staff Engagement. The Trust is average for one theme: We are compassionate and inclusive. The Trust has scored slightly below average for the themes of: We are safe and healthy, We work flexibly, and Morale.

4.0 The following section highlights the executive summary of findings, with the top and bottom scores for Whittington Health (WH) in comparison to the other Acute and Acute and Community Trusts across the NHS, as well as the most improved and most declined areas since 2021.

4.1 Areas with Significant Change (improved or declined scores)

4.2 Most Declined Scores

The below table indicates the most declined areas in comparison to the 2022 staff survey results. Q11a also featured in the most declined scores for the 2022 results. We are better than the NHS average in q9c and q9d, as well as average for q20a, although they are our most declined scores.

People Promise Element or theme	Question	Org 2023	Org 2022
We are safe and healthy	Q11a. Organisation takes positive action on health and well-being	50%	51%
We are a team	Q9c. Immediate manager asks for my opinion before making decisions that affect my work	63%	64%
We each have a voice that counts	Q20a. Would feel secure raising concerns about unsafe clinical practice	70%	71%
We are a team	Q9d. Immediate manager takes a positive interest in my health & well-being	70%	71%
Staff Engagement	Q2c. Time often/always passes quickly when I am working	73%	74%

4.3 Most Improved Scores

The table below shows the top five most improved scores for 2023 in comparison to 2022. We have seen improvements since 2022 in q4c *satisfied with level of pay* and q3h *have adequate materials, supplies and equipment to do my work*, which both featured in the most

declined scores for 2022. In addition, we have seen improvements in q10c *don't work any additional unpaid hours per week for the organisation, over and above contracted hours,* which featured in the bottom 5 scores for 2022. Q10c and Q3h were part of the Trust-wide five improvement areas for 2022.

People Promise element or theme	Question	Org 2023	Org 2022
We are safe and healthy	q3i. Enough staff at organisation to do my job properly	31%	23%
We are recognised and rewarded	q4c. Satisfied with level of pay	27%	21%
Not themed	q10c. Don't work any additional unpaid hours per week for the organisation, over and above contracted hours	41%	35%
We are safe and healthy	q3h. Have adequate materials, supplies and equipment to do my work	51%	46%
We are safe and healthy	Q11c. In last 12 months, have not felt unwell due to work related stress	58%	53%

4.4 Top 5 Scores in Comparison to the Picker Average for Acute and Community Trusts

The below table shows the top 5 scores for Whittington Health in comparison to the Picker average scores for NHS organisations, similar to Whittington Health. Q10b and q5c also featured in the top 5 scores for 2022 and both have improved by another 2%.

People Promise element or theme	Question	Org	Picker average
Not themed	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	74%	63%
Morale	Q5c. Relationships at work are unstrained	53%	47%
We are compassionate and inclusive	Q25b. Organisation acts on concerns raised by patients/service users	74%	69%
We are a team	Q7b. Team members often meet to discuss team's effectiveness	66%	61%
Not themed	Q19d. Feedback given on changes made following errors/near misses/incidents	64%	60%

4.5 Bottom Five Scores for Whittington Health in Comparison to the Picker Average.

The table below shows the bottom five scores for Whittington Health in comparison to the NHS average. We can see that there has been slight improvement in q31b on Disability: organisation made reasonable adjustment(s) to enable me to carry out work by 2% since 2022, which was one of the focus areas for Trust last year.

People Promise element or theme	Question	2023	Picker Average
Not themed	Q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	66%	74%
Not themed	Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	41%	48%
Morale	Q26b. I am unlikely to look for a job at a new organisation in the next 12 months	45%	52%
We are safe and healthy	Q11a. Organisation takes positive action on health and well-being	50%	57%
Morale	Q26c. I am planning on leaving this organisation	51%	58%

5.0 Equalities Indicators from the Staff Survey

5.1 In its fifth year, Workforce Disability Equality Standards (WDES) breakdowns are based on the responses to questions *Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?* The questions related to WDES results remain historically comparable since 2019, but the WDES labels have been updated to better reflect the new wording of the question, for example the word *'disability'* has now been replaced by *'long-term condition (LTC) or illness'.*

5.2 WDES (Workforce Disability Equality Standards) Indicators Reported in the Staff Survey for Whittington Health

5.3 The WDES table below shows **improvement** in **five out of the nine WDES indicators**, this includes: a decrease in staff with a long-term condition (LTC) or illness, who experience bullying or abuse from patients, managers or colleagues; staff with LTC or illness saying that they have felt pressure from their managers to come to work, despite feeling unwell; staff with LTC or illness feeling satisfied with the extent to which their organisation values their work; staff with LTC or illness saying that their employer has made adequate reasonable adjustments for them; and an increase in the staff engagement score of 0.1.

5.4 Significant effort from the Inclusion team has gone into improving reasonable adjustments for staff since the staff survey results of 2022, such as the holding of a Trust-wide listening event dedicated to this improvement area, the improvement of reasonable adjustment training, and further guidance to managers on how to carry out reasonable adjustments for staff.

5.5 However, two out of the nine WDES indicators have shown a decline since last year, these include the reporting of harassment, bullying or abuse at work of a staff with LTC or illness (by self or colleague), and staff with LTC or illness believing that their organisation provides equal opportunities for career progression or promotion.

WDES (Workforce Disability Equality Standards) indicators reported in the Staff Survey Results 2023

The table below provides a comparison of the Workforce Disability Equality Standard (WDES) results in 2022 and 2023. WDES results are based on a series of indicators, of which 4, 5, 6, 7, 8 and 9 are drawn from the NHS Staff Survey. Each 2023 response has been colour graded, green indicates a positive improvement for staff with a Long-Term Condition (LTC) or illness and red indicates a decline from the previous year.

	Table to show WDES Indicators		2022		2023	
Indicator	**Question**	**Description**	**LTC or illness**	**WITHOUT LTC or illness**	**LTC or illness**	**WITHOUT LTC or illness**
4a	Q14a Q14b Q14c	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients, Managers or Colleagues	53.1%	38.7%	50.9%	37.7%
4b	Q14d	Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or colleague reported it	46.5%	47.7%	44.6%	51.5%
5	Q15	Percentage of disabled staff compared to non-disabled staff believing that their trust provides equal opportunities for career progression or promotion	40.1%	51.8%	39.4%	54.2%
6	Q11e	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their managers to come to work, despite not feeling well enough to perform their duties	29.5%	20.7%	29.2%	19.2%
7	Q4b	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	34.7%	45.6%	38.4%	49.6%
8	Q30b	Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	64.7%	N/A	66.1%	N/A
9a	E_4	Staff engagement score (0-10)	6.3	7.0	6.4	7.1

5.6 WRES (Workforce Race Equality Standards) Indicators Reported in the Staff Survey Results 2023

5.7 In its sixth year of reporting there are four indicators comparing the experience of Black, Minority, Ethnic staff (B.M.E) and white staff in Whittington Health. This table shows a comparison of the Workforce Race Equality Standard (WRES) indicators over a six-year period. Each 2023 response is graded in green if there has been an improvement for B.M.E staff; or red, if there has been a decline compared to the previous year.

5.8 The table below shows **improvement** in **three out of the four WRES indicators** i.e. the percentage of BME staff experiencing harassment, bullying or abuse from staff; BME staff believing that the organisation provides equal opportunities for career progression or promotion; and BME staff experiencing discrimination at work from manager/team leader or other colleagues. Fairness in career progression for BME staff has shown the greatest improvement and this reflects the increased career development opportunities available across the Trust for example the Band 2-7 BME Career Development Programme, as well as the Trust-wide listening event held last year. However, there has been a **negative increase** in staff experiencing harassment, bullying or abuse from patients, relatives, or the public of 0.7%.

Table to show WRES Indicators	2018		2019		2020		2021		2022		2023	
Question	**BME staff**	**White staff**	**BME staff**	**White staff**	**BME staff**	**White staff**	**BME staff**	**White staff**	**BME staff**	**White staff**	**BME staff**	**White staff**
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	35.9%	30.5%	32.5%	30.6%	30.3%	28.9%	28.6%	27.9%	29.3%	30.4%	30.0%	27.2%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	36.2%	31.4%	31.9%	29.9%	29.7%	24.2%	27.7%	25.7 %	25.4%	24.3%	25.1%	21.6%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	35.8%	56.2%	39.7%	58.2%	39.7%	56.4%	39.9%	54.4 %	41.2%	57.5%	46.3%	56.4%
Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	20.3%	9.5%	16.1%	7.8%	16.9%	8.2%	15.2%	8.3%	15.0%	9.4%	11.8%	7.4%

6.0 Whittington Health Directorate/ICSU Report

6.1 The directorate/ICSU results for Whittington Health contain the results by directorate or ICSU for People Promise elements and theme results from the 2023 NHS Staff Survey. The below directorate results are compared to the unweighted average for the organisation.

