NHS
Whittington Health
NHS Trust

Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board held in public on **Thursday, 25 July 2024** from **9.15am to 10.55am** held at rooms A1 and A2 Whittington Education Centre Highgate Hill London N19 5NF

Item	Time	Title	Presenter	Action
		Standing agenda items		
1.	*0915*	Patient experience story	Chief Nurse	Discuss
2.	*0930*	Welcome, apologies, declarations of interest	Trust Chair	Note
3.	*0931*	24 May 2024 public Board meeting minutes, action log, matters arising	Trust Chair	Approve
4.	*0935*	Chair's report	Trust Chair	Note
5.	*0940*	Chief Executive's report	Acting Chief Executive	Note
		Quality and safety		
6.	*0950*	Quality Assurance Committee report	Committee Chair	Approve
		Performance		
7.	*0955*	Finance and capital report	Chief Finance Officer	Discuss
8.	*1005*	Integrated performance Scorecard	Chief Strategy Digital and Improvement Officer	Discuss
		People		
9.	*1015*	Workforce Assurance Committee report	Committee Chair	Note verbal report
		Governance and Strategy		
10.	*1020*	Audit and Risk Committee Chair's report	Committee Chair	Note
11.	*1025*	Improvement, Performance and Digital Committee Chair's report	Committee Chair	Approve
12.	*1030*	Engagement Plan for the development of a Clinical Strategy	Chief Strategy Digital and Improvement Officer	Approve

13.	*1050*	Questions to the Board on agenda items	Committee Chair	Note
14.	*1055*	Any other urgent business	Trust Chair	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 24 May 2024

Present:	
Baroness Julia Neuberger	Non-Executive Director and Trust Chair
Dr Clare Dollery	Acting Chief Executive
Dr Junaid Bajwa	Non-Executive Director (via Microsoft Teams)
Dr Clarissa Murdoch	Acting Medical Director
Naomi Fulop	Non-Executive Director (via Microsoft Teams)
Amanda Gibbon	Non-Executive Director
Chinyama Okunuga	Chief Operating Officer
Nailesh Rambhai	Non-Executive Director
Baroness Glenys Thornton	Non-Executive Director
Rob Vincent CBE	Non-Executive Director
Terry Whittle	Acting Deputy Chief Executive and Chief Finance Officer
Sarah Wilding	Chief Nurse & Director of Allied Health Professionals
In attendance:	
Kelly Collins	Associate Director of Nursing Emergency & Integrated Medicine (item 1)
Jonathan Gardner	Chief Strategy, Digital & Improvement Officer
Tina Jegede MBE	Joint Director of Inclusion & Nurse Lead, Islington Care Homes
Mark Livingstone	Chief Allied Health Professional (item 1)
Liz O'Hara	Chief People Officer
Marcia Marrast-Lewis	Assistant Trust Secretary
Andrew Sharratt	Associate Director of Communications and Engagement
Mirela Sidor	Patient Experience Manager (item 1)
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 and gave a warm welcome to Liz O'Hara, who was attending her first Whittington Health Board meeting being held in public.
1.2	The following declarations of interest were reported: • Dr Clare Dollery declared that her sister-in-law, Dr Caroline Dollery, had been appointed as a non-executive director on the Board of the North East London NHS Foundation Trust. • Junaid Bajwa declared that he had been appointed as a trustee on the Board of Health Data Research UK.

	• Nailesh Rambhai declared that he had been appointed as an assessor for the Solicitors Qualifying Exam. **The Board noted the declarations which would be added to the register of interests.**
2.	**Patient story**
2.1	Sarah Wilding introduced Mr X, who had attended the meeting to talk about his experience as a patient at the hospital receiving treatment for Crohn's disease. Mr X said that he had had exemplary care at Whittington Health over the past eight years and highlighted the following points: • He became unwell at the age of 17 and it was thought that the stress of his A-level examinations was linked to his symptoms. It took another 18 months for a firm diagnosis, but, during this time, his condition had affected his studies, and he had to retake his A-level examinations. • Mr X stated that, at the time, he had very little knowledge about Crohn's disease and he found his prognosis frightening. He remembered his first infusion, where he was accompanied by a nurse, Shamila, who very kindly stayed with him for the entire process, which he found reassuring. • He was successfully treated with Infliximab, but after five years his body built up an immunity to the drug, and the gastrio team recommended a change in his drug therapy. • By this time, Mr X was in his last year at university and was unwilling to risk a delay with the completion of his master's degree, particularly when the retake of his A-levels had put him two years behind his peers. The gastrio team were understanding. He felt that, by this time, he had built a good rapport with the team, and they allowed him to continue with Infliximab. Mr X graduated with an upper second class master's degree and decided that he would pursue teacher training, as a physics teacher. During this time, the gastrio team commenced his transition to a new drug therapy which, together with the stress of teacher training, did not have the desired effect and Mr X's health began to decline. • After two months, Mr X had to withdraw from the course to focus on his health. The gastrio team recommended surgery and he was placed on a waiting list. He said that he found this period difficult, as there was no certainty of when the surgery would take place, as the UK and the world was slowly emerging from the pandemic. With his mental health in decline, Mr X's mother kept pushing for a date and, eventually, a date was agreed for his surgery. He felt it was important to get a firm date, in order to remain positive and his mother, despite her persistence, felt that she was treated with respect and compassion by all staff who appeared to understand the issues. • Once Mr X had had the operation, he made a good recovery, and, after three to six months, he was fully fit and continuing with the new medication. Mr X stated that he has been well for over two years and never thought that he could be as healthy as he currently was. He realised that his consultant had managed his expectations, as the surgery had variable results, and he remains grateful and fortunate that his procedure was a success.

	• Mr X highlighted the importance of regular contact and communication with the gastrio team, who are always on hand to address any issues or concerns quickly and to minimise any risk of stress, which could cause a flare up of symptoms. • Mr X added that it was also important to highlight patient success stories to encourage other patients going through the same condition or course of treatment. • Mr X reflected that it had been two years since the operation, and he was now living life to the fullest. He was very fit and was busy planning a camping expedition for his birthday. He thanked the team for all that they had done for him and made a plea for more resources, and for concrete timelines for patients waiting for similar operations to be prioritised. His long-term goal was to travel around the world, which he recognised he could not consider before, because of his condition.
2.2	In discussion, Board members raised the following points: • Sarah Wilding stated that the patient experience story demonstrated the importance of patient-centred care. She acknowledged the need to improve on patient waiting times for operations and said that a patient group was currently looking at this issue. • Chinyama Okunuga said that it would be good to have a younger person in the patient experience group, which was usually made up of older people who had more interaction with the hospital setting. A young patient would bring a different perspective to the group. • Clarissa Murdoch found that the patient's description of his care was similar to the experience of other people with chronic health conditions. She explained that, traditionally, patients with long term conditions were offered bi-annual appointments in outpatients, but these appointments did not always coincide with a patient's needs. She suggested that patients might benefit more from an expert patient self-management plan. This would require improved arrangements with the chronic disease management team and improved models of care for patients. Clarissa Murdoch reported that there was a "waiting well" initiative, designed for patients on waiting lists. The initiative encouraged good communication with patients and allowed the self-management of their conditions, in order to maintain their health, while they waited for an appointment date. **The Chair thanked Mr X for sharing his experiences with Board members and noted that he would be invited to participate in the Trust's Patient Experience Group.**
3.	**Minutes of the previous meeting**
3.1	The minutes of the meeting held on 26 March 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 staff who continued to work extremely hard in the face of significant demand for services and the additional pressures caused by

	ambulance diversions to the Trust. She acknowledged the fortitude of the executive team who had worked under unprecedented levels of pressure on and in the emergency department, as a result of the London Ambulance Service (LAS) diversions from North Middlesex University Hospital (NMUH), which began late on the evening of Friday 17 May.
4.2.	Clare Dollery explained that the long LAS handover times at NMUH had raised concerns about safety and had impacted on the availability of ambulances for call outs. She reported that a decision was taken by the Accountable Officer for the Royal Free Group and the Chief Executive of the LAS and agreed with NHS England (London region) to put in place a blue light divert from 11:00pm to 7:00am the next morning. This was communicated to NCL's chief executives. The diversions were shared between five hospitals: Whittington Health, Whipps Cross, the Royal Free, University College London and the Princess Alexandra in Harlow. However, as the week progressed a decision was made with the NHS London region to suspend the arrangement.
4.3	The Chair highlighted the Board seminar in April where items covered were the fire remediation plans for Blocks A and L and the proposed implementation of a misting solution and the Trust's 2024/25 plan submission on finances, activity and workforce to the North Central London Integrated Care Board (NCL ICB); and the outcome from the 2023 NHS Staff Survey.
4.4	The Chair informed Board members that, since her last report to the Board, she had undertaken several walkabouts across the hospital site and was pleased to report that the hospital was noticeably cleaner. She also observed an optimism with staff and volunteers that she came into contact with. **The Trust Board received and noted the Chair's report.**
5.	**Acting Chief Executive's report**
5.1	Clare Dollery thanked the executive team for the time they took to carry out their walk rounds and drew Board members' attention to the following issues: • The revised financial plan had been submitted to the NCL ICB. She acknowledged that the year would bring certain challenges, but colleagues were committed to producing good outcomes for the Trust. • Since her last report to the Board in April, there had been developments on industrial action. She confirmed that consultants had accepted a pay offer, but that junior doctors remained in negotiations with the government. The Trust Board was made aware that general practitioners were about to open a ballot about collective action, which would close in July. Internal discussions had focussed on areas of work that would revert to the hospital if collective action went ahead.
5.2	Emergency care performance against the four-hour access standard remained in the 70% range. However, 12-hour trolley breaches were still a problem. In part, this reflected the impact of the LAS post code changes which had increased the numbers of patients now coming to Whittington Health's emergency department.

5.3	Clare Dollery reported on several good new stories: • The local area partnership Special Education Needs & Disabilities inspection in Haringey was carried between 15 January and 2 February 2024 and resulted in the highest achievable outcome. • The Trust achieved full compliance with the maternity incentive scheme. • Extra mile award winners included Filipa Braga, Women's Health Clinical Governance Manager, who was the lynchpin of quality governance in midwifery and the maternity team and the administration team at the Haringey Child Development Centre, in recognition of their dedication and support for the service. • Transformative sickle cell treatment had been approved by the National Institute for Clinical Excellence and could help up to 4,000 people reduce the need for blood transfusions. • A Trust wide online open forum was held to discuss the findings of the report, "Too Hot to Handle", which examined racism and the experiences of black and minority ethnic staff members working across the NHS. The event was very well attended by staff. Clare Dollery thanked Tina Jegede and Swarnjit Singh for their hard work in organising the forum. She also thanked Professor Joy Warmington, Chief Executive of BRAP and co-author of the report, who provided an overview of the report. • An event was held on 9 May to celebrate the International Day of Midwives and Nurses, and the first administration professionals' staff awards. Clare Dollery thanked Sara Wilding, Chief Nurse and Director of Allied Health Professionals, and Chinyama Okunuga, Chief Operating Officer, for their work in making these events a success. • Following a recruitment exercise and advice from the Chief Medical Officer for London, Charlotte Hopkins had been seconded from Barts Health NHS Trust as Acting Medical Director from 3 June 2024. She took the opportunity to thank Clarissa Murdoch, who had been the interim medical director since 1 April, and who would resume her clinical duties, as well as her role as deputy medical director.
5.4	In discussion, Board members raised the following points: • Nailesh Rambhai commented on the success of the "Too Hot to Handle" event and observed that over 200 people had joined the discussion online, which he felt indicated a good sense of engagement by staff and the most numbers of people seen at such an event. • Rob Vincent reflected that metrics did not always tell the entire story about discrimination and that people's anecdotal evidence, through their lived experience, was also valuable. He also felt that the Trust was potentially moving into another period of uncertainty related to potential GP industrial action. He suggested that, during this period, the Trust should take the appropriate steps to ensure that patients were clear on any actions the Trust would implement during any potential industrial action. • Rob Vincent also observed that health inequalities was missing from the national priorities set out in planning guidance and urged the Trust not to drop that work and its oversight.

	• Tina Jegede thanked executive colleagues for their support for the open forum event which discussed the "Too Hot to Handle" report, which she felt had made the difference to staff engagement, as it was important to show commitment from senior leaders. • Jonathan Gardner assured Board members that addressing health inequalities was still very much part of the Trust's strategic priorities. He reported that the 2023/24 population health annual report would be discussed by the Quality Assurance Committee in July and that a health inequalities dashboard had been developed. • Naomi Fulop endorsed the learning from the "Too Hot to Handle" event. She also queried whether there were any planning mechanisms in place to prepare for GP industrial action. • In response, Clare Dollery explained that information received to date indicated that the description of collective action would be differently structured to previous strikes by junior doctors and consultants. Collective action by GPs would more likely reduce the availability of patient appointments, lead to a refusal to remove sutures or change dressings that were applied in hospital, or to issue and sign off fit notes. She said that the aim was to ensure that any additional work undertaken by the Trust would be in cooperation with primary care services. Clare Dollery added that the Trust would maintain close contact with GP Federations and be ready to mobilise if any strikes by GPs took place. She assured the Board members that the Trust was committed to reducing health inequalities, which was at the heart of patient care at Whittington Health. **The Trust Board noted the Acting Chief Executive Officer's report.**
6.	**Quality Assurance Committee Chair's report**
6.1	Naomi Fulop presented the report of the 8 May meeting of the Committee, where good assurance was received on the following items discussed: • The Committee received a presentation of a helpful audit of sickle cell patients in the emergency department (ED) and the time taken for analgesia to be administered. The Committee discussed the length of time sickle cell patients spent in the ED and were assured that most patients preferred to receive their treatment in the ED, instead of being admitted to a ward. • There was a good discussion on quality account priorities which were agreed and would now also include communication between patients and the Trust and the implementation of a wayfinding strategy – both of these issues had been raised in a previous patient story heard by the Board. • Q4 maternity report where good progress had been achieved in several areas. The Committee also identified the need to improve safeguarding training rates.
6.2	Naomi Fulop reported that the Committee received partial assurance from some reports, including the trust risk register, the quarter four quality report and the patient-led assessment of the care environment (PLACE). She also highlighted the following areas to draw to the Board's attention which the Committee would be following to gain more assurance: infection prevention and control and the rising numbers of clostridium difficile cases; risks identified

	in the Barnet 0-19 service; an increase in hospital and community pressure ulcers; the quality impact assessment process for cost improvement programmes; and concerns identified from the PLACE assessment.
6.3	During discussion, Board members raised the following points: • Clarissa Murdoch welcomed the good work taking place on compassionate care, which sought to ensure that pain relief was administered to patients with sickle cell disease on time in a challenging hospital environment • Sarah Wilding acknowledged the staffing capacity and gaps in processes in the Barnet 0-19 service and reported that work was taking place with the Improvement team to help address these. • Chinyama Okunuga confirmed that there had been a good meeting of the Capital Monitoring Group on 23 May and equipment was being ordered to help with anti-ligature risk work now taking place. **The Board noted the Chair's assurance report for the Quality Assurance Committee meeting held on 8 May 2024 and approved the revised Committee terms of reference.**
7.	**Annual safeguarding children & adults declaration**
7.1	Sarah Wilding presented the annual declaration in relation to the Trust's statutory obligations for safeguarding children and adults. She said that it was important to note that the Trust had strengthened both the process for managing allegations made against staff and the adult safeguarding team, with an increased focus on domestic violence. Sarah Wilding reported that, although there were some staffing gaps in the children's safeguarding team, there were systems in place to help keep vulnerable patients safe. **The Trust Board approved the annual safeguarding declaration for children and adults**
8.	**Annual mixed gender inpatient accommodation declaration**
8.1	Sarah Wilding referred to the annual statement of assurance that patients who require inpatient/day case care are cared for in single gender accommodation. She highlighted the current consultation on the NHS Constitution on this issue and explained that, although the Trust was largely compliant with the current requirements, there were instances when this happened by exception, due to clinical need, in areas such as the critical care unit, emergency care areas and some high dependency observation bays. **The Trust Board approved the statement of assurance for publication on internet.**
9.	**Integrated Performance Report**
9.1	Jonathan Gardner presented the report and made the following points: • The community services' dashboard showed the positive performance in the improving access to psychological therapies service, with performance in March at 93% against a target of 75% for patients to be seen in less than six weeks.