Directorate/ICSU Reporting

**Each 2023 theme score for ICSUs and Directorates is graded in green if the score is above organisational average, and red where the score is below organisational average. Where an ICSU or Directorate has scored the same as the organisation's average it is graded black.*

Theme	WH Overall	ACW	ACS	COO	CYP	EIM	Facilities	Finance	IT	Medical Dir.	Nursing & Patient Exp.	Procurement	S&C	Trust Secretariat	Workforce
We are compassionate and inclusive	7.3	6.9	7.4	6.9	7.8	7.2	6.9	7.2	7.1	7.4	7.5	7.4	7.1	7.4	8.1
We are recognised and rewarded	6.0	5.5	6.1	6.2	6.5	5.8	5.8	6.3	5.5	6.4	6.5	6.3	5.7	6.6	7.2
We each have a voice that counts	6.8	6.3	6.9	7.4	7.2	6.7	6.5	6.7	6.5	6.6	7.3	6.9	6.6	7.0	7.2
We are safe and healthy	6.0	5.8	5.9	5.9	6.2	5.6	6.1	6.6	6.1	6.6	6.4	6.6	5.7	6.2	7.1
We are always learning	5.7	5.0	6.0	5.9	6.0	5.9	5.6	5.1	5.4	5.4	5.8	5.6	5.4	6.8	6.4
We work flexibly	6.2	5.4	6.2	6.2	6.7	5.9	6.4	6.9	6.2	6.1	6.5	6.6	5.7	7.2	8.0
We are a team	6.9	6.3	7.0	6.7	7.3	6.7	6.3	6.6	6.6	7.2	7.2	7.0	6.5	7.1	7.8
Staff Engagement	6.9	6.6	6.9	7.2	7.3	6.9	6.8	7.0	6.6	6.9	7.4	7.1	6.9	7.0	7.6
Morale	5.8	5.3	5.7	6.3	6.0	6.7	5.8	5.9	5.5	6.0	6.1	6.2	5.9	5.5	6.6

7.0 Communications, and Developing Action Plans

7.1 The Organisational Development Team along with the Communications Team have a proposed timeline for internal and external communications and developing action plans across the ICSUs and Directorates. For further information please see **appendix four.**

7.2 These plans will continue to be supported by organisational-wide initiatives such as: the ICARE Leadership Programme; Career Development programmes; the Inclusion Steering Group; Coaching; and wellbeing support through the Head of Wellbeing.

8.0 Current Developments and Future Plans

8.1 Last year, the Organisational Development team hosted five listening events alongside the Executive team focusing on the five Trust-wide improvement areas which included two of the People Promise themes: '*we are safe and healthy';* and '*we are compassionate and inclusive'*. After each listening event, an action plan was created by key stakeholders, executive leads, and subject matter experts, to help implement changes across the Trust.

8.2 As a result of these listening events, we have seen improvements in the 2023 results in the following four areas: having adequate materials; don't work any additional unpaid hours; career progression: reasonable adjustments. However, this year we have seen a slight decline in staff feeling that the organisation takes positive action on health and wellbeing.

Five Trust-Wide Improvement Area	People Promise theme	Staff Survey 2022 Results	Staff Survey Results 2023
1. Fairness in career progression	We are compassionate and inclusive	49% of staff believe our organisation acts fairly on career progression.	50% of staff believe our organisation acts fairy on career progression ↑
2. Working additional unpaid hours	Not themed	65% of staff are working additional unpaid hours.	57% of staff are working additional unpaid hours. ↑
3. Improving wellness at work	We are safe and healthy	51% of staff felt that the organisation takes a positive action on health and wellbeing.	49% of staff felt that the organisation takes positive action on health and wellbeing. ↓
4. Making reasonable adjustments for staff	Not themed	65% of staff felt that the organisation made reasonable adjustment(s) to enable them to carry out work with their disability.	66% of staff felt that the organisation made reasonable adjustment(s) to enable them to carry out work with their disability. ↑
5. Having adequate materials and supplies to do the job properly	We are safe and healthy	46% of staff felt that they had adequate materials, supplies and equipment to do their work properly.	52% of staff felt that they had adequate materials, supplies and equipment to do their work properly. ↑

8.3 The Organisational Development team has recognised that interpreting the results and data from the Staff Survey can be challenging for busy managers, and therefore they have produced a guide to support managers and the ask is to focus on improving one people promise theme in every team (**appendix five**). The Organisational Development team have

also started to offer Team Coaching sessions around the Staff Survey data to support action plans as well as supported managers in hosting local listening events to unpick the data.

9.0 Staff Survey Activities against the People Promises

9.1 We are Compassionate and Inclusive

Last year, the Organisational Development team hosted a culture conference with Professor Michael West, lead expert in compassionate and inclusive cultures for healthcare, as guest speaker. This event was attended by over 100 staff and promoted the value of the Staff Survey, during the time that the survey was open for staff to complete. In addition, coaching and team coaching sessions have been taking place across the Trust to support staff in their teams and roles. Furthermore, new training modules for 2024/25 are also aligned to this theme (**appendix three**). Evidence from other Trusts has shown that high scores in this People Promise theme result in higher levels of staff engagement.

9.2 We are Recognised and Rewarded

The extra mile monthly staff excellence award has been introduced to recognise colleagues who exceed the normal expectations in their day-to-day work. In 2023, special celebration events were held for staff who were celebrating a long service milestone. During COVID19, celebration events for learners had paused, last year the Organisational Development team re-introduced these celebration events for learners, giving recognition and signed certificates from the CEO to those that have completed programmes such as B2-7 BME Career development programmes or apprenticeships.

During the summer of 2023, the Executive team individually thanked and praised managers of teams that had scored well in the Staff Survey 2022 results, this included thank you emails, dropping into a team meeting or sending cards.

9.3 We each have a Voice that Counts

The Organisational Development team have worked closely with the Communications team on the Staff Survey to make it a year-long campaign. A new recognisable Staff Survey brand called ‘Your Voice Matters’ was created which focused on increasing the faith in the survey. Staff Survey messages were featured in CEO briefings, on the intranet homepage, in the noticeboard, calendar invitations were created and listening events were held from July-November 2023. A dedicated intranet page was created on the Organisational Development page to ensure that staff have access to the Staff Survey results and updates. In addition, to support the Trust-wide direction of becoming a listening organisation, similar promotions were also done for the National Quarterly People Pulse survey.

9.4 We are Safe and Healthy

The Organisational Development team worked with the WhitAbility network to refresh the Wellbeing Conversations paperwork last year. This ensured that meaningful conversations were taking place across the Trust. In addition, refresher training for the mental health first aiders took place. Furthermore, the new Head of Staff Wellbeing & Staff Engagement was welcomed into the Trust in Autumn 2023, and strategic plans have started to be developed to support the wellbeing of staff.

9.5 We are Always Learning

The leadership development training offer has been re-designed in line with the ICARE values to focus on aspiring leaders, emerging leaders, established leaders and executives/board (**appendix four**). This includes refreshed training modules that are aligned to the staff survey results such as assertiveness and setting boundaries training, situational leadership and giving and receiving feedback.

Following on from the success of the B2-7 BME Career Development programme, a fourth cohort will take place in Autumn 2024. Following the listening event for fairness in career

progression, the Organisational Development team alongside the Inclusion and HR team, have also successfully commissioned for a new Band 8A and above BME leadership development programme called 'Working Uphill' to take place in Summer 2024. This programme will explore the challenges and lived experiences of senior leaders in the organisation and will be delivered by BRAP – a charity transforming the way we think and do equality.

9.6 We work Flexibly

A new 'stop the clock' resource document was created to support managers and team members to have conversations around their working hours, as well as explore what changes could be made for staff that are working over their contracted hours.

9.7 We are a Team

The Organisational Development team have offered team interventions and team coaching sessions to twenty teams across the Trust in 2023, focusing on the themes of team working, leadership, morale, and resilience. Additionally, further training has taken place to expand the pool of internal mediators for the Trust, as well as additional dates have been put in for the Restorative Conversations training. CPD and supervision sessions have been put in place to support internal Coaches that are supporting teams and individuals.

10.0 Recommendations

Members of the Trust Management Group are asked to:

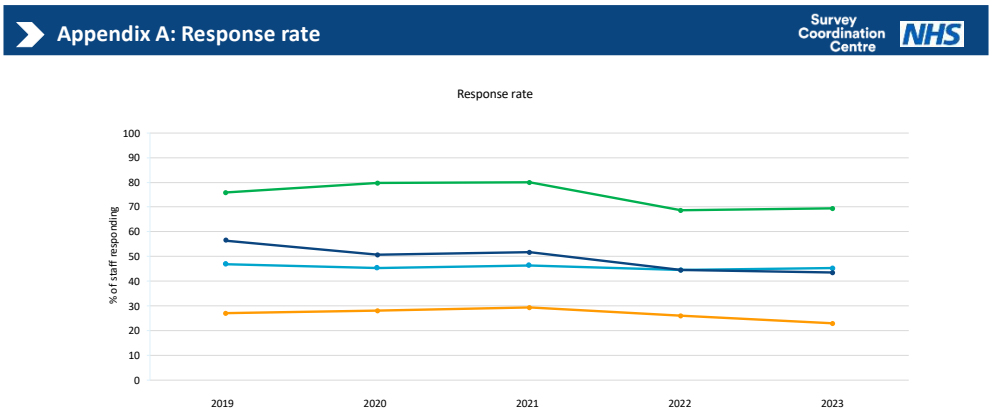
- Note the content of this report following the results of the 2023 NHS Staff Survey

- Agree the Trust-wide priorities for 2024/25 which will support staff retention and increase morale and engagement. These improvement areas will form the themes for Trust-wide listening events.

- The People Promise themes and area of focus include:

  - We are safe and healthy, particularly the view that the organisation is not doing enough to support health and wellbeing.
  - We work flexibly, particularly around having support for better home and work life balance.
  - Morale, particularly exploring the reasons for staff thinking about leaving the organisation.