	• The low scores for the integrated community therapy team service were being validated and the data quality reviewed. • There was a slight dip in waiting times for the adult community podiatry service, due to staff sickness absence, which had now been resolved. • Although under target, the musculoskeletal service continued to show an improvement in performance. • For children's community services, there remained challenges in occupational therapy and in speech and language therapy. Staffing gaps in the London Borough of Islington meant that waiting times had increased. The service continued to work with the local authority to progress the rollout of the universal training offer to schools, to help upskill them to support children and young people with additional needs.
9.2	During discussion, the following points were raised: • Sarah Wilding drew attention to the change in guidance on the classification of pressure ulcers as one factor behind the increase in grade three and grade four pressure ulcers. She explained that the increase in pressure ulcers in the hospital was unfortunate and reflected challenges within the health and social care system, particularly delays in accessing equipment in the community from NRS Healthcare. • Chinyama Okunuga highlighted the 67% performance in April against the 92% target for referral to treatment. She explained that the number of patients who had waited longer than 52 weeks had fallen to 452 and the aim was to have no patients who had waited longer than 52 weeks by September. Chinyama Okunuga also said that there were six patients who had waited longer than 78 weeks for treatment since their referral. The majority of these patients were in vascular services. • Jonathan Gardner reported that performance against the cancer target remained good, but had fallen below the performance achieved in the previous month. • Chinyama Okunuga confirmed that performance against the four hour access standard in the emergency department was 71.9% in April, a decline from the 73.1% level achieved in the previous month. She acknowledged that the number of 12 hour trolley waits was an area of concern. • In reply to a question from the Chair, Chinyama Okunuga explained that there were delays in the local health and care system for mental health patients to be admitted for an assessment or for placement in a bed in a mental health unit, due to a lack of capacity. • Jonathan Gardner cited the positive performance in outpatients which saw over 7,000 procedures being carried out in April. He thanked the Improvement team for their focused work on improving the level of coding and on the accurate recording of procedures. This increase in activity would have a positive impact on the level of elective recovery fund monies the Trust received. • Jonathan Gardner welcomed the increase in the number of positive family and friends test responses from inpatients to 94.6%, above the 90% target. He also reported that there continued to be improvements in the Trust's performance in responding to complaints to 71% in April. In terms of the

	well-led indicators, Jonathan Gardner explained that, apart from the slight dip in performance on appraisals, these indicators were all rated as green. • Amanda Gibbon welcomed the improvement achieved in theatre utilisation compared with the previous month but remained concerned that this was below target. In response, Jonathan Gardner confirmed that improvement work had been embedded in the elective recovery workstream and that there had been changes in pre-operative assessments which would help reduce the number of cancellations; he expected that theatre utilisation performance would increase again this Summer. **The Trust Board noted the integrated performance report.**
10.	**Finance report**
10.1	Terry Whittle reported that, at the end of April, the Trust reported a deficit of £3.3m, a £1.7m adverse variance to plan. He explained that there were several factors behind this: • pay overspends for enhanced care services and for staffing pressures within the emergency department; • increased agency staffing expenditure. In April, the Trust spent £1.6m on agency staff, which represented 5.9% of total pay costs and was above the agency cap target set; • under delivery against cost improvement programme targets. The monthly profiled target was £1.4m and £440k was achieved in April. There were 123 schemes in development currently; and • having more beds open than the substantively funded bed base was costing c. £500k each month. Discussions were taking place with the NCL ICB with an acknowledgement that 25 of the 43 winter capacity beds needed to be part of the funded bed base for 2024/25.
10.2	Terry Whittle confirmed that there was good news on improved performance on the elective recovery fund, which was a direct result of the work of the Improvement team. He reported that the Trust's cash balance, at the end of April, was £81.3m, which represented a £18.7m favourable variance against plan. At the end of month one, Terry Whittle also confirmed that £300k of capital expenditure had been incurred. He explained that this was in line with plans. **The Board noted the month one finance report.** .
11.	**Workforce Assurance Committee**
11.1	Rob Vincent thanked Swarnjit Singh for producing an impressive report very quickly after the Committee meeting held on 20 May and outlined the items from which Committee members were able to take good assurance. They included a staff story from Kiran Sanger, Associate Director of Nursing and Haringey Borough Lead, on the range of support available to support staff health and wellbeing; the outcome from the annual workforce disability and race equality standard submissions to NHS England; the outcomes from the 2023 NHS staff survey; the Freedom to Speak Up Guardian's report, which was a separate item on the agenda today; and activity in quarter four on staff wellbeing and engagement. Rob Vincent explained that the staff survey had

	highlighted bully and harassment and morale as areas for action and increased focus in 2024/25. **The Board noted 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. The Board also approved the revised Committee terms of reference.**
12. 12.1 12.2	**Freedom to Speak Up Guardian's Report** Liz O'Hara thanked Ruben Ferreira, Freedom to Speak Up Guardian, for the report and explained that he could not attend today due to annual leave. She took the report as read and highlighted important points to note. • There was a positive relationship and collaboration model in place between the Trust's Freedom To Speak Up Guardian and the lead non-executive director with responsibility for speaking up, Rob Vincent. This successful collaboration model would be used by the National Guardian's Office to help train non-executive directors at NHS providers in their responsibilities. • It was pleasing to see that a good and diverse range of Speak Up Champions were in place to support the Guardian and staff who wanted to raise a concern. • The high number of concerns raised where staff had not sought anonymity was a testament to the positive culture at Whittington Health for speaking up. Jonathan Gardner reported that an NHS Providers' event held on 23 May had highlighted how the Freedom to Speak Up Guardian could help with raising quality and improvement. **Trust Board members received and noted the Freedom to Speak Up Guardian's 2023/204 annual report**
13. 13.1	**2023 NHS Staff Survey** Liz O'Hara took the report as read. She highlighted the positive 44% response rate and the staff engagement score which was above the national average. These outcomes were welcomed as the survey was conducted against a backdrop of significant challenges last year. Liz O'Hara explained that there was no room for complacency as it was important to focus on areas such as morale, flexibility, staff retention and health and wellbeing. **The Board noted the outcomes from the 2023 NHS staff survey and agreed the areas of focus for action to be: safe and health working, flexibility and morale to help improve retention.**
14. 14.1	**Workforce Disability & Race Equality Workforce Standard Submissions** Liz O'Hara thanked Tina Jegede and Swarnjit Singh for producing the paper and the annual data submission for NHS England. She reported that the outcomes were good and showed a positive trend over the last five years on indicators and in relation to meeting the New Model Employer targets set by

	NHS England.
14.2	Tina Jegede highlighted the increase in proportion of staff from a black and minority ethnic background in the Trust's workforce from 41% to 45% and acknowledged there was more work to do to raise the level of staff ethnicity and disability disclosures. She reported that bullying and harassment remained an ongoing area of concern, especially from staff who reported an increase in instances of racial discrimination from patients and visitors. Tina Jegede also highlighted other areas of focus including: having diverse recruitment and selection panels, work with the Metropolitan Police in Islington to support NHS staff as part of a zero tolerance approach to discrimination and continuing with the talent management programme for staff at Agenda for Change bands 2-7 and introducing a new programme for staff at band 8A and above. Rob Vincent commented on the composition of the workforce, in indicator one of the race equality standard submission, which showed a near 7% difference between the proportion of staff from a white and those from an ethnic minority background. **The Board noted the outcomes from the workforce disability and race equality standard which would be submitted to NHS England before the end of May and publicised on our external webpages and agreed to continue to support the ongoing work arising from these results.**
15.	**Charitable Funds Committee**
15.1	Amanda Gibbon thanked the small Charity team for their hard work, in particular the successful application to the NHS Charities Together Greener Communities Fund for £150k for a garden at Tynemouth Road. She reported that the Committee welcomed the £25k raised by staff running in the London marathon and that £28k had been raised through the evening with Sir Michael Palin event held on 25 April at Cadogan Hall, which would be used to support services at the Michael Palin Centre. Amanda Gibbon also informed Board members that the Committee had finalised a policy for charitable reserves and had approved a number of applications for charitable funds, including an initiative about wearable technology for patients with Parkinson's disease which alerted clinicians at an earlier stage to changes in a patient's condition. Junaid Bajwa suggested that there was an opportunity for further collaboration with University College London Hospitals NHS Foundation Trust by seeing the research and work taking place at Queen's Square on Parkinson's disease.
16.	**Any other business**
16.1	There were no items raised.

Trust Board, action log

Action carried forward from January 2024 meeting

Agenda item	Action	Lead(s)	Progress
Patient story	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.

24 May 2024 meeting

Agenda item	Action	Lead(s)	Progress
Declarations of interest	Include the declarations from Clare Dollery, Junaid Bajwa and Nailesh Rambhai on the register of interests for Board members	Marcia Marrast-Lewis	Completed
Patient story	Invite the patient to be a member of the Patient Experience Group	Sarah Wilding	Completed
Annual safeguarding children and adults' declaration	Publish declaration on our external webpages	Sarah Wilding	Completed
Annual mixed gender accommodation declaration	Publish declaration on our external webpages	Sarah Wilding	Completed

Agenda item	Action	Lead(s)	Progress
Workforce Assurance Committee	Submit the outcomes from the workforce disability and race equality standard to NHS England by 30 May	Tina Jegede / Swarnjit Singh	Completed

Meeting title	**Trust Board – public meeting**	**Date: 25 July 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 24 May 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 emphasise my thanks to all of our staff and volunteers for their hard work in delivering safe services and a good experience for our patients. I recognise the pressures that colleagues continue to face with demand for services and the impact of industrial action and, along with all Board members, am very grateful to them.

May and June private Board meetings and June Board seminar

The Board of Whittington Health held private meetings on 24 May and 28 June. The items discussed in May included a fire rectification outline business case for works to remedy identified defects in blocks A and L of the former private finance initiative estate; a report on Simmons House; and the 2024/25 financial plan submission to the North Central London Integrated Care Board.

In June, the Board received an update on the Start Well programme which covered the themes arising from engagement and consultation on the proposed changes to maternity, neonatal and paediatric services, the methodology used and the proposed next steps. In addition, Board members considered items which included a report from the Acting Chief Executive; a report on Simmons House; the audited 2023/24 Annual Accounts and Annual Report, which had been approved by the Audit and Risk Committee, through delegated authority; the 2023/24 Quality Account; a Chair's assurance report from the Finance and Business Development Committee; the regular monthly finance and integrated performance reports; an update on the Barnet 0-19 service; and an update on hospital cleaning services. The topics covered at the June Board seminar included a presentation on the collaborative work taking place with University College London Hospitals NHS Foundation Trust, and a presentation on risk management and the role of the Board.

Fit and Proper Person Test (FPPT)

The Kark Review in 2019 reviewed the scope, operation and purpose of the Fit and Proper Person Test (FPPT) and highlighted areas that needed improvement to strengthen the existing arrangements. NHS England developed a Fit and Proper Person Test (FPPT) Framework in response to the recommendations from Tom Kark KC which also took into account the requirements of the Care Quality Commission in relation to directors being fit and proper for their roles. I can confirm that in line with the requirements of the FPPT regulations, our FPPT annual report was submitted to NHS England (London region).

Annual Appraisals

I had my annual appraisal with the Senior Independent Director using the updated Chair Appraisal Framework issued nationally, and the outcome was reported to NHS England by the deadline of 30 June. I also completed all of the appraisals for non-executive director colleagues, in line with the Leadership Competency Framework produced by NHS England.

Staff awards

I was delighted to attend this year's staff awards which were held at the Royal College of Physicians. It was a truly memorable night, with Michael Rosen sharing

the story of how we saved his life, with deep gratitude and loud humour, bringing life and energy to the awards themselves.

There were some very worthy winners of the staff awards and a full list of the successful nominees in each category are included in the Chief Executive's report to this Board meeting.

I have also participated in the following meetings and events:

- On 10 June and 8 July, I took part in corporate induction training and welcomed new starters to Whittington Health.
- University College London Health Alliance
- University College London Hospitals and Whittington Health Committee-in-Common
- NCL Strategy and Development Committee
- Quality Improvement celebration event
- Charitable Funds Committee
- Whittington Health Board meetings
- 1:1s with the Acting Chief Executive, Chief Finance Officer, Acting Medical Director and the Head of the Charity

Meeting title	**Trust Board – public meeting**	**Date: 25 July 2024**
Report title	**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.	
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

General Election and NHS review

Following the outcome of the 4 July General Election, Wes Streeting has been appointed as the Secretary of State for Health and Social Care[1]. The Ministerial team supporting him includes Stephen Kinnock, Karin Smith, Baroness Merron and Andrew Gwynne. The new Government has highlighted three priority areas: moving more care out of hospital into primary and community; a better use of technology and data and boosting prevention – maximising the opportunity of local partnership working to support people to stay well, reduce health inequalities and help people stay in work. On 11 July, the Secretary of State announced a full independent investigation into the state of the NHS. This review will be led by the Rt Hon Professor Lord Darzi, OM, KBE, a lifelong surgeon and innovator, independent peer and former health minister. The review's findings will feed into government's 10-year plan to radically reform the nation's health service. Amanda Pritchard, NHS Chief Executive, has said that ".this comprehensive analysis will be an important step in helping us to build an NHS fit for the future." During the State Opening of Parliament on 17 July, the King's speech outlined plans to introduce a gradual ban on smoking in a Tobacco and Vapes Bill and to have a Mental Health Bill to amend the Mental Health Act 1983 to give people detained greater choice and autonomy and limit its use for people with learning difficulties while broadening alternatives for care.

Industrial action and Ballot for Collective action

On 18 June, it was announced that speciality and associate specialist doctors accepted a pay offer. This was welcome news. The Trust prepared for the five-day strike by junior doctors from 0700 on 27 June to 0700 on 2 July, drawing on the experience from earlier industrial action. Patient safety remained our overriding priority. Talks between the new government and the British Medical Association have resumed with the aim of resolving the junior doctors pay dispute.

The BMA's ballot for collective action opened for GP partners in June and closes at midday on Monday 29th July. Collective action is different to industrial action and may include an indefinite period of reducing appointment numbers and other activity not within the GP core contract. The Trust will be working with the ICB and primary care to prioritise patient safety in the event of action taking place which is possible from August 1st.

Cyber security

Following the 3 June ransomware cyberattack on Synnovis, a provider of laboratory services to the NHS in South East London which resulted in the declaration of a critical incident, Whittington Health has reminded all its staff of the high priority placed on effective cybersecurity. We have also implemented comprehensive monitoring systems to oversee our entire IT infrastructure and conduct routine security patching to maintain our defences and the need to remain vigilant at all times in order to help stop phishing attacks.

[1] His Majesty's Government: Department of Health and Social Care - MPs and Lords - UK Parliament

Long Term Conditions
I am pleased to report that Whittington Health is keen to play its role in a new and exciting initiative being taken forward by the North Central London Health Alliance to help patients by improving healthcare outcomes and reducing the overall healthcare utilisation for adult patients, registered with primary care services, and living with highly complex multiple long-term conditions. Nadine Jeal, Clinical Director for Adult Community Health Services is representing Allied Health Professionals in this important work alongside Jonathan Gardner, who represents Whittington Health on the steering group.

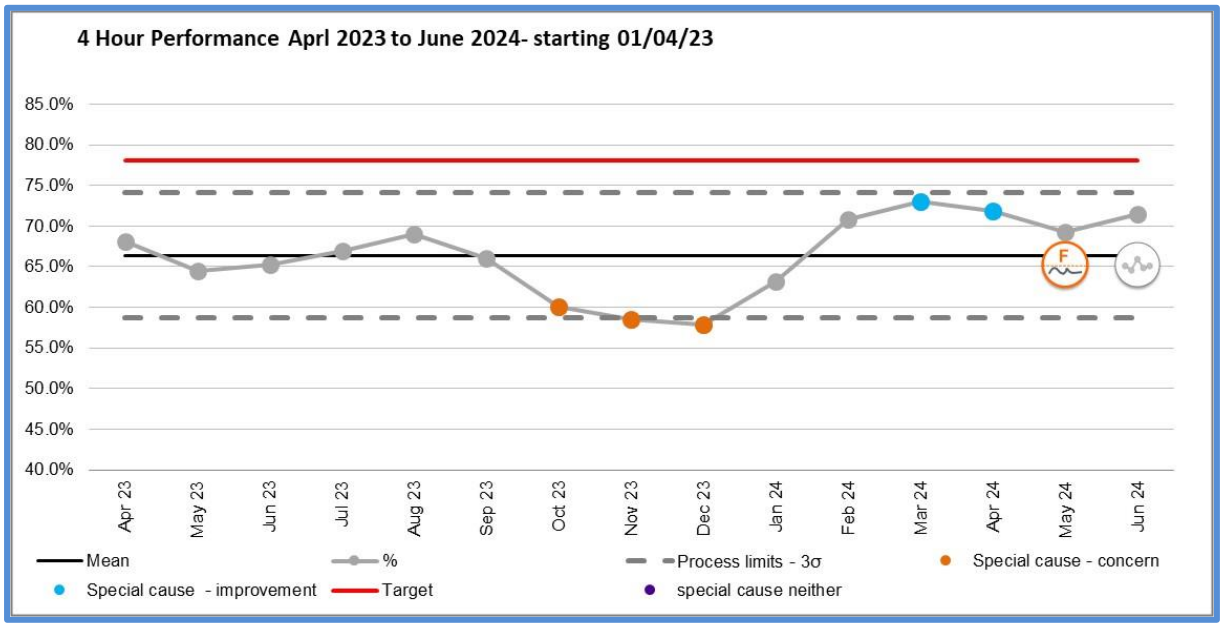
Highgate East Mental Health Centre

It was wonderful to attend the official opening of the Highgate East mental health inpatient building at North London Mental Health Partners, a brand new, 78-bed, inpatient mental health facility. It has been fascinating to watch this facility being built adjacent to our hospital on the site of the old Whittington Health Education Centre. Alastair Campbell, journalist, author and broadcaster opened the unit and our local MP, Jeremy Corbyn, jointly unveiled the plaque. This is a unique opportunity to take advantage of the very close co-location of mental and physical health inpatient facilities to improve care for patients with serious mental illness and physical health needs. I would like to thank all colleagues in our respiratory, care of elderly, and ambulatory care units who already collaborate clinically in this area.