Appendix 1 – Response Rate

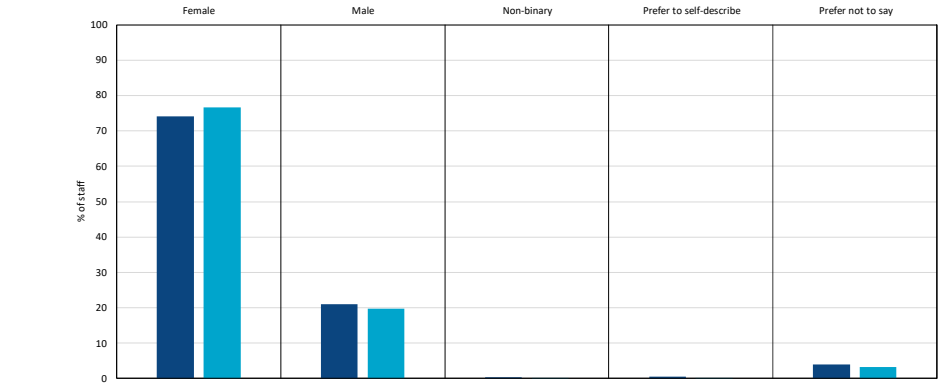


Response rate

	2019	2020	2021	2022	2023
Your org	56.40%	50.69%	51.77%	44.68%	43.64%
Highest	75.96%	79.77%	79.95%	68.69%	69.45%
Average	46.93%	45.43%	46.38%	44.46%	45.23%
Lowest	27.20%	28.09%	29.47%	26.17%	23.03%
Responses	2350	2198	2301	2019	2123

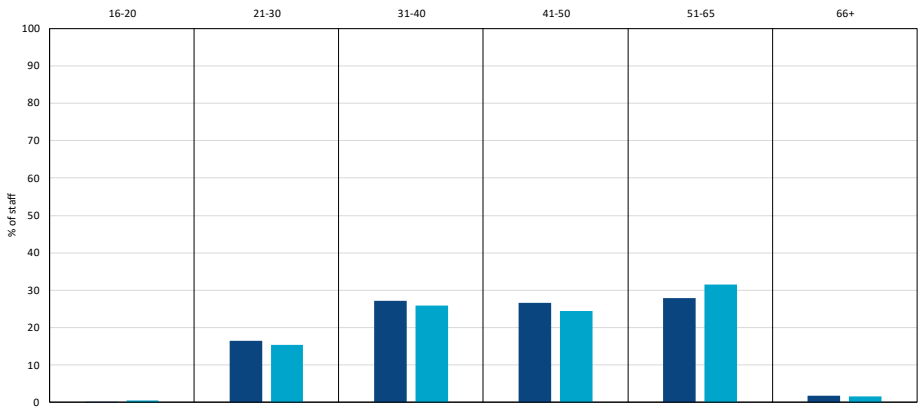
Appendix 2 – Respondents Details

Demographics - Gender



	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say
Your org	74.14%	21.06%	0.43%	0.48%	3.90%
Average	76.60%	19.78%	0.24%	0.18%	3.22%
Responses	2104	2104	2104	2104	2104

Demographics - Age

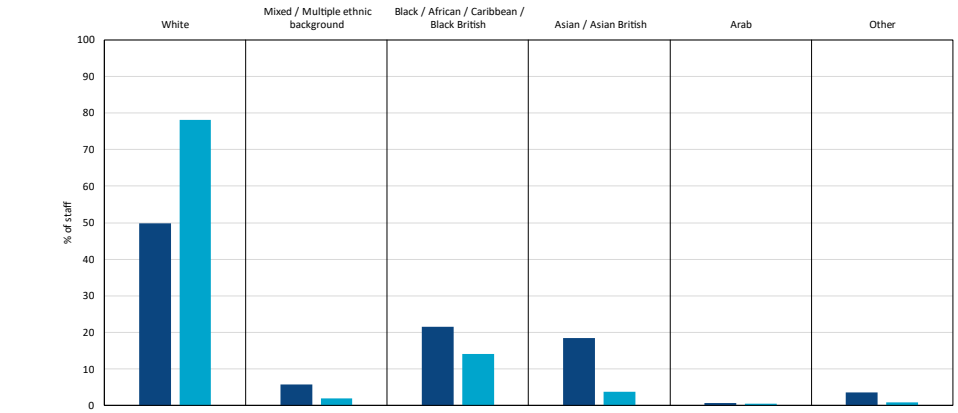


	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.05%	16.48%	27.11%	26.58%	27.92%	1.86%
Average	0.55%	15.42%	25.91%	24.51%	31.50%	1.70%
Responses	2099	2099	2099	2099	2099	2099

Demographics – Ethnicity

Background details - Ethnicity

Survey Coordination Centre NHS

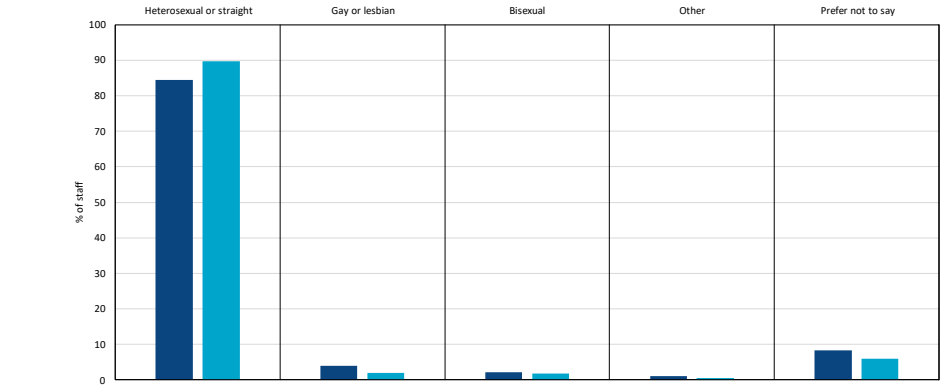


	White	Mixed / Multiple ethnic background	Black / African / Caribbean / Black British	Asian / Asian British	Arab	Other
Your org	49.83%	5.76%	21.49%	18.47%	0.77%	3.69%
Average	78.07%	1.97%	14.15%	3.83%	0.44%	0.84%
Responses	2085	2085	2085	2085	2085	2085

Demographics – Sexual Orientation

Background details – Sexual orientation

Survey Coordination Centre NHS

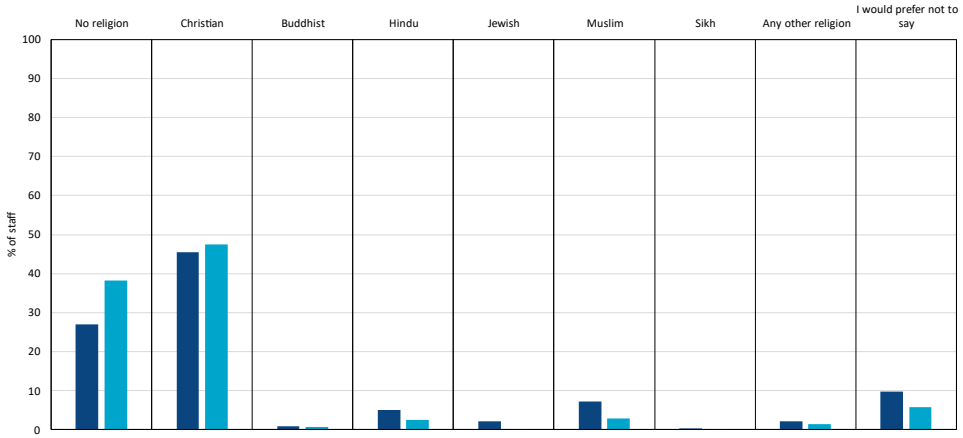


	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Prefer not to say
Your org	84.48%	4.00%	2.09%	1.05%	8.38%
Average	89.71%	2.00%	1.84%	0.52%	5.94%
Responses	2101	2101	2101	2101	2101