Senior staffing changes
I am delighted to welcome Dr Charlotte Hopkins who joins Whittington Health as Acting Medical Director from 3 June to 28 February 2025. Before joining the Trust, Charlotte held several leadership positions at Barts Health including Clinical Director and the Deputy Chief Medical Officer and was also seconded to University Hospitals Sussex as their Chief Medical Officer. I would also like to thank Dr Clarissa Murdoch,

who temporarily stepped into the role of Acting Medical Director for the excellent work she did as Acting Medical Director since 1 April.

Operational pressures and ED performance
Performance against the four-hour emergency department (ED) standard is shown in the graph below covering the first quarter of this financial year. Continued NCL sector pressures with regular LAS diverts and formal postcode redirections have continued. Issues to note include the high number of patients needing out of borough conveyancing and the discharge bottlenecks into the community, which impact on wider hospital flow. In June, the daily average for ED attendances (304 patients) remained similar to May's daily average of 307 patients.



ED attendances in June 2024 (9,127) were higher than when compared to June 2023 (9,098). There has been a noticeable increase in patient acuity. There was also a surge in paediatric activity through the front door which, when taken together with the increase in patient acuity, has resulted in a longer average inpatient length of stay on the wards. Internally, Whittington Health has established an ED Improvement Working Group which focuses on improving streaming pathways to the urgent treatment centre and primary care services and working with GP liaison to engage with primary care partners; increased collaboration and streaming to ambulatory emergency care to improve pathways. We are pleased that following collaborative discussions with Haringey Social Services, Social workers will be working on site at Whittington Hospital enabling us to work in tighter collaboration.

2023/24 Annual Report and Accounts and 2023/24 Quality Account
I would like to thank all colleagues who contributed to the successful submission of our 2023/24 Annual Report and Accounts to NHS England on 28 June, and for the publication of our 2023/024 Quality Account on our webpages on 30 June. Both publications showcased successes and achievements during the last financial year, of which Whittington Health is rightly proud.

Fire safety week

On 22 July, Whittington Health will be having a focused fire safety week including reminding everyone about the steps we can all take protect ourselves, our patients and service users and our colleagues from the risk of fire. It is our focus because one of the biggest fire risks is complacency. Fires can and do happen, and we must always be vigilant and follow all fire safety rules. Healthcare environments are at particular risk of fires – for example our use of oxygen can make it easier for fires to start. Our week of activities will include a fire evacuation drill, advice from fire fighters from our local fire station for staff at the Trust and tips for better home fire safety.

I would also like to update on other fire related work across the Trust. Following the Trust Board's consideration of a fire remediation Outline Business Case (OBC) in May, Whittington Health submitted the business case to the North Central London ICB and NHS England (London Region) on 24 June. The Trust has also received a Fire Safety Management Audit from our Authorising Engineer for fire (an independent advisor), Since the OBC submission, two meetings have taken place with partners to provide assurance on the proposed engineered solution.

New CT Scanner, 'Godfrey'

On 6 June, the emergency department unveiled its new state-of-the-art computer tomography (CT) scanner, retiring the older model which had served the community for many years. The name Godfrey was ultimately selected to honour Godfrey Hounsfield, someone who played a pivotal role in developing the CT scanner.

Neonatal Care accredited as Bliss Baby Charter Gold

I am especially delighted to report that our Neonatal Intensive Care Unit has been officially accredited as gold in the Bliss Baby Charter Scheme. Our unit is the first in London to achieve this level of accreditation from the charity. The scheme is the

UK’s standard for developing, measuring and improving family-integrated care for premature and sick babies.

This has been a ten-year project for our team as the unit progressed from bronze, and silver, to gold. Research has found that a family-integrated approach to care brings with it proven benefits to the baby, family and unit staff. Benefits for baby and family include improved long-term health outcomes, enhanced bonding, increased parental confidence increased breastfeeding rates and allows families to make positive memories even during a stressful and worrying period.

CEO staff briefings

Since the last Board meeting, well-attended staff briefings have been held for staff. The topics covered have included highlighting Volunteers’ week, 3-7 June; awareness of the history and background of Pride month and events taking place; the importance of completing annual fire safety training for all staff; and an update on the new Tynemouth Road gardens; a visit by a team from NHS Blood and Transplant; the work of the Improvement team in outpatient services; a spotlight on the Macmillan Cancer team and their invaluable work at the Trust, and the annual Quality Improvement celebration event the overall winner was a collaboration between London Ambulance Services and our rapid response teams.

Pride month

As part of June’s celebration of Pride Month, the Trust’s LGBTQ+ network organised a series of events to celebrate and educate colleagues. They included talks on asexuality and health inequalities and how to support LGBTQ+ individuals with a serious diagnosis.

Staff Awards
I would like to thank all the nominees and winners in our excellent annual staff awards on 4 July. Details of the winners in each category are shown in the table below, along with a picture of all of them.

Award category	Winner
Innovation or improvement of the year – Team award	Richard Cloudesley School Physiotherapy Team
Innovation or improvement of the year – Individual award	Naomi Wardle, Musculoskeletal Physiotherapist
Unsung Hero Award	Chemotherapy Day Unit Team
Paula Mattin Emerging Leader Award	Arul Bangalore, Rapid Response Matron
Annabelle Lake Administrator of the year	Derya Gulcelik, Receptionist
Commitment to Excellence in a Clinical Role Award – Team or individual	Sarah Tabarina, Healthcare Assistant
Commitment to Excellence in a Non-Clinical Role Award – Team or individual	Richard Peacock, Librarian
Outstanding Contribution to Ensuring Equity	Durline Griffiths, Co-Chair for Whittington Health Admin Forum
Outstanding Contribution to Ensuring Compassion	Integrated Community Ageing Team
Whittington Health Charity Fundraiser of the Year	Gemma Ingram-Adams, Lead Cancer Nurse
Chair's Special award	Jane Vallance, Speech and Language Therapist
Chair's Award	Alicia St Louis, Head of Midwifery

Extra Mile Awards

There are two deserved award winners for June. Laura Dick, Occupational Therapist, was cited for being an exceptional occupational therapist on the elderly care ward, who exemplifies excellence in her work, particularly in treating and assessing older adults with frailty and dementia. As a safeguarding champion, she consistently prioritises patient safety and well-being. Her dedication to understanding and addressing the unique needs of each individual, ensures that her patients receive the highest quality of care, with a supportive and respectful environment fostered, to facilitate patient independence so they can be discharged home safely with adequate support and aids. Eleni Christodoulou, Business Manager, Estates and Facilities was acknowledged for going above and beyond, on a daily basis and the fantastic job she did in organising the Estates and Facilities day on 19 June.

Meeting title	**Trust Board – public meeting**	**Date: 25 July 2024**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 6**
Committee Chair	Naomi Fulop, Non-Executive Director	
Executive leads	Charlotte Hopkins, 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 10 July 2024 and was able to take good assurance from the following items considered: • Haringey Urgent Response LAS/UCR Car project. • Q1 Board Assurance Framework Quality and Integration 2 entries • Maternity Board report • Impact of industrial action update • Serious Incident report • Annual Population Health report • Final Published Quality Account • Annual Compliments, Complaints and PALs report Committee members took partial assurance from the following agenda items: • Chair's assurance report, Quality Governance Committee • Trust Risk Register • Anti-ligature update report • Bi-annual Health & Safety report • Pressure Ulcer Update report • 0-19 Childrens Services update Following discussion, the following areas were agreed to be reported to the Trust Board: 1. Pressure Ulcers in the community. 2. Barnet 0-19, risks regarding transfer of a fragile service 3. Management of Ligature risks across the Trust	
Purpose	Noting	

Recommendation	Board members are asked to note the Chair's assurance report for the Quality Assurance Committee meeting held on 10 July 2024.
BAF	Quality 1 and 2 entries and Integration 2 entry
Appendices	1. Bi-annual Health & Safety Report 2. Annual Compliments, Complaints and PALs Report 3. Annual Population Health Report 4. 2023/24 Quality Account: https://www.whittington.nhs.uk/document.ashx?id=15692

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	10 July 2024

Summary of assurance:

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

Haringey Urgent Response LAS/UCR Car project

Committee members welcomed a presentation from Anthony Antoniou on an initiative developed with the London Ambulance Service (LAS) for the treatment of category 3 and 4 patients at home. The aim of the project was to reduce the number of ambulance conveyances to hospital with the support of a senior clinician on the call out. The Committee learned that the London Borough of Haringey joined the project in November 2023 and commenced training for nurses and allied health professionals. Committee members were advised that the service focussed mainly on frail patients who had suffered a fall. Adding a nurse or allied health professional to the call out meant that the patient would receive a multi-disciplinary approach to treatment and avoid the need to go to hospital. Prior to November, approximately 70% of those patients were taken to hospital but since then, clinicians have reduced the number of ambulance conveyances by approximately 35%. The Committee was assured that clinicians were reserved for an urgent response. Arrangements could also be made for therapists to return to patients the following day to link back to community services. Since the start of the service an additional 60 to 70 patients remained at home during the period mid-November 2023 to April 2024. It was confirmed that the LAS was carrying out data analysis to determine whether the patients that remained at home were later taken to hospital.

The Committee recognised that additional staff were not recruited but staff were used from hospital services, they queried whether there were any consequences from using hospital clinicians for this service. Committee members learned that out a seven-day period, Haringey provided the service for three days. The cost of bank nurses was borne by LAS.

The Committee queried whether staff going out with the LAS were kept busy. It was explained that clinicians saw an average of three to four patients a day but they had the opportunity to select the callouts they would attend so that they were slightly under-utilised. However, there was a drive to increase the numbers to five or six a day.

Committee members were assured that the service would not obstruct access to hospital services for the frail and elderly. They were also informed that, therapists were all part of the falls pathways and had been trained to carry out many multidisciplinary assessments, which was part of linking patients into appropriate services as quickly as possible.

The Committee thanked Antonio Antoniou for the presentation and would look forward to receiving the analysis of the data gathered on the numbers

of patients who were later taken to hospital and a cost benefit analysis of the service.

Board Assurance Framework – Quality & Integration 2 entries
The Committee reviewed the risks to the delivery of the Trust's quality and integration strategic objectives and agreed that the risk scores would remain the same. Committee members were informed that minor amendments to the wording around CQC preparedness meetings had been changed to "learn innovate and improve". Committee members were advised that no changes had been made to Integration risk's score. The Committee approved the scores and actions to mitigate but felt that more progress should have been made along the trajectory of population health.

The Committee approved the Board Assurance Framework

Serious Incident Board report
Committee members considered the Serious Incident (SI) report covering April to June 2024. They found that one patient safety incident investigation (PSII) was declared in June regarding pressure ulcers in community services. Four serious incident reports were submitted to the North Central London Integrated Care Board (NCL ICB) which were all overdue, with two serious incident investigations beyond the 60 day deadline for submission to the NCL ICB.

The paper also highlighted the learning shared with staff from the following SIs and one Never Event which included the following issues:

- Neonatal intraventricular haemorrhage. The key areas of learning included reviewing the risk factors before completing a lumbar puncture in a vulnerable patient; reviewing thresholds for consultant notifications and attending the unit out of hours; and reviewing the recognition and response to the deteriorating patient.
- A risk factor form was required prior to screening was completed incorrectly indicating that a baby had a programmable VP shunt. Key areas of learning included the re-design and co-production of the risk factor form; the update of local guidelines to be discussed at relevant meetings; an increase in formalised education and training regarding newborn hearing screening for neo-natal intensive care unit (NICU) and midwifery staff.
- A right ureteric stent insertion was due to be inserted, however, a left side ureteric stent was initially placed in error. Key areas of learning included the urology and theatres team embedding a process whereby both ureteric orifices were located prior to stent insertions; a second check should be done intraoperatively before the insertion of the guide in 2023/20135 23, in order to review the patient's imaging and correlate it with the surgical site; and, the Imaging team would develop a chart to be placed on each theatre x-ray machine to aid decision making regarding orientation.
- Committee members were informed that the full duty of candour had been undertaken for all these incidents.

Committee members discussed the effectiveness of the Patient Safety Incident Response Framework (PSIRF) methodology and reporting which would replace serious incident reporting in due course. Committee members sought assurance that PSIRF would facilitate open and transparent reporting of incidents as well as shared learning. Committee members were informed that

	the Trust held weekly Whittington Improvement Safety Huddle meetings in which all new incidents were discussed and learning shared. The Acting Medical Director also informed the Committee that discussions had been undertaken with other hospital trusts who were ahead on the roll out PSIRF, for new ideas, a measurement framework would be developed. **The Committee noted the report.** **Impact of Industrial Action update** The Committee received a verbal update on the impact of industrial action taken by junior doctors from 27 June to 2 July. During this period, the hospital site was covered safely, with no derogations. Committee members were informed that teams pulled together effectively and were agile covering for colleagues on sick leave. The Committee was advised that strike action had impacted activity. In outpatients' appointments, there was 9% reduction for first appointments and a 12% reduction for follow-ups. In theatres, a hybrid theatre of a mix of cancer and urgent cases was in place as well as trauma theatre for emergencies. Committee members received assurance that patient safety was not compromised. **Maternity Board report** The Committee took assurance from the comprehensive quarter one 2024/25 maternity report which detailed the following key issues: • Care Quality Commission (CQC) Standards – highlighted areas focus around mandatory training rates of medical staff, children safeguarding, level 3 training of medical staff, maternity theatre and support worker staff; the review of policies, guidelines and procedures and dedicated staffing cover for the maternity triage telephone .An area of concern noted was mandatory training rates of medical staff, children safeguarding level 3 training of medical staff, which had been escalated to the Obstetric lead and Clinical Director. • Maternity Incentive Scheme (MIS) year 6 was published in April. The ten safety actions for year six had been agreed and updated in partnership with the MIS Collaborative Advisory Group. The submission deadline is midday on 3 March 2025 • Quality improvement projects – the Neonatal Quality Improvement Project was a requirement of safety action 3 of the MIS. • Maternity dashboard with a focus on obstetric hemorrhage appeared to be on the higher side in April. All cases were clinically reviewed, and women had been seen in antenatal clinics. • Induction of labour rates had risen and stabilised at 30%, in line with the increased numbers of inductions. A plan was in place to carry out more audits to improve understanding. • There were 20 babies that required admission to the Neonatal Intensive Care Unit in May. The main reasons were respiratory distress or a need for further monitoring. • Midwifery workforce investment and restructure – the funding for an increase in the maternity and neonatal workforce has been confirmed to ensure safety actions were met. • Maternity and Neonatal Voices Partnership update – one of the co-leads of the group had announced her departure. A recruitment exercise was underway with the aim of appointing a new lead by September 2024.

The Committee discussed the Year 6 MIS scheme of work. It was noted that plans were in place to provide the evidence needed for compliance against each safety action. However, there were challenges around training and making sure that consultant training was completed on time. More training dates would be made available. Committee members were informed that maternity boards across NCL were scheduled to meet separately, to share learning on their compliance with safety actions. The meeting should take place by 30 November, in good time to complete their final submission by 30 March 2025.

The Committee noted the report.