Demographics – Religion

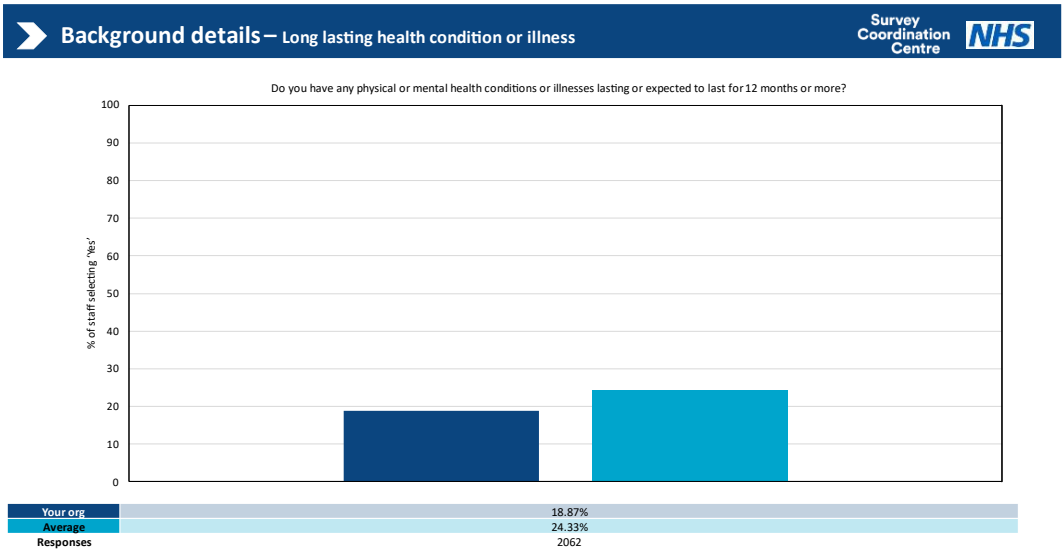
Background details - Religion

Survey Coordination Centre NHS

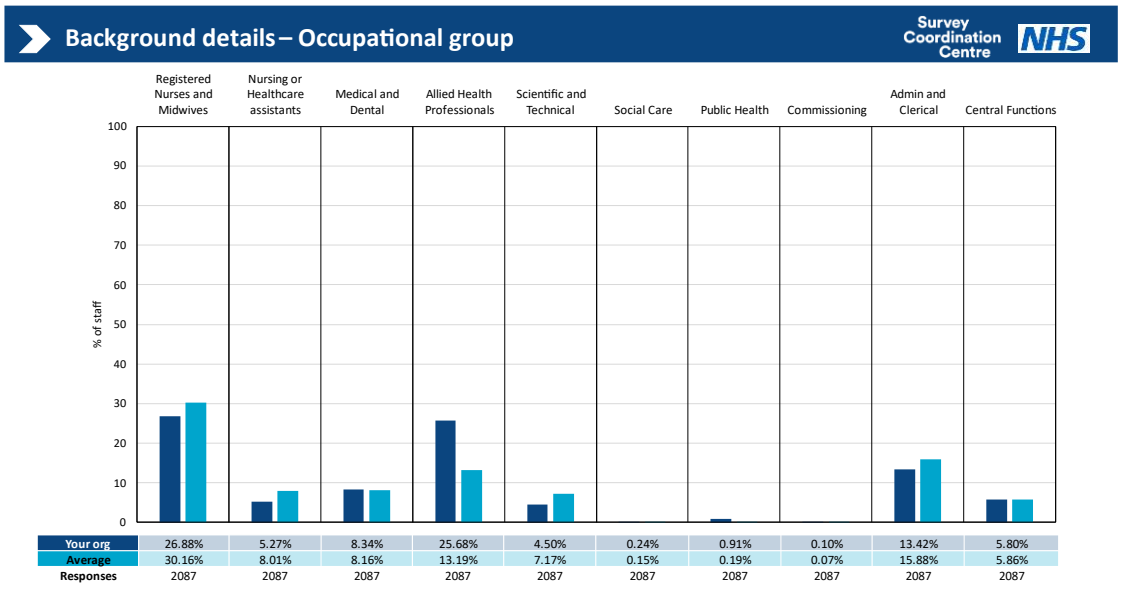


	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	I would prefer not to say
Your org	27.02%	45.48%	0.81%	5.04%	2.09%	7.18%	0.38%	2.19%	9.80%
Average	38.30%	47.38%	0.65%	2.43%	0.15%	2.93%	0.23%	1.51%	5.80%
Responses	2102	2102	2102	2102	2102	2102	2102	2102	2102

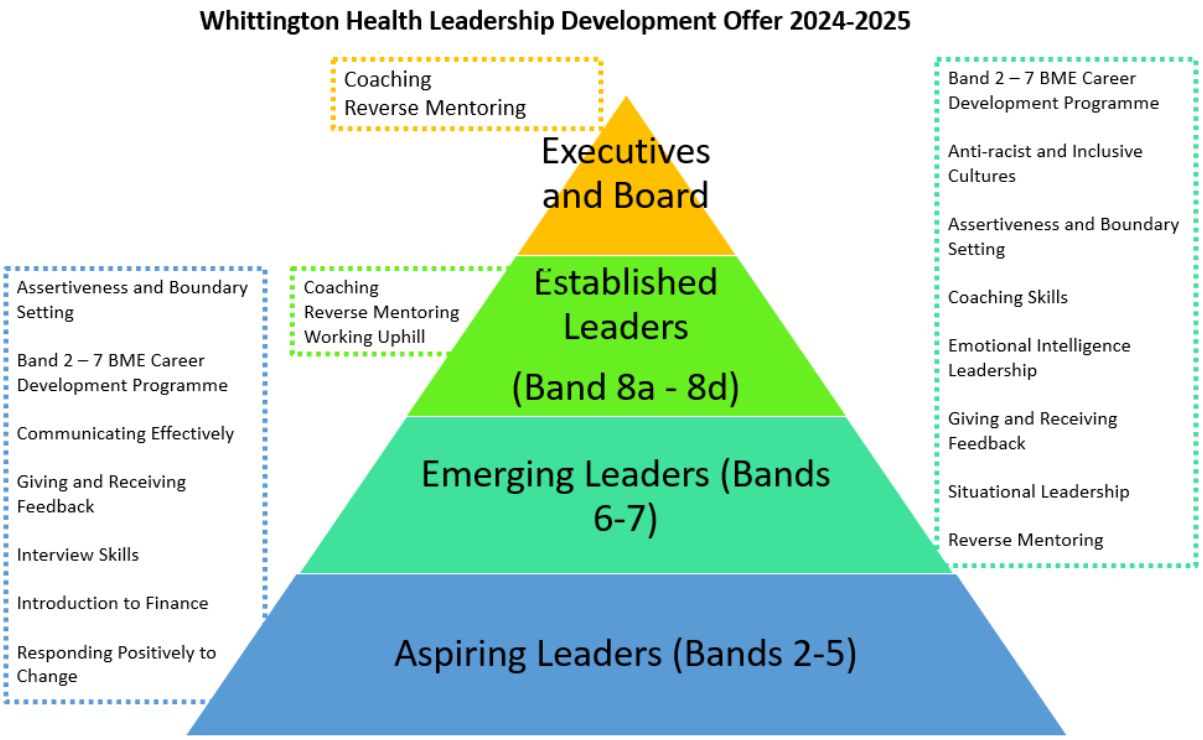
Demographics – Long lasting health conditions



Demographics – Occupational group



Appendix 3 – OD Leadership Development Offer



Appendix 4 – Communications Plan

Timeline and Activity	Timing	Audience	Lead on content creation
Full & Directorate Whittington Health ***draft*** reports sent to all senior leaders prior to TMG – EMBARGO STILL IN PLACE		Senior WH leaders	OD
Draft Staff Survey to be shared at TMG – Embargo lifted 30 March 9:30am		TMG	OD
Draft Staff Survey to be shared at WAC		WAC	OD
Report sent to Partnership Group		PG	OD
CEO Blog on results (email and intranet)	Thursday 7 March	All Staff	Comms
Noticeboard article with link to intranet blog	Friday 8 March	All Staff	Comms
Reactive media lines signed off	TBC	Public	Comms
Social media highlighting any positives	Thursday 7 March	Public	Comms
Internet story	Thursday 7 March		
Trust Board report – overall results and next steps agreed		TMG	Dir. of Workforce
CEO Briefing	7/3 (Preamble) and then Spotlight - WC April 15	Managers/All Staff	Comms
Provide information on Incentive		ICSU Leads	OD
Share themes of free text commentary.	TBC (Astrid)	All Staff	External
WH Managers guide for using staff survey data: sent to all ICSU/ Directorates	6/3	Senior WH leaders	OD & HRBPs
Partnership Group – overall results briefing	May (9)	Staff side	OD/ Dir of Workforce
ICSU/Directorate leads to cascade information via relevant Boards including 'We Said We Did' template. HRBPs to support and ensure placed on agendas.	August/September	All staff	Dir of Workforce
ICSU/Directorate leads to present draft staff survey action plan at next Quarterly Performance Review		Leads	ICSU Directorate leads
Design/deliver/ commission interventions in ICSUs	From April onwards	Leads	HRBPs/ Inclusion / OD / OH
ICSU/ Directorate leads to review interventions and report to QPR Boards		Leads	ICSU/ Directorate leads
Review of interventions/Trust wide listening events with executives shared with all staff – 'Your voice matters'	March ready for April	All staff	Comms

Appendix 5 – Four step guide and templates for Managers

ICARE EQUITY

Step 1 - Deep dive into your data

1) Open your RAG report (the excel spreadsheet that has been sent to you)

2) Within the excel spreadsheet, find either:
- Your **directorate** in **Locality 1** tab
- Your **departments** in **Locality 2** tab, or
- Your **team** in **Locality 3**

3) The RAG report will show whether you are green, amber or red for the survey questions
- Green = better than organisation average
- Amber = in between organisation average
- Red = below organisation average

4) Use these results and encourage open discussions in teams to address specific concerns and strengths

ICARE EQUITY

NHS Whittington Health NHS Trust

Step 2 – Reflect and discuss your data:

1. What reflections have you had about your data?
2. What areas have been positive and shows effective ways of working?
3. What has contributed to these strengths?
4. What are the developmental areas – the things that need to change and improve?
5. What do you think has contributed to this?
6. What might you do to change this and move forward?
7. How will you know you have achieved this?
8. When do you want to achieve it by?

ICARE EQUITY

Step 3 – Staff Survey Improvement Plan

We Listen, We Respond

NHS Whittington Health NHS Trust

- Consider your People Promise theme for improvement based on the data.
- Use the model to help shape your plans and discuss the timelines necessary for success.
- One in each box is plenty if impactful!