Annual Population Health Report

Committee members were apprised of the progress with the population health work undertaken at the Trust. The Committee learned:

- That Trust's strategic objectives aligned with the Population Health national strategy, particularly priorities set out for adults and children in the Core20 PLUS5 initiatives,
- The Trust worked with public health colleagues across Islington and Haringey to update data.
- The local population was younger, there were increased areas of deprivation, A&E attendances were higher and the main causes of avoidable death, in line with Core20PLUS5 were cancer, cardiovascular and respiratory disease. Cardiovascular and mental health illness were higher than in other parts of London.
- Apart from looking at the population health data Trust data indicated a high number of did not attend (DNA) rates in outpatients, related to deprivation.
- The data was used to inform the programme of work, which covered communications and the review of data quality and as well as the anchor institution work.
- A Health Inequality Steering Group had been set up to keep track of progress across the services and which focussed on providing oversight of the anchor work, improving the quality of the data, and looking at the Core20PLUS5 deliverables.
- Relevant projects across services included:
  - Tobacco dependency service for inpatients.
  - Health Equity audit which was carried out at the Community Diagnostic Centre (CDC). It looked at referrals which found that the CDC had an impact on some of the more deprived and under-represented groups.
  - A research study which looked at health literacy and health, numeracy. The findings would support the improvement in communications with the local population.
  - The health anchor institution work. The partnership with local providers had rolled out programmes of work around employment procurement.
  - The corporate health inequalities self-assessment tool from NHS Providers gave objectives around how the trust should address health inequalities

The Committee discussed the practical steps around working with public health teams to drive the population health agenda. Work undertaken thus far, looked at gaps in services, health literacy and numeracy which had influenced the outpatient transformation work; training staff in the CDC to ask about ethnicity and the development of dashboards.

Committee members were referred to the plan of work and priorities which had been derived from an analysis of data obtained on diabetes, respiratory heart failure, cancer, and quality improvement to address DNA rates. The Committee agreed that a clear action plan would support more understanding and track progress.

The Committee noted the report and would look forward to receiving regular updates on progress.

Annual Compliments and Complaints report

The Committee considered the report which included the following highlights:

- The patient experience team and volunteers continued to work with patients and service users to obtain feedback and through friends and families tests.
- A focus group on patient letters had been set up and received good engagement from a wide cross-section of patients and service users, including people with learning disabilities.
- Work with Healthwatch Haringey to look at DNA rates amongst young black men to see if services could be adapted to support those service users.
- Boards had been erected in wards to display compliments, complaints, lessons learned and carers concerns. Wards were encouraged to complete these boards to promote a culture of openness and transparency.
- There were 347 complaints in 2023/24, an increase of 31%. The biggest areas for complaints covered long waiting times, the emergency department and the cancellation of appointments due to industrial action.
- Complaint response times were 55% against a target of 80%. Improvements were noted in the first quarter of 2024/25.
- Four complaints were referred to the Parliamentary and Health Service Ombudsman. One was upheld and related to a complaint around the care of a patient with breast surgery. The other three complaints were still under investigation.
- An analysis of the ratio of complaints to people that attended the Trust had been carried out and indicated that 0.3% of service users had cause for concern.
- The Patient Advice and Liaison team had 2,605 patient and service user contacts, for the same reasons as complaints around appointments, cancellations and communication.
- Local GPs had raised five alerts which were general concerns and not patient specific. There were also 129 complaints from GPs relating to appointments, communication delays and difficulties getting through on the telephone.

The Committee received assurance that complaints training would continue throughout the year.

The Committee noted the 2023/24 Annual Complaints and Compliments Report.

Final Published Quality Account

The Committee received and noted the final published report.

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 12 June 2024 where significant or reasonable assurance was taken from most of the items discussed. The Committee noted the areas of risk escalated to it by the Quality Governance Committee (QGC): • Ligature risks –there was a lack of assurance around the regular meetings of the team and the appropriate level of clinical engagement of ligature risk work. • Community pressure ulcers and NRS equipment issues. • Insufficient access to water fountains had impacted staff morale and patient experience and feedback from staff had been received at clinical and non-clinical meetings. • Food allergen training required as part of Health & Safety compliance was having an impact on large clinical teams. The training needed to be planned to limit the impact on teams while essential targets were met. The QGC acknowledged several areas of work outlined in the Adult Community Services report which highlighted: • Good self-management and accessibility to the diabetic service evidenced by the data from the service. The report stated that 79% of diabetic foot ulcers were less severe at presentation, as patients now presented earlier to the service. • Challenges around the capacity to manage the complexity and intensity of post stroke rehabilitation and the mismatch between commissioner and provider expectations. The Committee noted that the QGC had received a report from the Acute Patient Access Clinical Support Services Women's Health clinical division which highlighted the trial of a radiographer led Hot-Reporting service for the Emergency Department (ED). This service aimed to provide definitive chest X-ray and musculoskeletal X-ray reports for patients before they left ED. The initial impact had shown a significant reduction in report turnaround times, compared with previous arrangements. The Committee also noted that there was moderate assurance from the Health and Safety report and that the fire watch security team was now at full capacity. The Committee discussed the issues related to the deployment of water fountains across the Trust and were assured that work was ongoing to ensure that water coolers were in place in peak areas, before the next heat wave. The Committee was informed that additional communication would be sent out to staff on how to keep cool during hot weather. The Committee received assurance that issues had been brought to the attention of the executive team who would approve the substantive programme of work needed to resolve the issues going forward. **The Committee noted the report and agreed that an update report would brought back to the next meeting.**

Trust Risk Register

The Committee reviewed the risk register report which had been updated to reflect:

- 37 risks were scored at 15 or above on the risk register, of which seven yet to received executive approval.
- There were five new covering the following issues:
  - The C block main intake panel was obsolete and at risk of a significant catastrophic power failure.
  - Staffing and workload in the Children's Safeguarding team. There was a gap within the Head of Children's Safeguarding, an interim arrangement was in place to mitigate the risk. There were also gaps at named nurse level due to sickness and resignations. Discussions were ongoing with University College London Hospital NHS Foundation Trust to agree a joint arrangement, as an interim measure for the named Midwife role . The named nurse role in Haringey had been filled, the successful candidate is due to start towards the end of July.
  - A 6-facet survey of asset management, critical infrastructure, and back log of works. Funding of around £127m over a ten-year period was needed for rectification. Funding allocations for the year would be used to address the highest risks.
  - The Barnet Healthy Child Programme had long waits for mandated contacts and contacts for children moving into the borough. An Interim Head of Children's Safeguarding for Barnet had been appointed. The Deputy Chief Nurse would meet with safeguarding teams to offer additional support and the chief nurse continues to work with the NCL ICB to develop mitigations.
- There were three closed risks
  - No CT scanner on same floor as Critical Care for 16 weeks due to upgrade works - a CT scanner is now in place.
  - Simmonds House environment and estate. There were currently no inpatients in this facility and therefore no immediate risk to patients.
  - Delivery of Barnet 0-19 health visiting and school nursing service – this risk was incorporated into other risks related to the Barnet 0-19 service and was therefore closed.

The Committee discussed the Barnet 0-19 Service and the risks related to health visiting and new birth visits at 10 weeks and agreed that they represented a risk to newborn babies and families. Committee members were informed that an Interim Head of Safeguarding had been appointed in Barnet who would work closely with the interim Head of Children's Safeguarding. The long term plan was that the teams would eventually merge. Health visiting teams were also working closely with safeguarding colleagues and continue to provide support to the Barnet and Haringey teams.

The Committee noted the report.

Bi-annual Health & Safety report

The Committee reviewed the report which highlighted the corrective actions that were undertaken around Safety Alert Notices specifically related to food allergens. The Committee was informed that progress had been made with the formulation of patients' daily diet status. In addition, Committee members learnt

that Trust-wide training for a compliant food service and adherence to Food Standards Agency requirements would also be rolled out imminently.

The Committee was informed that the Trust's performance for monthly health and safety and weekly fire returns was 85%, the risk was considered moderate. Several actions to improve performance included, face-to-face visits at health centres and sending monthly chaser emails. Security inspection returns were monitored at the Security and Personal Safety Group.

The Committee received assurance that fire risks remained moderate and that fire remediation projects were in progress and mitigating actions were in place. The risks were regularly reviewed by the Executive team. The London Fire Brigade and NHS England were regularly updated. A number of capital schemes were in development and progress was also reported to the capital investment group.

The Committee noted the report.

Pressure Ulcer update

Committee members considered the report which highlighted:

- An overall 10% reduction in pressure ulcers for 2023/24 against a target of 20%, and a target of 50% for full thickness pressure damage.
- The number of pressure ulcers in the community were higher than in the hospital. Some of the challenges in the community were around equipment issues.
- The data indicated that full thickness pressure ulcers in the community were higher.
- The critical care unit had the highest number of medically related pressure ulcer injuries, the severity and full thickness was much lower in the ED. Cavell and Mercers wards had twice achieved 100 pressure ulcer free days.
- Mercers ward had the only category 4 pressure ulcer in an acute setting in February 2024.
- The themes identified were found to be delayed and incomplete skin assessments; insufficient evidence of pressure ulcer prevention care planning; a lack of evidence for repositioning because community services were heavily reliant on carers and family to help; non-concordance by families and patients who constantly refuse equipment. Ongoing issues with the timely delivery of pressure relieving equipment by NRS.
- Mitigating actions in place included ongoing discussions with suppliers and a robust escalation plan. Increased training and education for staff and patients' families
- Pressure ulcer workshops were held to identify issues related to management of pressure ulcers. Committee members discussed early skin assessment, it was recognised that the responsibility lay with both families and clinicians to make sure that patients could get treatment for ulcers as quickly as possible. All new patients were assigned a skin bundle which meant that they would have regular skin checks. Wound photography was also peer reviewed. The Committee noted a Patient Safety Incident Investigation (PSII) had been undertaken in June related to the rising number of grade 3 and 4 pressure ulcers within the community. The Committee welcomed a future deep dive

report on the outcome of the investigation and the learning shared across multi-disciplinary teams.

The Committee discussed potential mitigations to address the supply issues with NRS, as patients had to wait up to a week for urgent equipment. It was acknowledged that the issues had continued for a considerable time which placed the supplier in breach of contract. The Trust had escalated the breach to the NCL ICB Board as this was a London-wide problem.

The Committee noted the report and agreed that an update report that addressed the concerns raised would be considered at it next meeting.

Ligature risk assessment update

The Committee considered the report which set out the Trust's plans to reduce the risk of self-harm and suicide by ligature. The Committee was informed that a risk assessment was carried out for patients identified as presenting a risk of self-harm or suicide. Five factors were considered in the assessment: environment, staff training, engagement, technology and procurement. The Trust had worked hard to ensure risk reduction was increased across the organisation. An improved anti-ligature policy would be ratified through the quality governance process by 1 August. A working group had been expanded to include the Deputy Chief Operating Officer, the Director of Operations for Children and Young People and a Deputy Chief Nurse, who would drive the anti-ligature work forward. Five areas had been identified as high risk and an action plan of the works to be carried out had been shared. Capital funding for c. £500k had been approved to commence the work which was expected to take between 8 and 14 weeks to complete.

The Committee approved the governance framework and noted the action plan.

0-19 Children's Services update

Committee members were apprised of the latest developments in the Barnet service, which included the following:

- Substantial changes would be made to improve the service and were expected to take effect within an initial two-year period of recovery.
- An exercise to recruit to senior roles with high quality candidates was underway.
- Further changes to the structure and resolving backlogs in recruitment would be made. Agency staff would continue to work in the service while recruitment to substantive posts continued.
- A specific action plan incorporating CQC actions and governance processes was in place.
- Improving staff morale was key to uncovering issues that had affected teams.

The Committee suggested that any workforce issues in this service should be brought to the attention of the Workforce Assurance Committee.

The Committee agreed that the Committee should receive regular progress updates.

3.	**Present:** Naomi Fulop, Non-Executive Director (Chair) Amanda Gibbon, Non-Executive Director Baroness Glenys Thornton, Non-Executive Director **In attendance:** Dr Clare Dollery, Acting Deputy Chief Executive Charlotte Hopkins, Acting Medical Director Chinyama Okunuga, Chief Operating Officer Sarah Wilding, Chief Nurse & Director of Allied Health Professionals 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 Marcia Marrast-Lewis, Assistant Trust Secretary Clarissa Murdoch, Assistant Medical Director Anthony Antoniou, Physiotherapist Isabelle Cornet, Director of Maternity Pauline Vyse, Lead Nurse for Tissue Viability Vanessa Cooke, Director of Operations CYP ICSU Jeanette Barnes, Associate Director of Nursing CYP ICSU Helen Taylor, Clinical Director ACW Jonathan Gardner, Chief Strategy, Digital and Improvement Officer Mameeyaa Adabie, Associate Director of Nursing Kyle Durkin, Interim Deputy Director of Estates & Facilities **Apologies** Swarnjit Singh, Joint Director of Inclusion & Trust Company Secretary Paddy Hennessey, Director Estates & Facilities

Meeting title	**Quality Assurance Committee**	**Date: 10th July 2024**
Report title	Health and Safety Bi-annual Report 1st October 2023 to 31st March 2024	**Agenda item: 4.4**
Executive director lead	Paddy Hennessy - Director of Estates and Facilities	
Report author	Paddy Hennessy - Director of Estates and Facilities	
Executive summary	The aims of this report are to provide: • Assurance that the Health and Safety Committee (**HSC**) is delivering organisational compliance on legislative health and safety requirements. • Health and safety performance for the period from 1st October 2023 to 31st March 2024 The Committee is asked to note the content of this report and to: • Agree on the level of assurance provided by the data presented. • Determine what additional measures if any are required to improve the level of assurance.	
Purpose:	Approval	
Recommendation(s)	The Trust Committee is asked to approve the bi-annual health and safety report.	
Risk Register or Committee Assurance Framework	Compliance with Health and Safety Legislation, Regulatory Reform (Fire Safety) Order 2005 NHS Health Technical Memoranda.	
Report history	For Quality Assurance Committee	
Appendices	Appendix 1	

1. Overview

1.1 The HSC is responsible to the Quality Assurance Committee for the promotion, development and monitoring of health, safety and welfare standards across the organisation.

1.2 The HSC is part of the Whittington Health Risk Management Strategy organisational structures. The Committee remit is to facilitate consultation on health, safety and welfare issues and to promote a positive and open safety culture.

1.3 The HSC Chair is responsible for effectively monitoring and progressing Committee's actions within a reasonable timeframe.

1.4 The HSC is accountable for:

- Asbestos Group
- Compliance Group
- Environment and Food Hygiene Group
- Fire Safety Group
- Medical Gas Group (Staff)
- Pathology Safety Group (Now HSL)
- Radiation Safety Group (Staff)
- Security and Personal Safety Group

1.5 Each Group's Chair is responsible for the administration, planning and organising of the Group's work. Each Group operates within a regulatory compliance workplan and provides a bi-annual exception report to the HSC on key performance indicators, enforcement agencies activity and significant/intractable issues. Each Chair is required to effectively monitor and progress actions within a reasonable timeframe. Each chair is a member of the Health and Safety Committee.

1.6 The HSC and sub-groups provide forums for staff and management participation and consultation on health, safety and welfare issues. Consequently, the Trust can listen to, act upon staff safety concerns, and develop policies and procedures.

1.7 The Health and Safety Executive (**HSE**) is the regulatory body with responsibility for enforcing health and safety legislation.

1.8 The Fire Authority is the regulatory body with responsibility for enforcing fire safety legislation; this is discharged in London by the London Fire Brigade (**LFB**).

1.9 The Local Authority (**LA**) is the regulatory body with responsibility for enforcing food safety legislation and trading standards.

1.10 The Environment Agency (**EA**) is the regulatory body with responsibility for enforcing waste and environmental legislation standards.

2.0 Introduction

2.1 The bi-annual health and safety report aims to demonstrate the Trust's level of legislative compliance across seven key health and safety metrics.