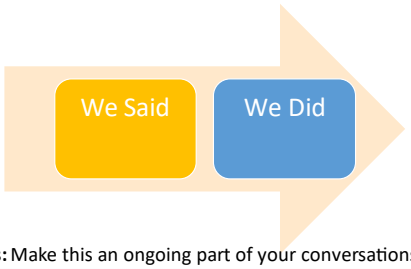
Easy Wins	High Priority
Celebrations & Strengths	Long term planning (for next 2 years)

Choose one People Promise theme to improve and put in this box

People Promise

Step 4 – Communicate your Improvement Plan and Success Stories

- Report back to your ICSU Leads/Senior Management Team what your improvement area is for your team by **May 2024** (share your 4 -grid model)
- Celebrate your achievement using the below model when improvement has been made. Display it in your department:



TIP for ICSU Leads: Make this an ongoing part of your conversations and check-ins

Meeting title	**Trust Board – public meeting**	**Date: 21 May 2024**
Report title	**Annual Workforce Race and Disability Equality Standard submissions**	**Agenda item: 14**
Executive lead	Liz O'Hara, Chief People Officer	
Report authors	Tina Jegede & Swarnjit Singh, Joint Directors of Inclusion and Simon Anjoyeb, Equality, Diversity and Inclusion Lead	
Executive summary	This report presents the outcome of the annual workforce disability (WDES) and race equality standards (WRES) before submission to NHS England. The outcomes from both the WRES and WDES (see tables 1 and 3) will also be publicised on our intranet and on our external web pages. Headlines from the current WRES results, this year shows increase in BME staff representation from 41% to 45 % and with non-ethnicity disclosure rate of 18% from 21% in 23/24. some improvements in several indicators; bullying and harassment from staff (indicator 6), equal opportunities for progression (indicator 7) and experiences of discrimination from staff (indicator 8). However, there has been a deterioration in indicators 2 (recruitment), indicator 3 (disciplinary processes) and indicator 5 (bullying and harassment from patients). BME representation on the board (indicator 9) remains static. The 2024 WDES results show, that there continues to be a very low level of disclosure of disabilities in our electronic staff record (ESR) system. Our results over the ten metrics show that staff with a disability fare less well in comparison with staff with none; although there have been a number of improvements in many metrics particularly around bullying and harassment (4a-c), reasonable adjustments (8) and overall representation (1), the gap in experience appears to be widening for metrics 5 (equal opportunities), 6 (presenteeism) and 7 (feeling valued).	
Purpose	Noting	
Recommendation(s)	The Board is asked to: i. note the outcomes from this year's WRES and WDES which will be submitted to NHS England before the end of May and publicised on our external webpages; and ii. continue to support the ongoing work arising from these results.	
BAF	People 1 and People 2 entries	
Report history	Annual equality submissions to NHS England	
Appendices	1: 2017/23 WRES outcomes summary	

Annual Workforce Race and Disability Equality Standard submissions

1. Workforce Race Equality Standard (WRES)

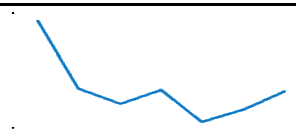
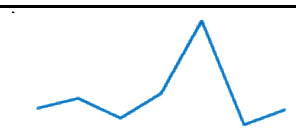
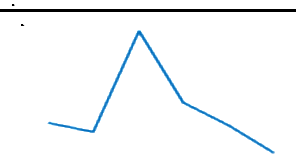
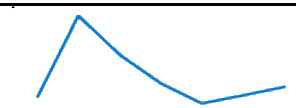
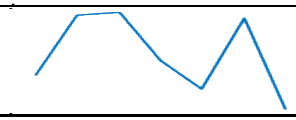
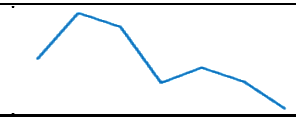
1.1 Collecting data on diversity and inclusion enables organisations to focus on specific areas for improvement to create and sustain a more inclusive culture. The Trust has accumulated nine years of data, and some parameters and reporting requirements have changed over that period (for example, for indicators nine and seven). However, seeing the data together provides an overview of progress.

1.2 The WRES outcomes are drawn from data held in the Trust's Electronic Staff Record (ESR) and other systems, as follows:

- Indicator 1: Data is taken from ESR with a snapshot date of 31 March 2024.
- Indicator 2: Data is taken from the Trust's TRAC Recruitment Software with a data collection period of 1 April 2023 to 31 March 2024.
- Indicator 3: Data is taken from internal the internal employee relations database with a data collection period of 1 April 2023 to 31 March 2024.
- Indicator 4: Data is taken from the Trust's Elev8 learning management system with a data collection period of 1 April 2023 to 31 March 2024.
- Indicators 5-8: Data is taken from the 2023 NHS Staff Survey.
- Indicator 9: Data is taken from ESR with a snapshot date of 31 March 2024.

1.3 Table 1 overleaf summarises the Trust's WRES results since 2018. More detailed data, including a gap trend, is available in Appendix 1.

Table 1: Summary of WRES Indicators, 2018-2024

WRES Indicator			2018	2019	2020	2021	2022	2023	2024	7 Year Trend
1	Workforce Ethnicity	BME	43.00%	41.60%	40.20%	40%	38.20%	41.50%	45.00%	
		White	-	42.60%	37.80%	37%	37.70%	37.40%	37.40%	
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		2.14	1.65	1.55	1.64	1.42	1.51	1.63	
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.18	1.44	0.85	1.57	3.75	0.68	1.11	
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development compared to BME		-	0.94	0.91	1.26	1.01	0.93	0.84	
5	Percentage of staff experiencing harassment, bullying or abuse from the public in last 12 months	BME	29.10%	35.90%	32.50%	30.30%	28.60%	29.30%	30.00%	
		White	28.40%	30.50%	30.60%	28.90%	27.90%	30.40%	27.20%	
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	32.50%	36.20%	31.90%	29.70%	27.70%	25.40%	25.10%	
		White	26.70%	31.40%	29.90%	24.20%	25.70%	24.30%	21.60%	

WRES Indicator			2018	2019	2020	2021	2022	2023	2024	7 Year Trend
7	Percentage of staff who believe that trust provides equal access to career progression or promotion	BME	39.80%	35.80%	39.70%	39.70%	39.90%	41.20%	46.30%	
		White	59.50%	56.20%	58.20%	56.40%	54.40%	57.50%	56.40%	
8	Percentage of staff who experience discrimination at work from a manager or other colleagues	BME	17.10%	20.30%	16.10%	16.90%	15.20%	15.00%	11.80%	
		White	8.20%	9.50%	7.80%	8.20%	8.30%	9.40%	7.40%	
9	Percentage membership of Board		20.00%	20.00%	16.70%	16.50%	17.60%	26.70%	26.70%	
	Representation of BME in Board membership compared to the workforce		-23%	-21.80%	-23%	-16.50%	-20.60%	-14.80%	-18.30%	

1.4 Commentary on the results and trends follows below for each of the nine WRES indicators.

Indicator 1 (Trust profile: white, black, and minority ethnic (BME) staff at different pay bands)

1.5 In many NHS trusts, including Whittington Health, a typical workforce representation shows white staff increasing with bandings and BME staff decreasing the higher the pay bands. At Whittington Health, band 7 (clinical) and band 8a (non-clinical) is the point where BME underrepresentation becomes a declining trend. It is hoped that the Trust will be able to use these analyses to focus ongoing efforts on making career progression more equitable for BME employees in specific roles and pay bands where significant disparities exist.

1.6 This was one of the key drivers for the London Race Strategy setting Model Employer targets for individual providers. The suggested targets are to appoint BME staff at senior levels (band 8A and above) over ten years (2018-28), to help achieve equity and to demonstrate that they are an employer more reflective of the communities served at all organisational levels.

1.7 The table below shows that the suggested targets are not fully being met, and whilst some pay bands exceed targets, others are falling behind, as shown in Table 2 (below). This data will continue to be reviewed to ensure accurate information is available on senior staff bandings in integrated clinical service units and corporate departments.

Table 2: Progress against the Model Employer suggested targets

	2020 Actual	2020 Goal	2020 Gap	2021 Actual	2021 Goal	2021 Gap	2022 Actual	2022 Goal	2022 Gap	2023 Actual	2023 Goal	2023 Gap	2024 Actual	2024 Goal	2024 Gap
Band 8A	60	70	-10	62	75	-13	80	81	-1	101	87	+14	129	93	+36
Band 8B	24	24	0	21	25	-4	29	27	+2	34	29	+5	38	31	+7
Band 8C	6	6	0	5	7	-2	8	9	-1	9	10	-1	10	11	-1
Band 8D	4	3	+1	3	3	0	5	3	+2	6	3	+3	4	4	0
Band 9	1	1	0	1	1	0	1	1	0	1	1	0	1	2	-1

1.8 **Indicator 2 (Relative likelihood of being appointed)**

Since 2019 this indicator has fluctuated between 1.42-1.64. In 2023, the relative likelihood was 1.51, which indicates that white candidates are more likely to be appointed from shortlisting than BME candidates. In 2024, it increased to 1.63, indicating a slight decline in this indicator's performance.

1.9 **Indicator 3 (Relative likelihood of entering into a formal disciplinary process)**

In 2023, the relative likelihood was 0.93, which indicates that BME staff are slightly less likely to enter formal disciplinary processes than white staff. In 2024, the likelihood increased to 1.11, indicating that BME staff are more likely to enter disciplinary processes than white, but is now within the target range of 0.8 to 1.25 for this indicator. Out 16 cases reported, 8 are BME staff and 6 are white staff. All of the cases have been thoroughly reviewed and meet the requirements of the formal trust process.

1.10 **Indicator 4 (Access/uptake of CPD and non-mandatory training)**

In 2022, the relative likelihood of was 0.93 indicating that BME staff were slightly more likely to access training that white staff. In 2023, the relative likelihood dropped further to 0.84, indicating that BME staff are more likely to access non-mandatory training than white staff, however, the 2024 score remains within the target range of 0.8 to 1.25.

1.11 **Indicator 5 (Experiences of bullying, harassment and abuse from the public)**
Performance for this indicator had been improving between 2019-2022, and the gap in experience between BME and white staff was narrowing. However, performance reduced in 2024, for BME staff rising to 30.0% (+0.7%) and white staff decreasing to 27.2 (-3.2%); the gap in experience between BME and white staff has increased from 1.1% points to -2.8% points. The performance for this indicator for acute/community trusts in England was 24.7% for white staff (-2.5% compared to the Trust), and 28.1% for BME staff (-1.9% compared to the Trust), indicating the Trust has a lower performance compared to the national average.

1.12 **Indicator 6 (Experiences of bullying, harassment and abuse from colleagues)**
Since 2019, this indicator has been on a downward trend for BME staff. The results show an improvement in BME staff experiences, decreasing from 25.4% in 2023 to 25.1% (-0.3%) and white staff decreasing from 24.3% in 2023 to 21.6% (-1.4%). The gap in experience between BME and white staff also increased from 1.1 to 3.5% points in the same period. The average scores for acute/community services in England for BME staff is 26.2% and white 22.4%, indicating the Trust has slightly higher performance compared to the national average.

1.13 **Indicator 7 (Percentage of staff believing there are equal opportunities for career development)**
The experience of the Trust's BME staff been increasing since 2020. In 2024, the experiences of BME staff increased 5.1% from 41.2% in 2023 to 46.3%, for white staff this decreased by 1.1% from 57.5% in 2023 to 56.4%; the gap in experience decreased from 16.3% in 2023 to 10.1% in 2024. However, the acute/community average in England is 49.6% for BME and 58.8% for white staff, indicator the Trust has a lower performance in comparison.

1.14 **Indicator 9 (Board representation)**
The minus 18.3% shows an under-representation on the Board compared to the organisational profile, which represents an increase in under-representation compared to 2023.

2. Workforce Disability Equality Standard (WDES)

2.1 The WDES outcomes are drawn from data held in the Trust's Electronic Staff Record (ESR) and other systems, as follows:

- Indicator 1: Data is taken from ESR with a snapshot date of 31 March 2024.
- Indicator 2: Data is taken from the Trust's TRAC Recruitment Software with a data collection period of 1 April 2023 to 31 March 2024.
- Indicator 3: Data is taken from internal the internal employee relations database with a data collection period of 1 April 2023 to 31 March 2024.
- Indicators 4-9: Data is taken from the 2023 NHS Staff Survey.
- Indicator 10: Data is taken from ESR with a snapshot date of 31 March 2024.

2.2 **Indicator 1 (Trust profile for staff with and without disabilities at different bands)**
The first report submitted at the end of July 2019 was based on 2018/19 data. The 2024 submission provides data for 2023/24. The ten indicators for WDES are taken from ESR and other systems for indicators 1- 3 and 10; and from the annual staff survey for indicators 4-9. There also has been a 12.5% reduction from 2023 in staff where their disability status is unknown, which the largest in year decrease since the standard was introduced. Increasing the workforce's disability declaration will remain a high priority for the Trust.

2.3 I**ndicator 2 (Relative likelihood of being appointed)**
In 2023, the relative likelihood was 1.18; meaning disabled candidates were less likely than non-disabled candidates to be appointed from shortlisting. In 2024, this rose to 1.28, meaning non-disabled candidates are more likely to be appointed. This score now moves outside of the target of 0.80 – 1.25, meaning there may be a statistically adverse impact on disabled candidates.

2.4 **Indicator 3 (Relative likelihood of entering formal capability process)**
In 2023, the relative score for this indicator was 5.37; this means that disabled staff are more likely to enter a formal capability process than non-disabled staff (over a two-year rolling average period, this relates to one case involving disabled staff out of four cases). In 2024, this rose to 6.74, (over a two-year rolling period, one case involving disabled staff out of four cases) showing a decline in performance. The relative likelihood is impacted by the low levels of declaration and the low number of cases of capability, this is an issue that has been picked up nationally by the national team.

2.5 **Indicator 4a (Relative percentage of staff experiencing bullying from patients)**
In 2024, the performance for this indicator improved for disabled staff to 33.1% (a decrease of 4.3%), and for non-disabled staff 27.9% (a decrease of 0.1%) compared to the previous year. The gap in experience between both groups has also reduced from 9.4% in 2023 to 5.2% in 2024. The national average for acute/community trusts in England are disabled staff 30.4% (2.7% lower than the Trust) and for non-disabled staff 23.8% (4.1% lower than the), indicating the Trust has a lower performance compared to the national average.

2.6 **Indicator 4b (Relative percentage of staff experiencing bullying from managers)**
Since 2019, there has been an improvement in performance for this indicator. In 2024, the performance for this metric improved for disabled staff to 17.3% (a decrease of 5%) and non-disabled staff to (a decrease of 0.5%) compared to the previous year. The gap in experience between both groups also reduced to 6.6% (a 4.5% reduction) compared to 11.1% in 2023. However, the Trust has a lower performance for both groups compared to the national average for acute/community trusts in England. The national average is 15.9% (1.4% lower than the Trust's score) for disabled staff, and 8.7% (2% lower than the Trust's score).

2.7 **Indicator 4c (Relative percentage of staff experiencing bullying from colleagues)**
Since 2019, the performance for this indicator has improved for disabled staff. In 2024, the performance improved for both disabled to 24.5% (2% reduction) and non-disabled staff to 17.0% (0.3% reduction) compared to 2023. The gap in experience also reduced by 1.7% points to 7.5% in 2024, from 9.2% in 2023. Compared to the national average for acute/community trusts in England, the Trust has a higher performance for this indicator than the England average for disabled staff 25.9% (1.4% higher than the Trust), and slightly lower for non-disabled staff 16.6% (0.4% lower than the Trust).

2.8 **Indicator 4d (Reporting bullying and harassment when experienced it)**
In 2024, the performance for this indicator reduced to 44.6% (2.5% lower) for disabled staff and improved for non-disabled staff to 51.5% (3.3% increase) compared to 2023. The gap in experience between the two groups also increased from -1.8% to -6.9%. The national average for acute/community trusts in England is 50.4% (5.8% bigger than the Trust) for disabled staff, and 49.3% (2.2% lower than the Trust), indicating the Trust has a lower performance for disabled staff and higher performance for non-disabled staff compared to the national average.

2.9 **Indicator 5 (Percentage of staff believing there are equal opportunities for career development)**
In 2024, the performance for this indicator decreased for disabled staff to 39.4% (0.7% lower) and increased for non-disabled staff to 54.2% (2.4% higher) compared to 2023. The gap in

experience between both groups also increased from -11.7% in 2023 to -14.8% in 2024. The national average for acute/community trusts in England for disabled people is 51.5% (12.1% higher) and for non-disabled staff 57.5% (3.3% higher), indicating the Trust has a lower performance that the national average.

2.10 **Indicator 6 (Experiences of feeling pressure from manager to work when not well)**
In 2024, the performance for this indicator improved for disabled staff to 29.2% (0.3% lower) and for non-disabled staff to 19.2% (1.5% lower) compared to 2023. However, the gap in experience between both groups rose from 8.8% in 2023 to 10.0% in 2024. The national average for acute/community services in England is 28.6% (0.6% lower) for disabled staff and 19.5% (0.3% higher) for non-disabled staff; this indicates the Trust's performance is slightly lower for disabled staff and slightly higher for non-disabled staff.

2.11 **Indicator 7 (Staff satisfaction of how much the Trust valued their work)**
In 2024, the performance for this indicator improved for both groups, with disabled staff scoring 38.4% (3.7% increase) and for non-disabled staff 49.6% (4% increase) compared to 2023. However, the gap in experience between the two groups increased from -10.9% in 2023 to -11.2% in 2024. The national average for acute/community trusts is 35.7% (2.7% lower than the Trust) for disabled staff and 47.2% (2.4% lower than the Trust); this indicates that the Trust has a higher performance than the national average.

2.12 **Indicator 8 (Percentage saying employer made reasonable adjustments)**
Since 2022, the performance for this indicator has been improving annually. In 2024, the score rose to 66.1% which is an increase of 1.4% from 2023. However, compared to the national average for acute/community trusts of 73.4% (7.3% higher than the Trust) indicates the Trust has a lower performance than the national average.

2.13 **Indicator 9 (Engagement scores)**
In 2024, the Trust's performance for this indicator increased to 6.4 (increase of 0.6) for disabled staff and 7.1 (increase of 0.1) for non-disabled staff compared to 2023. The national average for acute/community trusts in England is 6.5 (0.1 higher than the Trust) for disabled staff and 7.0 (0.1 lower than the Trust) indicating the Trust has slightly lower performance for disabled staff and slightly higher for non-disabled staff compared to the national average.