2.2 These metrics are:

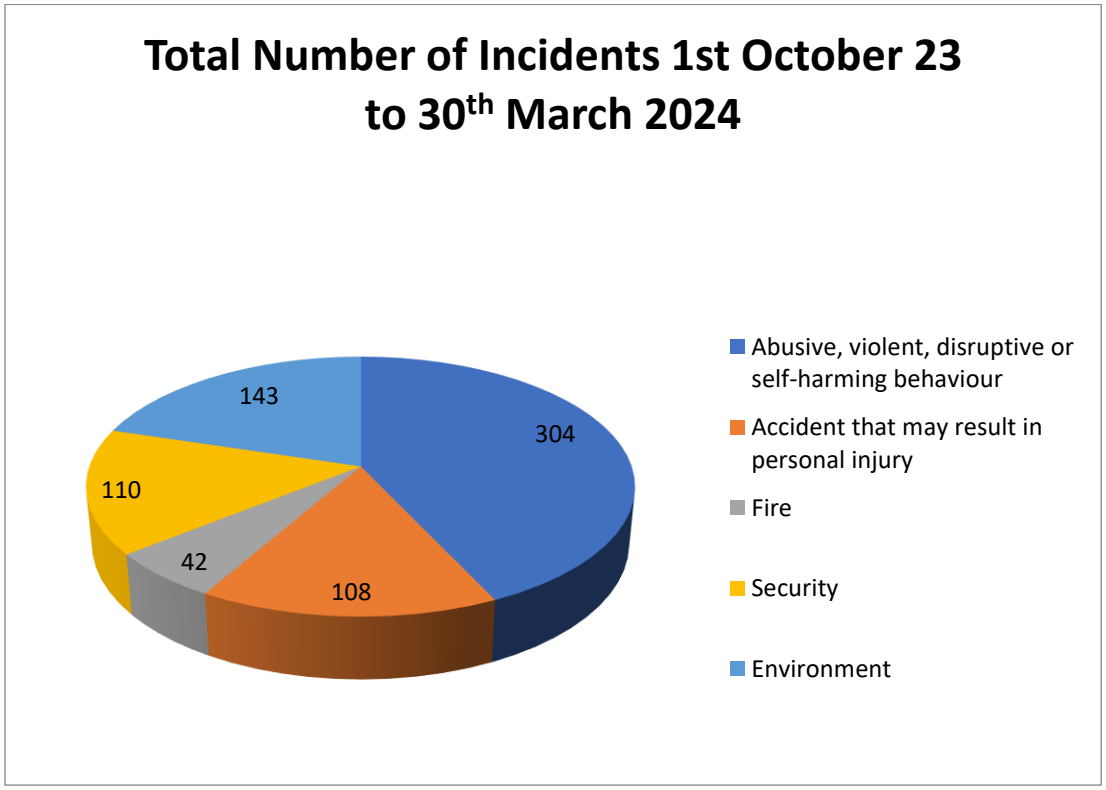
- Incident reporting within seven days
- Incidents and Investigations
- Policy management
- Safety notices
- Mandatory training
- Inspection
- Fire Safety

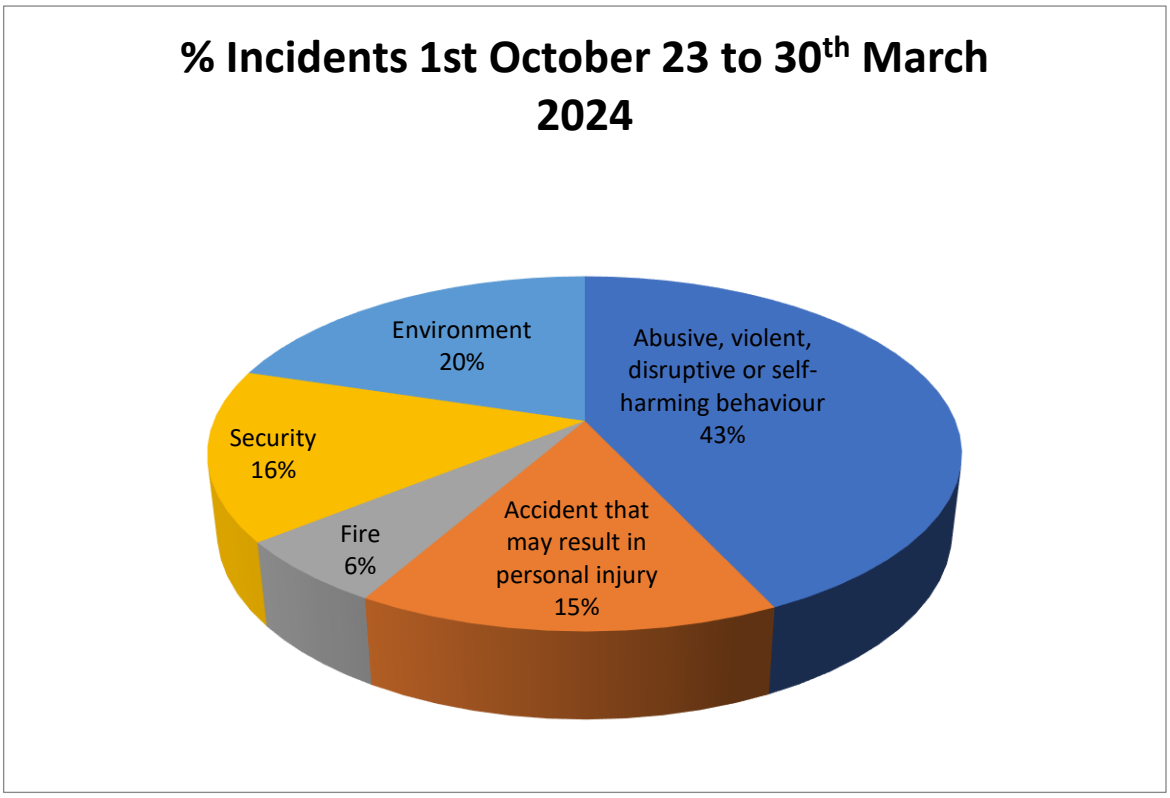
3.0 Analysis

3.1 Incident reporting within seven-days

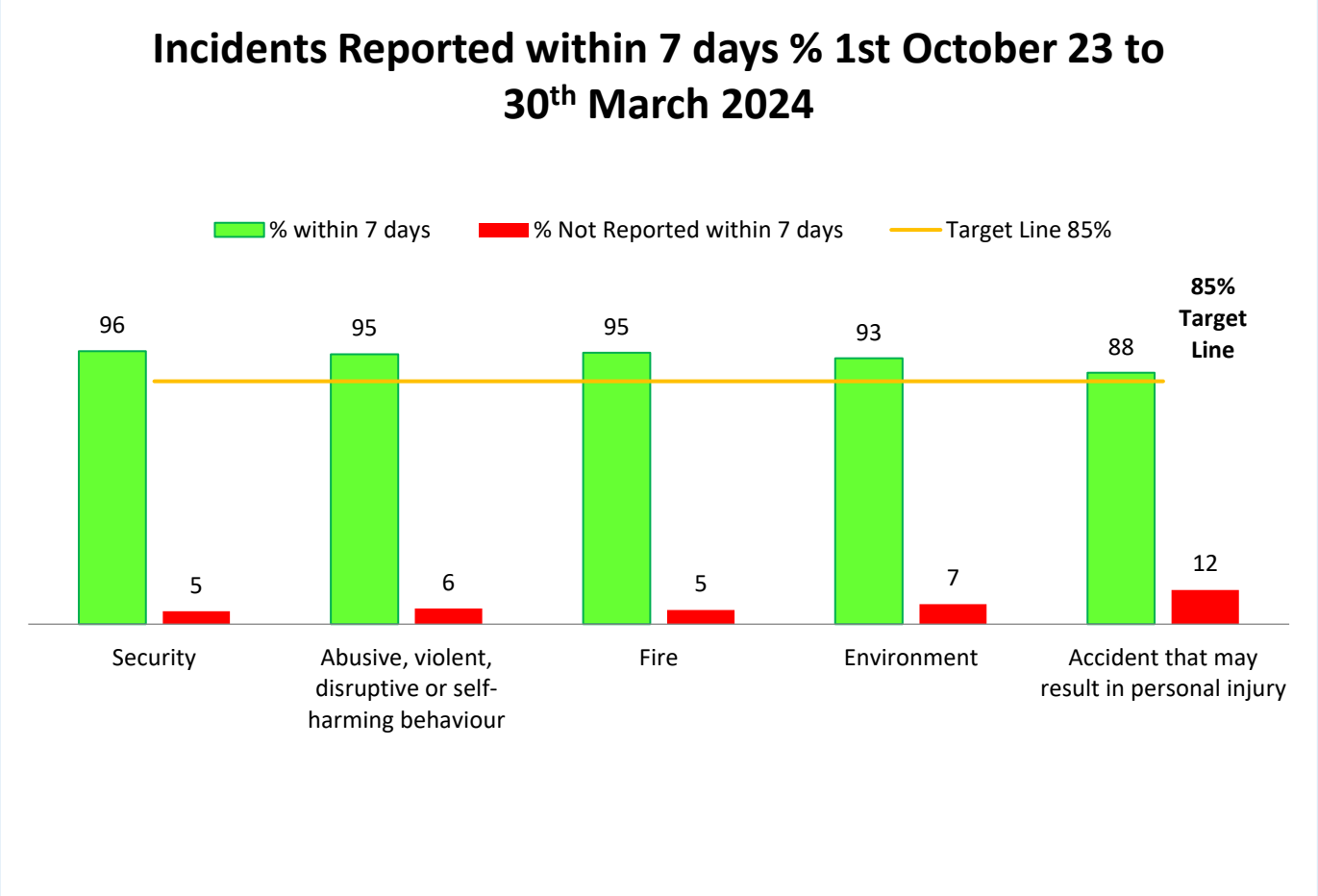
This metric assesses the reporting of incidents in accordance with the Trust's Incident Reporting Policy that requires incidents to be reported on the day of or no later than the day after they occurred (or when staff are first made aware of the incident).

- **Performance:** 85% target. The health and safety, fire and security reporting standard is being met at 93%. Information provided is based on Datix's five incident categories.





Incident Types	All	Security	Affecting staff or Visitors	Abusive, violent, Disruptive	Fire	Environment
1st Oct 23 to 30 March 24	707	110	108	304	42	143
1st April 23 to 30 Sept 23	611	67	114	296	47	87
Comparative Incidents with previous period	▲ (96)	▲ (43)	▼(6)	▲ (8)	▼(5)	▲ (56)



The total number of incidents not reported within 7 days is 43 from a total 707. This is 4 incidents up from the previous reporting period. The breakdown of incidents are:

Comparative figures between the periods are detailed below:

Incident Types	All	Security	Affecting staff or Visitors	Abusive, violent, Disruptive	Fire	Environment
1st Oct 20203 to 30 March 2024	43	4	13	16	0	10
1st April to 30 Sept 2023	39	4	13	18	0	4
Comparative Incidents with previous period	▲ (4)	— ()	— ()	▼(2)	— ()	▲ (6)

- **Risks:** This risk of delay in reporting is considered low.
- **Actions to Improve:** Whilst it is acknowledged that the reporting standard target of 85% is being met, ICSU and Corporate Directorate's should monitor incident reporting to maintain appropriate governance. The HSC will continue to monitor compliance.

  In terms of reduction of abusive, violent, disruptive, or self-harming behaviour incidents, the Managing Challenging Behaviour Group is charged at developing strategies to help the organisation reduce current levels.

3.2 Incidents and Investigations

This metric assesses the Trust's management of non-clinical incidents and investigation covering serious incidents, high risk and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). A total of 5 non-clinical incidents occurred within the reporting period. The RIDDOR incidents are detailed in Appendix 1.

- **Performance:** All RIDDOR incidents have been investigated, any resulting actions monitored and managed at the HSC.

- **Risks:** RIDDOR incidents are reported to the **HSE** who may consider additional action if deemed necessary. The risk is considered moderate.

- **Actions to improve:** The HSC will continue to review all high-risk and RIDDOR incidents for necessary actions to prevent re-occurrence and confirm staff welfare issues have been fully considered.

- **For information:** Serious Incident Panel reviews, monitors and closes Serious Incidents. HSC closes all RIDDOR incidents.

3.3 Policies

This metric assesses the policy compliance on reviews and updates that are approved at the HSC.

- **Performance:** Health and Safety, Fire and Security Policies are mostly up to-date – 77%. Performance target is 100%.

- **Risk:** This risk is considered moderate.

- **Actions to improve:** The HSC chair will continue to administer a policy register at Committee's meetings. All chairs and authors of policies have been requested to drawn up a program so that policies are updated within 2024. The HSC will monitor progress on this action.

- **For information:** Each HSC sub-Group have a policy register as a standing agenda item for the Chair and members to review policies and standard operating procedures compliance. Each Committee/Group Chair is charged with ensuring policies and standard operating procedures are kept up to-date. Any policy that is out-of-date is required to be added to the Committee/Groups respective action log for action.

3.4 **Safety Alert Notices**

This metric assesses the Trust's response to Health and Safety, Fire and Security Safety Alerts received through the Central Alert System (CAS) relating to NHS Estates, Medicines & Healthcare Products Regulatory Agency (MHRA), NHS England Patient Safety Alerts, the Department of Health Local Authority, Fire Authority and Health and Safety Executive.

- **Performance**:
    - There were no alerts notified during the reporting period.
    - Actions remain for the alert:
        - EFA/2020/001 Allergens Issues- Food Safety in the NHS. Ongoing. Target completion date is autumn 2024.
- **Risk:** This risk is considered moderate.
- **Actions to improve:**

  FA/2020/001 Allergens Issues - Food Safety alerts.

  The Food Policy and HACCAP policy incorporates FA/2020/001 Allergens Issues- Food Safety alerts requirements. The Policy was presented at the Health and Safety Committee on the 14 November 2023 for consultation/ratification.

  Patient's daily diet status sheet have been completed. The diet status sheet identifies patient's allergies or eating disorders prior to meal services. Senior Ward Nurses are responsible for daily completion of patient's diet status sheet in the morning, prior to food orders.

A food allergens presentation has been produced that aligns with Food Standards Agency requirements. Each Ward/Department management is responsible for ensuring staff have read and are familiar with the contents. Melanie Anderson, Deputy Head of Facilities is consulting with Director of Nursing on how best to ensure Ward staff are trained on the contents. This training for clinicians may prove challenging to complete - due to staff workload. One hundred licenses have been purchased for designated catering staff to attend food hygiene training– on-line.

- Target completion date is respectively: September/October 2024.

- **For information:** HSC chair will continue to administer a safety notice register at the HSC meetings.

3.5 **Mandatory & Statutory Training**

This metric assesses the Trust's performance with respect to mandatory and statutory training. The performance target is 90%.

- **Performance:** Mandatory training for Health and Safety: 91%, Fire: 83% Moving and Handling: 89% and Conflict Avoidance: 85%.
- **Risk**: This risk is considered moderate.
- **Actions to improve:** Learning and Development lead on mandatory courses. Mandatory Training Group monitors compliance. A mandatory training report is issued monthly on staff training compliance. This report is displayed on the Trust's intranet. ICSU's and Corporate Directorate's line management are charged with monitoring mandatory training compliance.
- **For information:** The HSC will continue to monitor mandatory training. Course tutors do provide additional courses when requested.

3.6 Inspection

This metric assesses the Trust's performance respectively monthly health and safety and weekly fire returns.

- **Performance**: Performance Target is 85%.

  Community Inspections are Health and Safety 98%, Fire 90% and Security 77%.

  Hospital Inspections are Health and Safety 89%, Fire 90% and Security 60%.

- **Risk**: This risk is considered moderate.
- **Actions to improve:** The Trust's Local Security Management Specialist is targeting poor responders by undertaking (a) face to face visits health centres and (b) sending monthly chaser emails.
- Security inspection figures returns are being monitored at the Security and Personal Safety Group.
- Chief Operating Officer is supporting Local Security Management Specialist on actions to improve responsible leads responses.
- **For information:** The HSC will continue to monitor inspection performance.

3.7 Fire safety

This metric assesses the Trust's Fire Risk Assessments performance with Regulatory Reform (Fire Safety) Order 2005 to take all reasonable steps to ensure that fire safety levels are always appropriate. All Trust areas have had a Fire Risk Assessment completed previously, the Fire Team is presently reviewing and updating existing risk assessments (acute site, community sites and shared community sites). Fire Risk Assessments are reviewed annually or 18 months dependent upon risk categorisation.

- **Performance:** Fire Risk Assessments reviewing and updating are acute site (100%), community sites (100%) and shared community sites (35% - carried out by individual Landlords)). Performance Target is 100%. These figures relate to % completed to date within the Calendar year.

- **Risk:** This risk is considered Moderate.
- **Actions to improve:**
- The fire incident in 2018 within the PFI building, resulted in major fire safety remediation projects that are still currently in progress.
- The Trust has put in place a mitigation strategy that includes increased levels of security guards, fire wardens, additional fire drills and an enhanced fire response team. The number of trained fire wardens is currently circa 165 in date which provides adequate cover all areas. Staff have been emailed and training course is on ESR. Fire Safety Group monitors training compliance.
- The mitigation strategy is reported to both NHSI and London Fire Brigade and is currently acknowledged as robust.
- Director of Estates and Facilities submits a monthly Fire Safety Management Report to the Executive Group on key statutory safety compliance and operational readiness performance indicators.
- The Chief Operating Officer and Director of Estates and Facilities provide regular fire safety compliance reports at various Committee levels.
- The Fire Safety Group meets bi-monthly. The Group is chaired by the Trust's Chief Operating Officer and Director of Estates and Facilities. Listed below are other key members:
    - The Chief Operating Officer.
    - The Director of Estates and Facilities.
    - The Deputy Director of Estates and Facilities
    - ICSU's Fire Safety Responsible Person.
    - The Fire Safety Manager.
    - Authorising Engineer (AE) Fire
    - The Trust's Emergency Planning Officer.
    - The Trust's fire response team.