2.14 **Indicator 10 (Board representation)**
This metric relates to the representation of Board members in comparison to the Trust's overall workforce profile. Given the level of staff disclosure throughout the Trust, the results have limited meaning. The 2024 results show that there is a 2.4% (overall Board), 6.8% (voting members) and 6.8% (executives) over-representation of people with disabilities. There is an under-representation of 5.4% (overall Board) and an over-representation of 8.0% (voting members) and 8.0% (executives) for non-disabled members.

Table 3: Summary of performance on each WDES indicator

WDES Indicator		2021 Results			2022 Results			2023 Results			2024 Results		
1	Profile – disability at different bands	Disabled staff: 2.09% Non-disabled staff: 49.38% Unknown status 48.53% Staff survey results show 14.2% of staff have a disability.			Disabled staff: 2.5% Non-disabled staff: 48.1% Unknown status:49.4% Staff survey results show 17.0% of staff have a disability.			Disabled staff: 3.0% Non-disabled staff: 47.6% Unknown status: 49.5% Staff survey results show 18.6% of staff have a disability.			Disabled staff: 4.3% Non-disabled staff: 58.7% Unknown status: 37.0% Staff survey results show 18.3% of staff have a disability.		
2	Likelihood of being appointed (non-disabled vs disabled applicants)	1.02			0.84			1.18			1.28		
3	Likelihood of entering formal capability process	Zero: (no staff with disclosed disabilities have entered into formal capability)			2.44			5.37			6.74		
4a	Percentage of staff experiencing harassment and bullying from ***patients & public***	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**
		33.0%	29.0%	4.0%	33.4%	27.4%	6.0%	37.4%	28.0%	9.4%	33.1%	27.9%	5.2%
4b	Percentage of staff experiencing harassment and bullying from ***their managers***	30.0%	13.0%	17.0%	22.7%	13.8%	8.9%	22.3%	11.2%	11.1%	17.3%	10.7%	6.6%
4c	Percentage of staff experiencing harassment and bullying from ***other colleagues***	30.0%	19.0%	11.0%	27.7%	19.9%	7.8%	26.5%	17.3%	9.2%	24.5%	17.0%	7.5%
4d	Percentage of staff that reported harassment and bullying when they experienced it	43.8%	47.1%	-3.3%	44.7%	48.6%	-3.9%	47.1%	48.9%	-1.8%	44.6%	51.5%	-6.9%

WDES Indicator		2021 Results			2022 Results			2023 Results			2024 Results		
5	Percentage of staff believing there are equal opportunities for career development	41.8%	49.7%	-7.9%	38.5%	49.2%	-10.7%	40.1%	51.8%	-11.7%	39.4%	54.2%	-14.8%
6	Experience of feeling pressure from manager to work when not well	37.4%	21.6%	15.8%	28.5%	22.0%	6.5%	29.5%	20.7%	8.8%	29.2%	19.2%	10.0%
7	Percentage saying they are satisfied with how the extent to which the Trust values their work	37.1%	53.7%	-16.6%	33.8%	46.5%	-12.7%	34.7%	45.6%	-10.9%	38.4%	49.6%	-11.2%
8	Percentage saying employer made reasonable adjustments	67.0%			62.3%			64.7%			66.1%		
9	(9a) Engagement scores	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**
		6.7	7.3	-0.6	6.5	7.0	-0.5	6.3	7.0	-0.7	6.4	7.1	-0.7
	9(b) Enabling disabled staff to have a voice in the organisation.	'WhitAbility' Network has an executive sponsor and governance structure.			'WhitAbility' Network has an executive sponsor and governance structure.			'WhitAbility' Network has an executive sponsor and governance structure.			WhitAbility' Network has an executive sponsor and governance structure.		
10	Board representation (Executives)	There appears to be an 18% over-representation of people with disabilities, a 31% over-representation for non-disabled members resulting from the almost complete disclosure in Board and 2% Trust disclosure			There appears to be an 17.5% over-representation of people with disabilities, a 11.9% over-representation for non-disabled members.			There appears to be an 8.1% over-representation of people with disabilities and an 8.0% over-representation of non-disabled members.			There appears to be an 6.8% overrepresentation of people with disabilities, and an 8.0% overrepresentation of people without disabilities.		

3. Priorities and next steps

3.1 **The following areas have been identified from 2023-24 WRES data reporting as areas requiring our greatest focus:-**

Indicator 2 **-** BME applicants recruitment from shortlisting compared to white applicants
Indicator 5 **-** Bullying & Harassment of BME staff from staff
Indicator 7 **-** Percentage of staff who believes that the Trust provides equal access to career progression
Indicator 9 **-** BME Board Membership

The following table outlines some of the interventions that are planned and included in the Whittington Health Equality, Diversity, and Inclusion Improvement Plan 2024-26. This plan aligns with The NHS Equality Diversity & Improvement Plan, which aims to promote workforce diversity, encourage inclusion, and reduce discrimination across the NHS workforce in England through six high-impact actions.

WRES indicator	Action areas
1 - Percentage of BME staff	• Improving our information and coverage of the workforce to reduce the level of unknown ethnicity in the workforce • Internal development of BME staff at band 8A and above. Secure places on national and sectoral talent management programmes • Rollout of Band 8 Development Programme and monitor take-up. • Individual development schemes in ICSUs and corporate departments to diversify their senior leadership positions • Continue with the offer of external mentoring and coaching
2 – Recruitment outcomes	• Continue work to build on data access and quality • Complete review of recruitment and selection policy to ensure alignment to guidance on inclusive and diverse panels • Continue with training for inclusive and diverse panels
5 – Bullying & Harassment	• Monitor incidents quarterly and with targeted action plans for areas reporting a high incident
7 – Career Progression	• Create and implement a talent management plan to improve the diversity of staff across the agenda pay band and evidence progress of implementation (by June 2025) • Expanding our talent management approach to include competency-based career progression paths for all levels, not just executives • Further consideration of band 2-7 and band 8a development programs • Work on the perception of staff from BME backgrounds around being able to progress their careers so they can engage with development and career progression opportunities.
9 – Board membership	• Identify and support senior leaders from ethnic minority backgrounds to move beyond leadership within their area of expertise to executive roles through Leadership programmes such as the Nye Bevan • Develop proposals to help increase diversity on the Board through the NExT Director programme with NHS England's Non-Executive Director Appointments team.

3.2 As with the 2023 report, there is a limit to how meaningful and transferable the outcomes of the WDES data can be when the NHS National Staff Survey indicates that 18.3 per cent of staff who have a disability, and ESR indicates that only 4.3 per cent of staff have disclosed their disability. A concerted effort has been made to request disclosure at staff network events, through emails and declaration campaigns since the 2019 results were known and this will continue. The low disclosure rates means that there is limited meaning to the analysis provided.

3.3 The most important priority for WDES improvement continues to be the disclosure rate. This is being encouraged through the WhitAbility Staff Network, line management, equality and inclusion modules of leadership, appraisal, and other training programmes. In addition, work is also focussed on implementing health passports and Whittington Health's first policy on reasonable adjustments, including clear guidance for staff and their managers on the access to work scheme. It is envisaged that implementing the reasonable adjustment policy will add to the current efforts to improve the disclosure rates.

3.4 Adopting a 'Just and Learning Culture' is being advanced through collaborative exploration of relevant processes and procedures throughout the Trust and remain at the early stages of implementation. This is a key priority in bringing together different aspects of the culture improvement work, including reducing bullying and for increasing inclusion with staff engagement and programmes such as reciprocal mentoring and reverse mentoring.

4. Recommendations

4.1 The Executive team, Trust Management Group, Workforce Assurance Committee and Trust Board are asked to:

i. note the outcomes from this year's WRES and WDES which will be submitted to NHS England before the end of May and publicised on our external webpages; and
ii. continue to support the ongoing work arising from these results.

APPENDIX 1 – SUMMARY OF WRES INDICATORS FOR FROM 2018 TO 2024, INCLUDING THE GAP BETWEEN WHITE AND BME STAFF
(Colour coding is based on movement from the previous year: red is a fall in performance; green is an improvement)

WRES Indicator	2018		2019		2020		2021		2022		2023		2024	
	White	BME	White	BME	White	BME	White	BME	White	BME	White	BME	White	BME
1. Ethnic Profile		43.0%	42.6%	41.6%	37.8%	40.2%	37.5%	39.7%	37.7%	38.2%	37.4%	41.5%	37.4%	45.0%
2. Likelihood of being appointed	2.14		1.65		1.55		1.64		1.42		1.51		1.63	
3. Likelihood of entering a formal process for disciplinary	1.18		1.44		0.85		1.57		3.75		0.68		1.11	
4. Take-up of non-mandatory training	-		0.94		0.91		1.26		1.01		0.93		0.84	
5. Experience of bullying from public	28.0%	29.0%	31.0%	36.0%	31.0%	33.0%	28.9%	30.3%	27.9%	28.6%	30.4%	29.3%	27.2%	30.0%
Gap	1.0%		5.0%		2.0%		1.4%		0.7%		-1.1%		2.8%	
6. Experience of bullying from colleagues	27.0%	33.0%	31.0%	36.0%	30.0%	32.0%	24.2%	29.7%	25.7%	27.7%	24.3%	25.4%	21.6%	25.1%
Gap	6.0%		5.0%		2.0%		5.5%		2.0%		1.1%		3.5%	
7. Career development	59.5%	39.8%	56.2%	35.8%	58.2%	39.7%	56.4%	39.7%	54.4%	39.9%	57.5%	41.2%	56.4%	46.3%
Gap	-19.7%		-20.4%		-18.5%		-16.7%		-14.5%		-16.3%		-10.1%	
8. Experience of discrimination	8.0%	17.0%	9.0%	20.0%	8.0%	16.0%	8.2%	16.9%	8.3%	15.2%	9.4%	15.0%	7.4%	11.8%
Gap	9.0%		11.0%		8.0%		8.7%		6.9%		5.6%		4.4%	
9. Board / Trust comparative representation	-21.8%		-23.0%		-16.5%		-20.6		-27.2%		-14.8%		-18.3%	
Basic % of Total	12.0%		20.0%		16.7%		12.5%		17.6%		26.7%		26.7%	