- site manager (bronze lead),
- security lead and,
- estates operational management team.

- The Group's agenda has two principal performance lines:
  - Firstly, each ICU's fire safety measures compliance: online weekly fire check, drills, operational condition of their locations, training, and fire incidents.
  - Secondly, the Trust's fire safety technical compliance: risk assessments and actions arising, preventive maintenance programs and Fire Engineering Group sub-reports.
- The Fire Engineering Group meets monthly. The Group manages and monitors fire safety technical compliance of assets.
- Fire Safety meetings occur weekly. These meetings monitor and review fire incidents and training.
- Fire safety capital investments are reported to the Trust's Capital Monitoring Group using the Trust's risk register Datix reporting platform.

4 Conclusion

- This report is structured to demonstrate HSC mandate in delivering compliance regarding the health and safety legislative requirements.

Appendix 1

RIDDOR Incidents

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, regulates the statutory obligation to report deaths, injuries, diseases and dangerous occurrences that take place at work or in connection with work.

A total of 5 incidents were reported to HSE between 1st October 2023 and 31st March 2024. These are detailed below.

Dates – delete at end check in order	Datix Reference	Investigation findings, Recommendations and actions
09/10/2023	A110243	Staff sustained a sharp injury to right hand middle finger whilst administering insulin to a patient during disposal of the needle in a sharp bin. Patient is known to be Hepatitis C positive. District Nurse Team Manager completed an investigation. Staff followed the sharps injury protocol: (a) Immediately bleeding the area and washing under running water. (b) Staff attended A&E and (c) Staff to attend occupational Health. Staff member was wearing gloves. Occupational Health monitored staff. Manager has discussed the incident with staff on positioning of sharp bin at the point of use - to enable safe disposal. Manager has provided staff aftercare. Management is supervising standards of working practices.
10/10/2023	A107253	Ambulatory care bank staff suffered a fracture to left wrist when they lost their balance whilst moving/kicking a stool out of the way. Staff put their arm out to brace/stabilise themselves during the fall. Clinical Nurse Manager - Ambulatory Care has completed an investigation. Equipment reviewed and found to be in good working order. Staff member was seen on the day by AE. Staff is under own orthopaedic lead and has been advised to take time off work. The Hospital Bank Staffing Team referred staff to OH. Manager is supervising working practices at the location.

Dates – delete at end check in order	Datix Reference	Investigation findings, Recommendations and actions
20/11/2023	A108600	Staff sustained an injury to their right shoulder whilst attempting to plug in cardiotocograph (CTG) monitor at a patient's bedside. Staff over-reached. Midwifery Team Leader Murray Ward has completed an investigation. Staff was attended to by other staff at time of the incident. Staff has been referred OH and advice given. Staff has returned to work. Manager has discussed the incident with staff and on lessons learnt. Particularly, positioning bed in the middle of the cubicle bay to enable safe access and before proceeding with the CTG machine. Manager is supervising working practices. Manager provided staff with aftercare and advice as required.
18/01/2024	A110147	Staff injured their back whilst pushing a large wheelchair with a patient. Staff continue working for the rest of the day. Assistant Clinical Director and Manual Handling Advisor have undertaken an incident investigation. Manual handling risk assessments have been reviewed relating to use of wheelchairs. All staff attend moving and handling course as part of mandatory training. Manager discussed the incident with staff and lessons learnt. Particularly, the need to seek assistance when moving patient in a large wheelchair. Management held a toolbox talk with staff to discuss incident and safe working practices. Staff was referred to Occupational Health. Management provided staff with aftercare and advice as required. Manager is supervising working practices.

Dates – delete at end check in order	Datix Reference	Investigation findings, Recommendations and actions
29/02/2024	A111428	Security (2) was called to attend room 12A with a patient under a Section 2. Patient was refusing to go back inside the room. An altercation occurred between the patient and security staff (2). One of the security staff suffered bruising and laceration to left Knee whilst helping to restrain the patient. Patent was secured in the safe place room . Emergency Department Matron, Local Security Management Specialist and C&I mental Health lead have undertaken an incident investigation. Bed/mattress has been removed from the location and replace with a more suitable equipment for the location. Staff attended their own GP the following day. Staff attended Occupational Health and their advice followed. Security guards attend four-day CFSM control and constraints and a one-day conflict avoidance course. The Trust provides 24/7 security guards presence.

Meeting title	**Quality Assurance Committee**	**Date: 10th July 2024**
Report title	Annual Compliments, Complaints & PALS Report 2023-2024	**Agenda item: 4.5**
Executive Director Lead	Sarah Wilding, Chief Nurse and Director of Allied Health Professionals	
Report author	Paul Macpherson, PALS & Complaints Manager Antoinette Webber, Head of Patient Experience	
Executive summary	This report provides an annual overview of compliments, complaints, Patient Advice and Liaison Service (PALS) and quality alerts received during the period 1st April 2023 – 31st March 2024. **Compliments** • We formally recorded 631 compliments this is an increase of 34% (161) 2022-23 (470) compliments. These exclude any compliments sent directly to services where we do not formally record these vias PALS. **Complaints** • During 2023-2024 we received 347 complaints where a response was required, these are broken down by quarter (Q1) 97, (Q2) 87, (Q3) 77 and (Q4) 86. This is an increase of 31% (82) compared to 2022-23 (265). • 97% of complaints were acknowledged within the stipulated 3 working days, exceeding our internal target of 90%, the same as 2022-2023. • Our internal target is to respond to 80% of complaints within the 25 day or 40 days' timeframe. Our performance for 2023-24 was 55% a decrease of 1% on our 2022-2023 performance of 56%. • Some complaints were resolved through contact from the service involved and did not require a written response	

	• We received 15 requests from the Parliamentary & Health Service Ombudsman (PHSO) for information an increase of 4 on 2022-2023 (11). **PALS & GP concerns** • During 2023-24, a total of 2,734 PALS contacts were recorded (including those received from GP practices regarding individual patients) an increase of 38 in compassion to the previous year of 2,696. • 74% (2,021) of PALS enquiries related to concerns and 26% (713) were requests for information. **Quality Alerts** • We received 5 quality alerts from GP Practices, compared to 4 in 2022-23.
Purpose:	The Committee is asked to review and approve the attached Annual Report. This report provides a high-level overview of compliments, complaints, PALS and quality alerts for 2023-24. Please note this report is being presented for the Committee to approve the report's content; document design to be finalised for wider publication by September 2024.
Recommendation(s)	The Committee is asked to review and approve this report for circulation.
Risk Register or Board Assurance Framework	This links to BAF Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.
Report history	The previous annual report for 2022-23 was presented to QGC in June 2023. This report for 2023-24 will be presented to QGC in June 2024 and will be available as a public document by September 2024.

Introduction

Whittington Health NHS Trust serves a diverse population of 500,000 people living in the boroughs of Islington and Haringey, in addition to other London boroughs including Barnet, Enfield, Camden and Hackney. The Trust has a strong focus on improving patient experience which continues to evolve.

The Trust values and recognises the importance of patient, service user and careers feedback, this helps shape our services and drive ongoing improvements to reflect the needs of the population we service. The experience of patients is captured through the Friends & Family Test (FFT) information gathered through complaints and PALS and national surveys. We listen to our patients through patient engagement meetings, our volunteering programme and in addition every other Trust Board meeting starts with a patient story, presented by the patient.

In accordance with the NHS Complaints Regulations (2009) this report sets out a detailed analysis of the number and nature of complaints received by Whittington Health during the 2023/2024 financial year. The report includes details of the PALS concerns, enquiries and compliments including concerns from GP Practices related to individual patients received during the same period

The report includes details of the number of complaints received during the year, performance in responding to complaints, Parliamentary and Health Service Ombudsman (PHSO) investigations, and action taken by the Trust in response to complaints.

The complaints team have a robust process in place to monitor the progress of complaints and now this information is shared.

A dashboard of 'live' complaints is kept and shared with our Integrated Clinical Service Units (ICSU's) on a weekly basis. Weekly meetings with ICSU lead investigators take place to ensure complaint investigations are progressing and any barriers to timely completion identified.

Patient complaints are reported to the Trust Board monthly in the Integrated Board Performance report, which forms part of the Patient Experience Group report.

Themes and trends from complaints are incorporated into the Quality Account and Patient Experience Strategy priority setting, to ensure we focus on what matters most to our patients.

In summary during 2023-2024 there were:

- 347 complaints requiring a response in 2023-24, (Q1 -97), (Q2- 87), (Q3 -77) and (Q4 – 86). This is an increase of 31% (82) compared to 2022-2023 (265).
- 97% of complaints were acknowledged within the stipulated 3 working days, exceeding our internal target of 90%. This is the same as in 2022-23.
- Our internal target is to respond to 80% of complaints within the target response time (25 day or 40 days). The performance for 2023-24 was 55% compared to 56% in 2022-23, a decrease of 1%. (Q1 53%, Q2 55%, Q3 47% & Q4 63%).

- The improvement during in Q4 has been noted and the ICSUs are working to continue that improvement during the year 2024-25.
- There were 15 requests for information from the Parliamentary & Health Service Ombudsman (PHSO)an increase of 4 in comparison to 11 in 2022-23.
- 631 compliments were received thanking 749 individuals or teams.
- A total of 2,734 PALS & GP concerns were received, compared to 2,696 in 2022-2023.

To put these figures into context, during 2023-2024 as a very simple calculation 0.03% of patient encounters resulted in complaints and 0.2% resulted in a PALS concern. It is acknowledged that patients /services users may have multiple encounters across the Trust.

Table 1: Patient Encounters v Concerns comparison

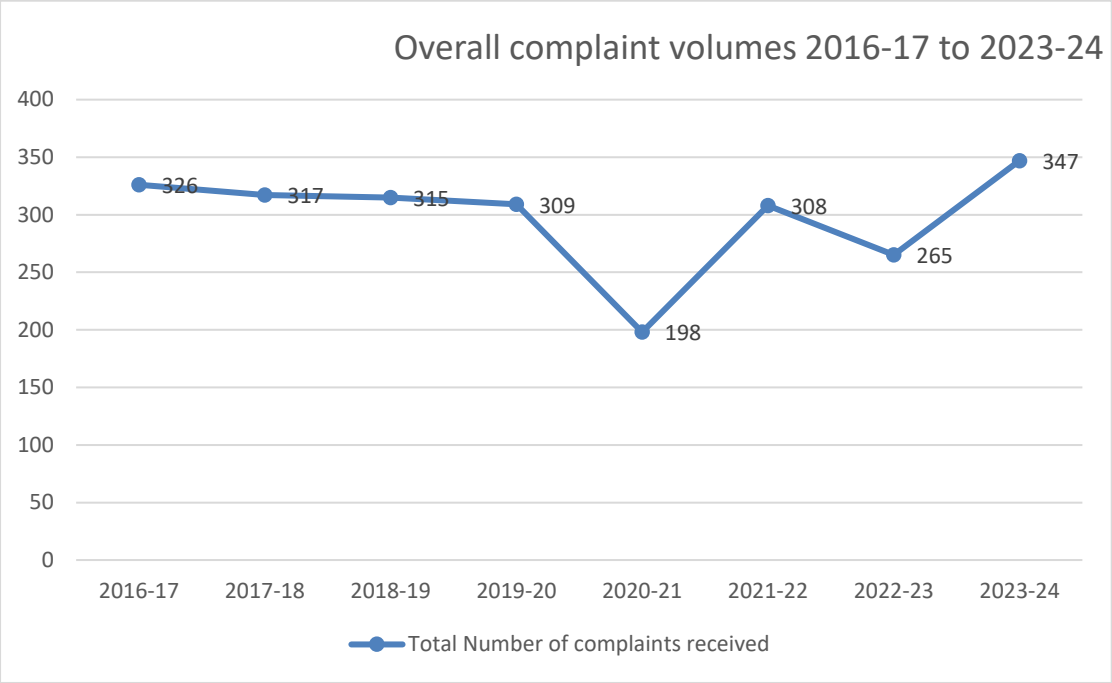
Appointments/episodes of care 2023/24	
Emergency Department attendances	103,893
Outpatient appointments	424,128
Imaging Department attendances	187,352
Theatre procedures	8,398
Community episodes	543,376
Inpatient admissions	42,057
TOTAL	1,309,204
Complaints (number)	347
Complaints (%)	0.03%
PALS concerns (number)	2,605
PALS concerns (%)	0.2%

1.0 COMPLAINTS

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

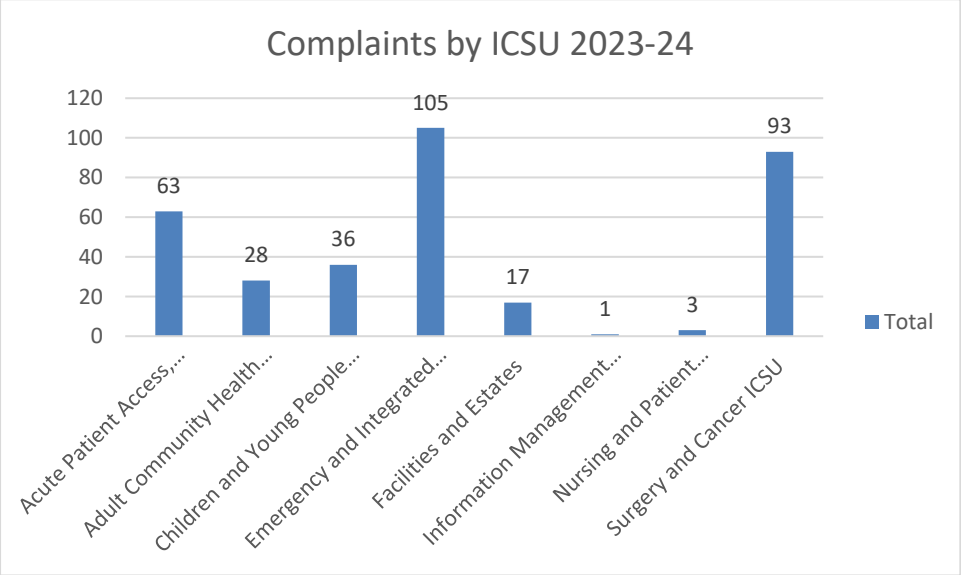
The number of complaints in 2023-4 is in line with the figures since 2016-2017 shown in graph 1 below. The decline noted in 2020-21 (198) occurred during the Coronavirus pandemic, the rationale for the drop can only be speculated upon as a reflection of the general public's response to the NHS during this unprecedented time.

Graph 1: Overall complaint volumes



Emergency & Integrated Medicine (E&IM) ICSU received the largest number of complaints at 105, followed by Surgery & Cancer (S&C) ICSU 93, Acute Patient Access, Clinical Support and Women's (ACW), 63, Children and Young People (CYP) 36, Adult Community Services (ACS) 28, Facilities & Estates 17, Nursing & Patient Experience (3) and Information Management (1). (Graph 2).

Graph 2: Complaints numbers by ICSU April 2023 to March 2024

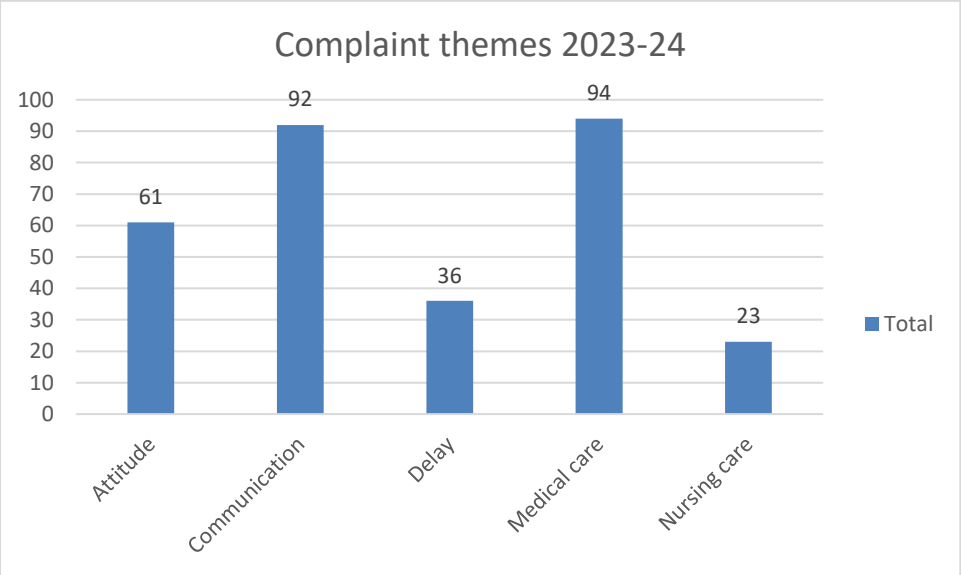


1.2 Complaints across the Trust by theme

Themes and trends from complaints are incorporated into the Quality Account and Patient Experience Strategy priority setting, to ensure we focus on what matters most to our patients.

The top 5 themes cited include communication between clinicians, patients, their families and carers, is the most common theme received through complaints and remains an ongoing priority for the Trust.

Graph 3: Top 5 complaint themes 2023-2024

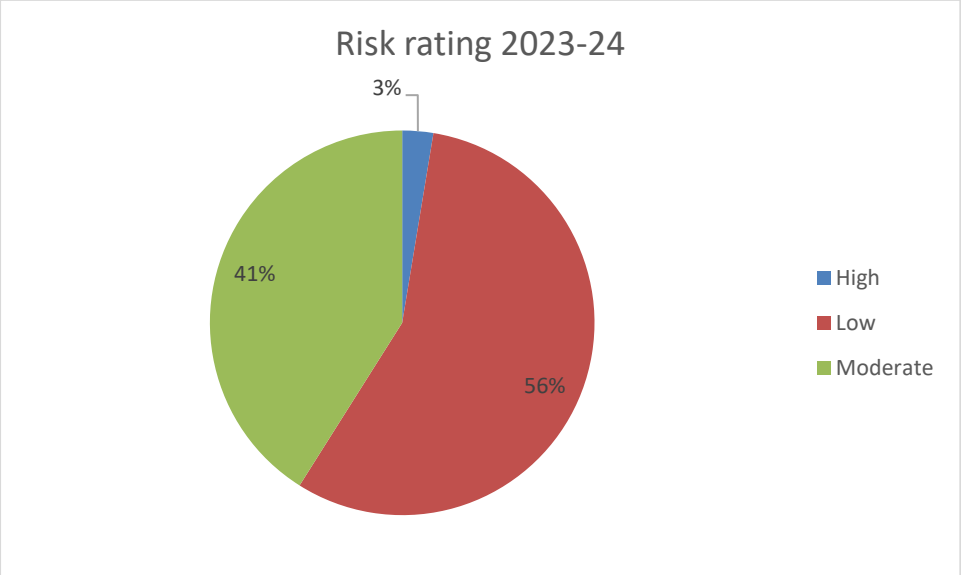


1.3 Complaints across the Trust by risk rating

All complaints are risk assessed by the PALS & Complaints team upon receipt and are risk-assessed by the lead investigator following completion of the investigation. High risk complaints are those where concerns are raised about patient care that may have had an adverse effect on the outcome for the patient, or perhaps has a risk of reputational damage.

During 2023-2024 - 9 (3%) of complaints were designated as ‘high’ risk compared to 19 (7%) complaints in 2022-23, a decrease of 10%. Most complaints 195 (56%) were designated ‘low’ risk and 142 complaints (41%) were designated ‘moderate’ risk.

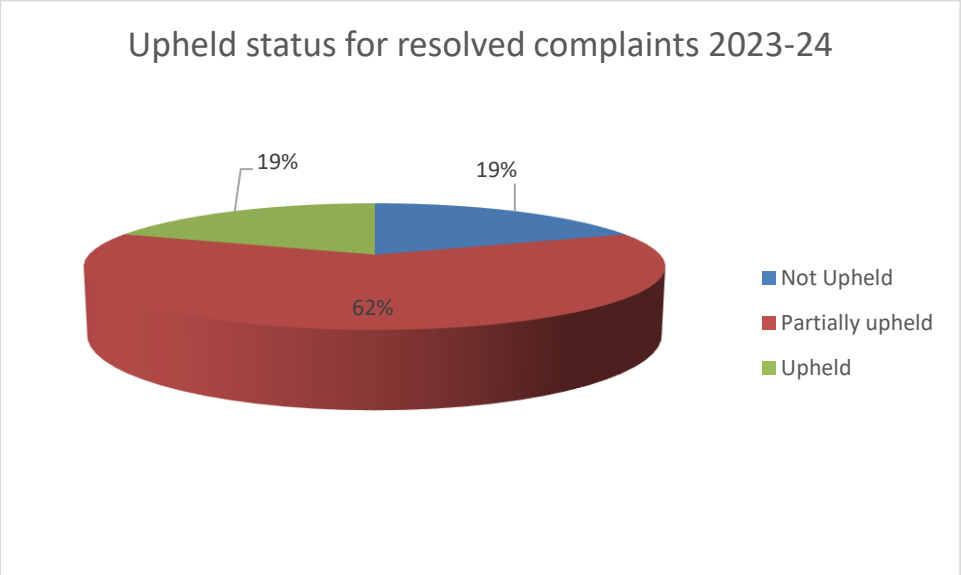
Graph 4: Trust Complaints by risk rating 2023-2024



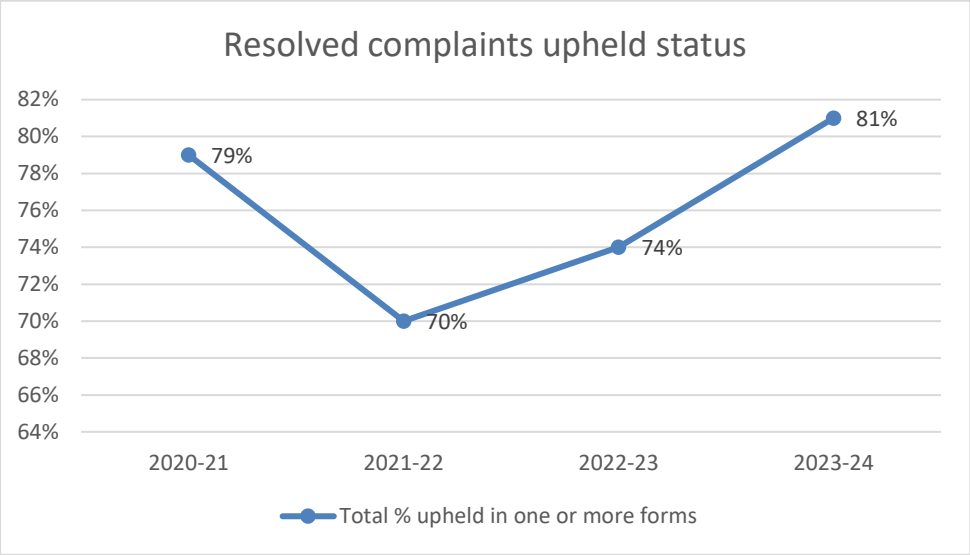
1.4 Complaints across the Trust by Upheld Status

Of the complaints that were closed during 2023-24, 42 (27%) were fully upheld, 83 (54%) were partially upheld and 29 (19%) were not upheld. 81% of closed complaints were upheld in one or more forms, compared to 2022-2023 where 74% of complaints were upheld in one or more forms, an increase of 7% (Graph 5).

Graph 5: Complaints by Upheld Status 2023-2024



Graph 6: Complaints by Upheld Status annual comparison

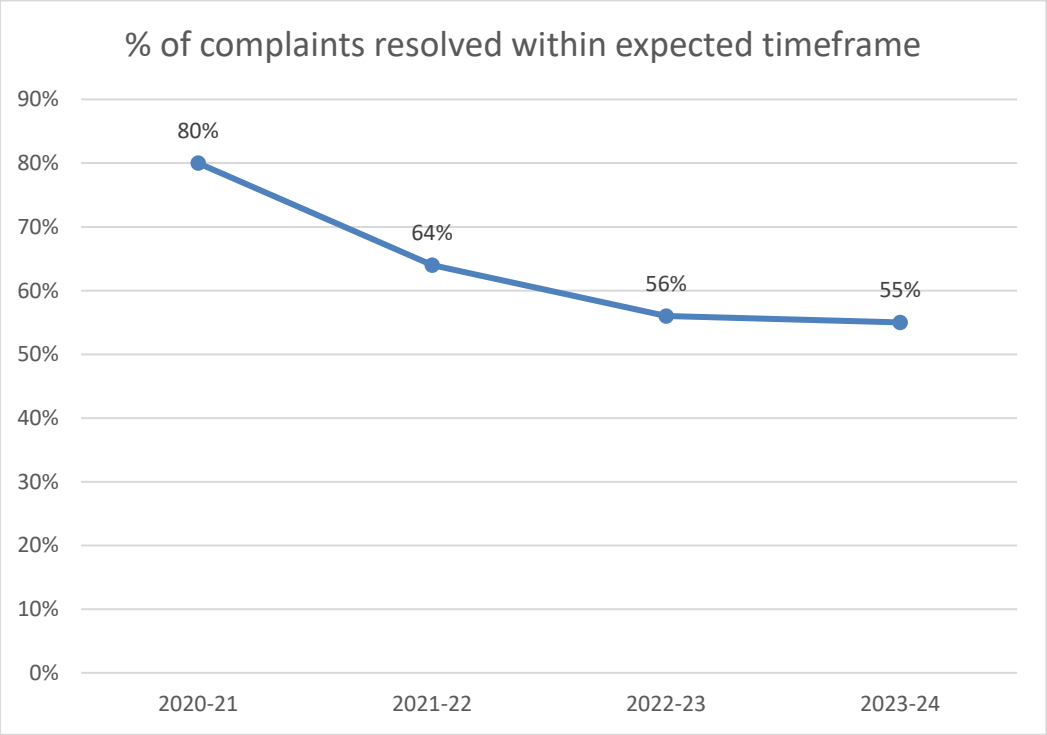


1.5 Response Timescales

The Trust internal target is for 80% of complaints to be responded to within the expected timeframe (either 25 or 40 working days) and some 'bespoke' timeframes, where the complaint is linked to an Incident investigation.

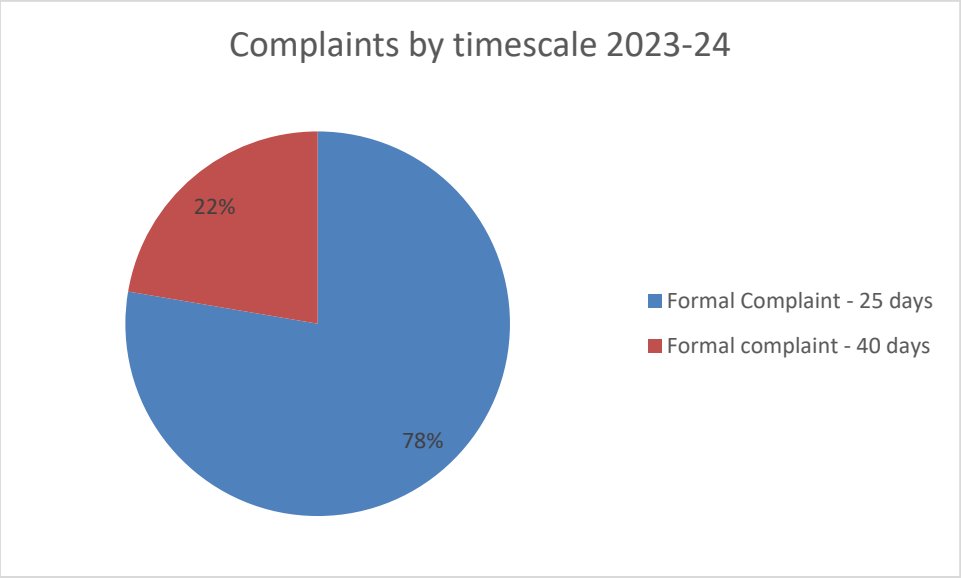
We have seen a decline year on year in achieving our internal 80% performance target. During 2023-2024 55% of complaints were responded to within the targeted number of working days, in comparison to 83% in 2019-2020, 80% in 2020-21, 64% in 2021-22 and 56% in 2022-23 (graphs 6 & 7).

Graph 7: Response timescales



Whilst it is recognised that much of the delay in responding to complaints is due to capacity, winter pressure, and industrial action as well as competing demands for clinical and administration time, delays in responding to complaints leads to a poorer patient/ family and carer experience. To improve the response rates, additional temporary resource has been provided to S&C ICSU and the complaints team. In addition, regular ICSU meetings were held with the CEO during Q1 & Q2 2023-24, with particular focus on the oldest complaints. This has resulted in a steady reduction in the number of older open complaints, as well as a gradual improvement on the overall response rate.

Graph 8: Complaints by Timescale 2023-2024



1.6 **GP Quality Alerts**

Quality alerts relate to wider issues raised by GP practices, opposed to concerns about an individual patient, which are logged as 'GP concerns' rather than a 'Quality Alert.' Each of these were immediately shared with the ICSU involved and have been resolved.

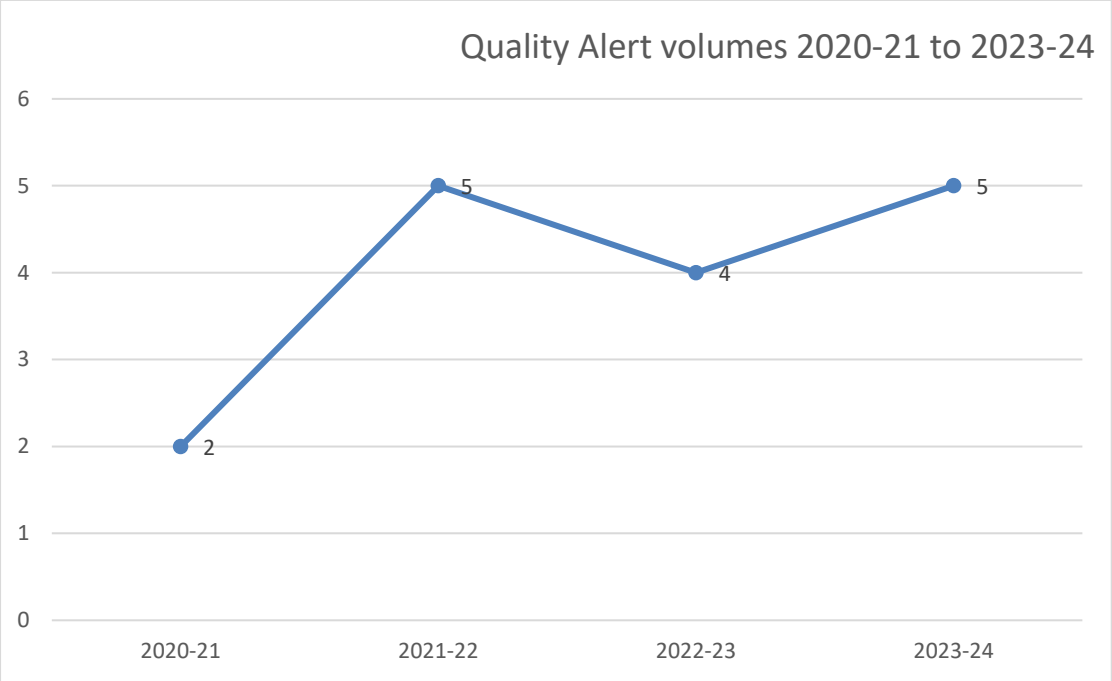
During 2023-2024 the Trust received 5 Quality Alerts, compared to 4 in 2022-2023 – one related to the failure to share management plans regarding Urology patients with GP Practices, two related to a delay in sending test results, one related to the failure of Pathology to respond to several email requests for assistance with codes, and one related to the lack of Musculo-skeletal (MSK) appointments.

Table 2: Quality Alerts by ICSU 2023-2024

ICSU	2023-2024
ACS	1
ACW	3
S&C	1
Trust	5

All quality alerts were responded to, and learning taken by the ICSUs, including a review of resources to ensure generic mailboxes are monitored regularly and responses sent.

Graph 9: Quality Alert volumes



1.7 Dissatisfied complaints

Graphs 10 & Table 2 below show the number of complainants returning complaint responses as dissatisfied or requiring further clarification. During 2023-2024, 37 complainants returned as dissatisfied or asking for clarification, this is a decrease of 3 on 2022-2023 (40).

Whilst all of our responses are subject to several reviews before they are finalised, there will always be some complainants who will remain dissatisfied despite every effort to address their concerns. All 'dissatisfied' complaints are shared with the ICSU involved and carefully reviewed to determine if anything further can usefully be added, and a further response or local resolution meeting is arranged where appropriate, or the complainant is reminded of their right of referral to the PHSO.