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2024**
Report title	**Charitable Funds Committee Chair's Assurance report**	**Agenda item: 15**
Committee Chair	Amanda Gibbon, Non-Executive Director	
Executive lead	Jonathan Gardener, Chief Strategy, Improvement and Digital Officer	
Report author	Marcia Marrast-Lewis, Assistant 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 20 May 2024 Charitable Funds Committee meeting which included: • Month 12 Finance report including fund balances. • Charity report – including door drop mailing proposal, budgets and targets and key performance indicators • Applications for funding • The Reserves Policy • Funding attendees of service user groups 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. Commend the Charity Team for their successes. 2. Door drop exercise 3. Charity budgets and reserves. 4. Parkinsons watches and gap between NICE approval and hospital treatment.	
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	20 May 2024

Summary of assurance:

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

Month 12 Finance report

- The Committee reviewed the draft finance report and noted these points:
- Reported income to March 2024 was £497k.
- Expenditure to March was £714k.
- There was a net consumption of Charitable funds in the amount of £130k after movements in the investment portfolio were taken into consideration.
- The investment portfolio's performance is reported quarterly and showed a gain of £87k for the period 1 April 2023 to 31 March 2024.
- As of 31 March 2024, the total fund balance was £1.955m.
- Donations and grants contributed £413k (83%) of total income. A significant proportion (£190k) related to donations received from the Stuttering Foundation.
- The statement of financial position outlined that the Charity had settled several of its liabilities with the Trust and that had had an impact on cash balances, which reduced from £1.67m to £1.03m at the end of March.
- All the individual funds ended in a positive balance as of 31st March.

The Committee noted that the improvement in the value of investments reflected the strength of the market in recent months.

Reserves Policy

The Committee reviewed the Charity's Reserves Policy which sets out the responsibilities of the Trustee for the management of the Charity's unrestricted funds and noted that it is essential to have an appropriate policy in place both for compliance with Charity Commission requirements but also as a prerequisite for many applications for funding particularly to trusts and foundations who would need to see that unrestricted funds were managed appropriately. The Committee was informed that the amount of unrestricted funds is currently higher than usual as a result of the exercise to lift restrictions on some smaller funds and the consolidation of funds. Additionally, funds had been set aside as part of the designated funds for Integrated Clinical Support Units (ICSU) and were in fact unrestricted but could only be spent in those areas.

The Committee also discussed the accumulation of the investment revaluation reserve which had grown to £537,603 and agreed that £287,603 should be transferred to be distributed equally between the Designated/Unrestricted funds accordingly. It was also agreed that Trustees retain sufficient reserves to fund six months of general expenditure in the amount of £250k.

Charity Report

The Committee reviewed a report setting out all significant charity activity during the period 15 February to 20 April 2024. They noted the following issues:

- The Charity was successful with its application to the NHS Charities Together Greener Communities Fund to create a garden at Tynemouth Road and was awarded £150k courtesy of Starbucks. An additional donation of c£10k-£30k was expected from the Alexandra Grace Halley Foundation
- London Marathon runners raised £25.6k for the year.

- There had been a dip in challenge event income following the pandemic and this was now recovering. However the availability of London Marathon places for the charity would be reduced next year. The Charity Team would look at other ways to augment challenge event income.
- On 25 April, the event 'An Evening with Michael Palin' at Cadogan Hall raised approx. £28.5k, which will be used to support services at the Michael Palin Centre
- The Stuttering Foundation of America had pledged another year of support amounting to between £180k and £200k.
- The Trust had received two Macmillan grants to refurbish a counselling room with pro bono support from an interior designer and a grant to better engage the LGBTQIA+ community.
- The Dementia and ITU garden designs were in progress, design and costings would soon be available.
- A meeting with Alzheimer's Research UK had led to several introductions, including to some dementia design specialists. Expressions of interests had been submitted to large value donors.
- The maternity and neonatal project is progressing, with in-kind/pro-bono contributions amounting to more than £120,000. This contribution includes pro-bono design work, in-kind donation of materials and items, storage and installation and contractor works at a reduced rate.

The Committee was pleased to note that the door drop mailing campaign was almost ready and was scheduled to commence in the first week of June. The Committee extended its thanks to the Charity Team for their hard work, the result of which had raised the profile of the Charity and the level of fund-raising activity.

The Committee was assured that all donations were recorded to ensure that funds were utilized in the way that they were intended. Unless donations are made with specific purpose in mind then they will be included in general funds to be used at the Trustee's discretion.

The Committee discussed the individual successes of the London Marathon Fundraising and An Evening with Michael Palin event which had both raised similar amounts. The Committee agreed that while the two events were very different the main drivers for success were around the stewardship of both events. It was agreed that the runners' targets for next year's London Marathon would be raised. Additionally, significant of interest about the Charity had been raised at the Michael Palin event and many patrons had given consent to be contacted by the Charity.

Budgets and Targets

The Committee was informed that considerable work had been undertaken to develop a budget for the year ahead following a review of past income and expenditure which also considered current fund-raising targets. The Committee noted the following:

- Total forecast income was estimated at £554K with a stretch target of £936K
- Fundraising costs (including salaries, training, and professional development) were estimated at £199k
- Governance costs were calculated at £55k.

The Committee approved the forecast budget and confirmed that any requests for expenditure outside of the budget would follow the request for funding process.

Key Performance Indicators
The Committee noted that KPIs had been revised to align with approved budgets and targets for the year ahead and as a result did not have sufficient data to allow meaningful analysis. The Committee agreed to consider KPI in three months' time by which time, an additional three months of consistent data would be available.

Funding Attendees of Service User Groups
The Committee considered a proposal to fund the provision of vouchers to attendees of service user groups. The Committee was advised that a formal proposal from the Patient Experience Team, to remunerate service users, carers or their families would also be considered at the Executive Team Meeting. Specific amounts had yet to be determined, however it was agreed that any funding should be allocated from Trust resources rather than from charitable funds.

Grant Making Policy
The Committee reviewed year one of progress against a two-year grant-making strategy which runs from April 2023 to March 2025 and had been developed to direct the Charity's grant making activities and ensure that funds were utilised in an effective and impactful way. The Committee was assured that the strategy comprised several grant-making objectives which would encourage applications to deliver projects against these objectives as well as provide opportunities to communicate with donors around the impact of their donations around specific projects.

The Committee noted the following progress against year one of the strategy had been made:

1. State of the art technology and equipment objective had provided grants totalling £30,364 against a £100,000 target.
2. Enhancing the health environment had provided grants totalling £15,526 against a £200,000 target; and
3. Patient and community wellbeing had utilised £57,727 of £150,000 target.
4. Staff wellbeing had used £117,496 of £200,000
5. Innovation and education had spent £32,931 of a target of £150,000.
6. Small grants programme had spent £1,915 of a target of £20,000.

The Charity was scheduled to spend significantly more for objectives two to four to progress several transformational projects. The Committee was pleased to learn that NHS Charities had announced the launch of a £16m Workforce Wellbeing Programme to support NHS staff across the UK. The level of funding would be matched by NHS England and would support the Charity's staff wellbeing objective.

The Committee approved the suggestions that applications would be encouraged in line with themed grant making months ahead of the Committee meetings. This would complement the usual application process of applying for funding against the objectives set out in the Charity's grant making strategy.

Applications for Funding
The Committee reviewed and approved the following bids for charitable funding:

- Parkinson's Walking Football (£9,500)
- International Nursing & Midwifery Week Events (£3,889.19)
- PKG Watches (£9,600)
- LGBTQIA+ Conference Day (£9,940.70)

	The Committee agreed that the cost of the international nursing and midwifery event would be spread across ICSU budgets. The Committee also discussed the success of a recent admin staff event which had been solely funded by sponsorship from a supplier and agreed that organisers might consider fund raising to fund these events.
2.	**Attendance:** Amanda Gibbon, Non-Executive Director (Committee Chair) Clare Dollery, Acting Deputy Chief Executive Jonathon Gardner, Chief Strategy, Digital and Improvement Officer Julia Neuberger, Non-Executive Director Nailesh Rambhai, Non-Executive Director Terry Whittle, Chief Finance Officer Clarissa Murdoch, Acting Medical Director Vivien Bucke, Business Support Manager Ellen Kyriacou, Charity Accountant Martin Linton, Assistant Director Financial Services Sam Lister, Head of Charity Katherine Mobey, Fundraising Manager Sydney Ramunno, Grants Officer Marcia Marrast-Lewis, Assistant Trust Secretary **Apologies:** Tony Rice, Independent Director Swarnjit Singh, Trust Company Secretary Sarah Wilding, Chief Nurse and Director of Allied Health Professionals