Some complainants need a discussion with clinical staff to clarify what and why actions were taken during an attendance to the hospital. There are delays to some responses being sent which can dilute the effectiveness of any apologies that are offered, however sincere and well meant, as some complainants believe that these are disingenuous.

Graph 10: Dissatisfied complainants by quarter 2023-24

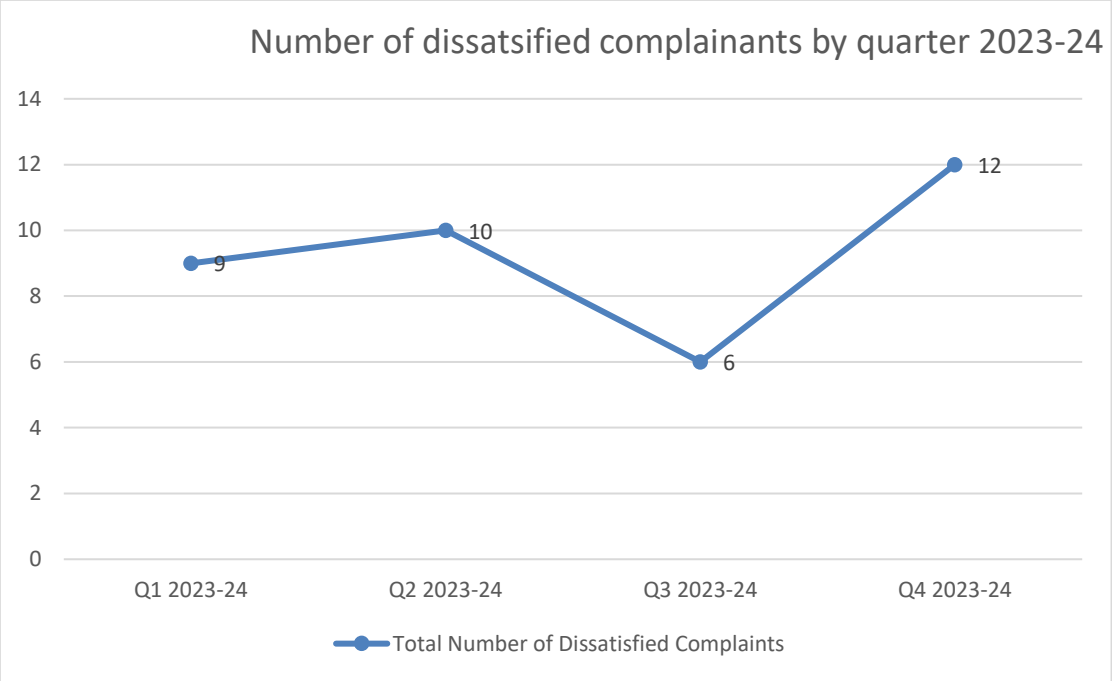


Table 3: Dissatisfied Complaints by ICSU 2023-2024

ICSU	Total
Surgery and Cancer ICSU	11
Community Health Services for Adults ICSU	4
Emergency and Integrated Medicine ICSU	15
Acute Patient Access, Clinical Support Services & Women's Health ICSU	5
Children and Young People Services ICSU	4
Trust	**37**

1.7 Parliamentary Health Service Ombudsman (PHSO) Cases

The Ombudsman Service makes final decisions on complaints in the NHS in England, UK, where the complainant remains dissatisfied. The PHSO investigates complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or has given a poor service or failed to resolve their concerns to the complainant's satisfaction.

During 2023-24 the Trust received fifteen requests from the PHSO requesting our complaint file and any associated records in order for the PHSO to review and consider whether they will undertake an independent review. This is an increase of 4 compared to eleven in 2022-2023. In each case the information has been provided to the Ombudsman Service. Three cases are under investigation, a final decision has been received on one, and the Trust is awaiting further updates from the Ombudsman Service on the remaining two.

1.8 Improvements and learning from Complaints.

ICSUs are required to monitor actions resulting from complaints within their own risk and governance meetings.

One of the main purposes in investigating complaints is to identify opportunities for learning and to improve services for patients, their families and carers. With this in mind complaints learning is monitored and case examples of both complaints and compliments are reported within our Patient Experience Group (PEG) and subsequently to the Quality Governance Committee (QGC) and Quality Assurance Committee (QAC). Learning from complaints forms part of the new Patient Safety Incident Response Framework (PSIRF) which is being rolled out across our Trust.

Examples of learning to improve the patient experience.

Complaint	Action and Learning
A complaint about problems experienced by a partially sighted patient who had difficulty navigating the main staircases.	As a result of the complaint, the patient was invited to attend and present his story to our Trust Board. Following this yellow edging markers have been added to the main staircases to aid partially sighted patients & visitors to the hospital.
A complaint relating to misleading information in an appointment letter for a blood test. The letter advised the patient not to come to the hospital, which would have resulted in the blood test not being possible.	The complaint highlighted a problem with one of the template letters in Careflow. The letter template has been removed and a wider piece of work looking at all template letters has begun to ensure that any out-of-date letters are removed and that a much smaller suite of template options are available to minimise the risk of misunderstandings.
A complaint about the delay in referring a patient from our Urology service to the Lower Urinary Tract Service (LUTS)	As a result of the complaint a new referral form has been introduced to ensure all the necessary information is shared from Urology to LUTS to minimise the risk of delay

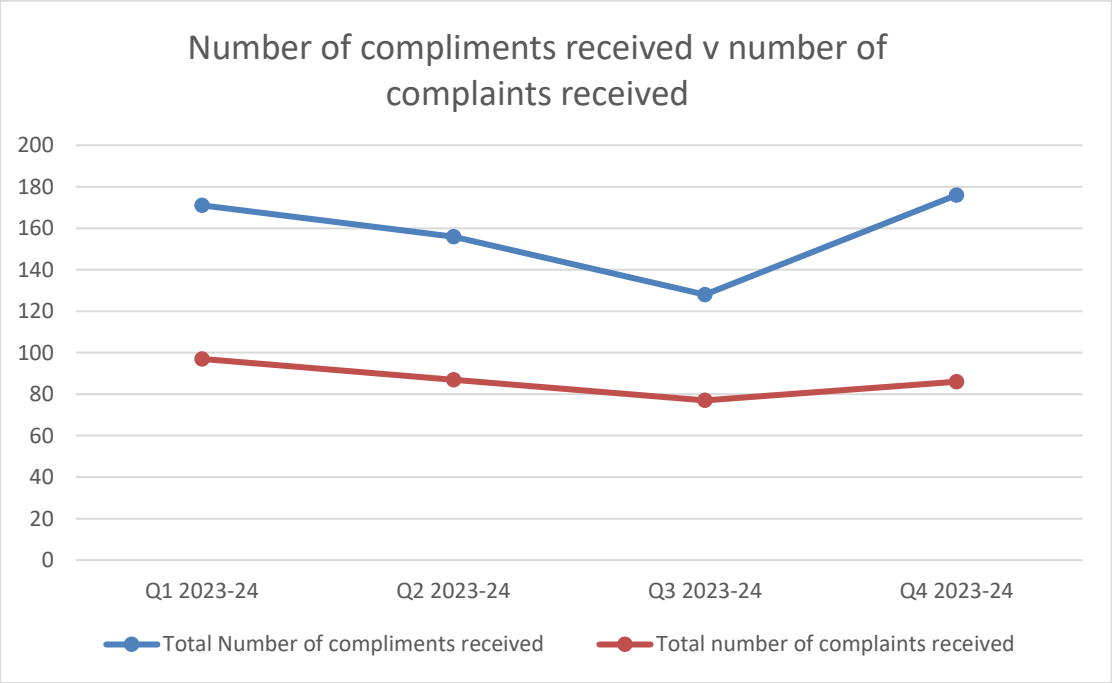
2.0 COMPLIMENTS

As a Trust we recognise the great work undertaken by our staff and it is important to recognise that the number of compliments received by ICSU outweighs the volume of complaints we receive. During 2023-2024 we received 631 compliments through PALS (for 749 individuals or services) compared to 470 compliments during 2022-2023, this is an increase of 161 and a true testament to our staff's commitment to providing quality care and a good patient experience.

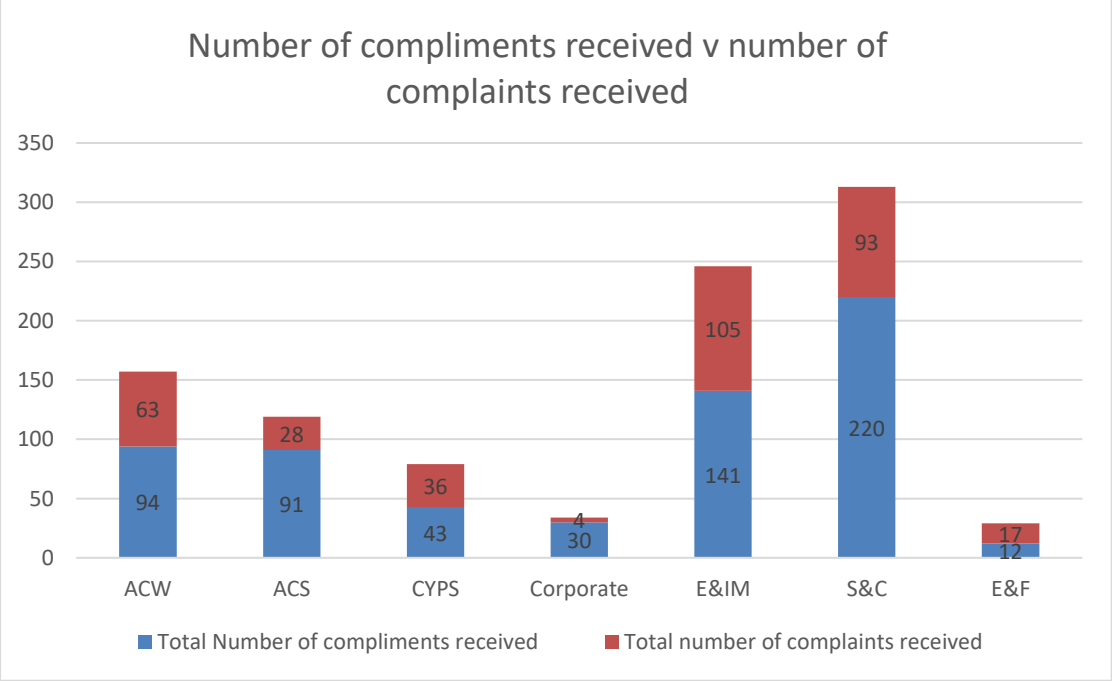
These are compliments received via our PALS service or through our Chief Executive's Office, however, many more compliments are received directly by services across our Trust. As in previous years, we received more compliments than formal complaints.

S&C received the largest number of compliments (220), followed by E&IM (141), ACW (94), ACS (91), CYPS (43), Corporate (30) and E&F (12). (graph 12). As with complaints, it is important that ICSU's and the Trust share the learning from compliments, to celebrate and to share best practice that can be emulated elsewhere.

Graph 11: Compliments v Complaints volumes 2023-24 by Quarter



Graph 12: Compliments v Complaints by ICSU 2023-2024



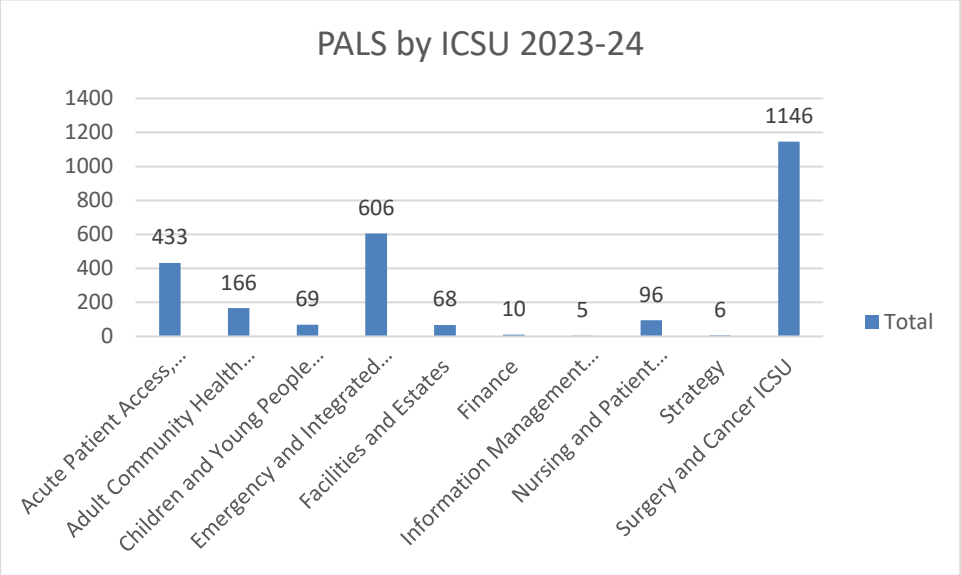
Examples of the compliments received are shown below.

3.0 PALS

3.1 PALS contacts by ICSU

A total of 2,605 PALS contacts (not including those from GP Practices – see GP concerns section 3.3 below) were logged compared to 2,696 contacts during 2022-23. 1,892, 73% related to concerns and 713, 27% related to requests for information.

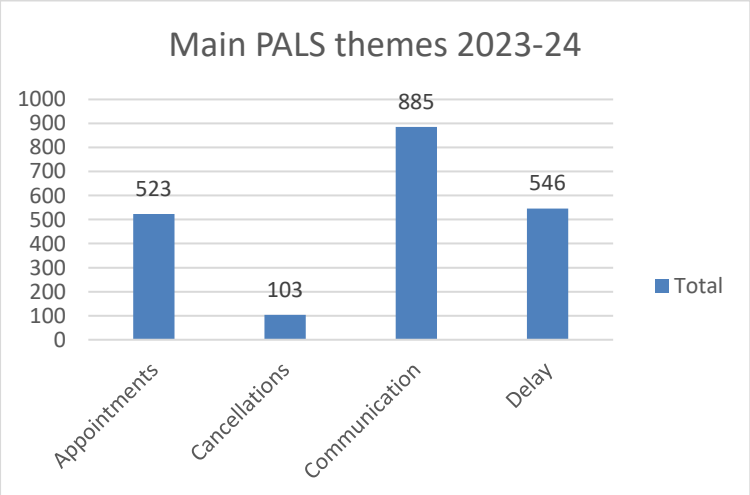
Graph 13: PALS Contacts



3.2 PALS Contacts by subject area

Graph 14 shows the top subject areas cited in PALS contacts received. On receiving contact from patients, the PALS team will either try to resolve the issue with the patient at the time e.g., access to appointments or escalate to the relevant ICSU where it is not possible for PALS to solve the problem.

Graph 14: Top themes for PALS concerns & information requests 2023-24

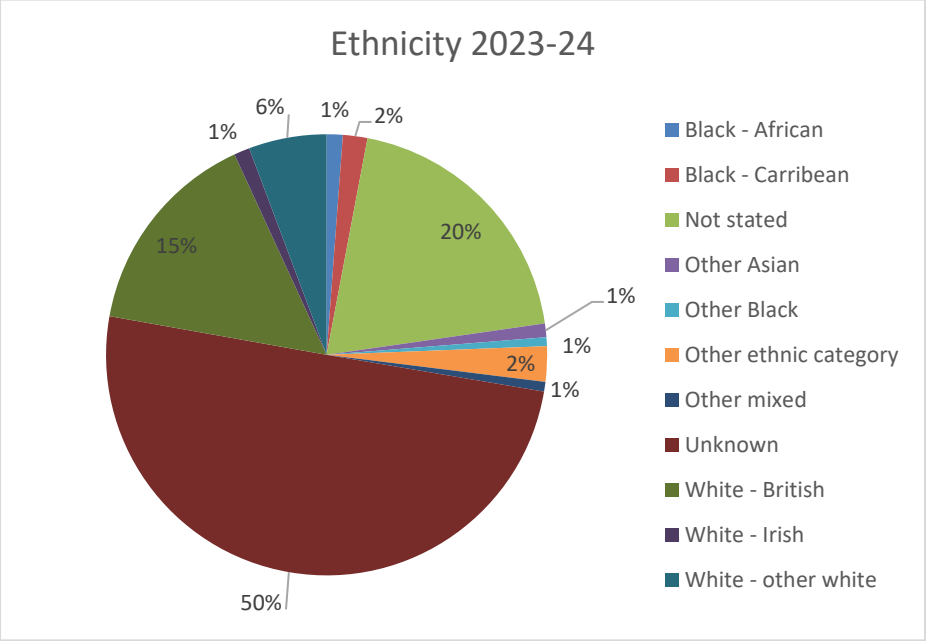


3.3 Diversity Data

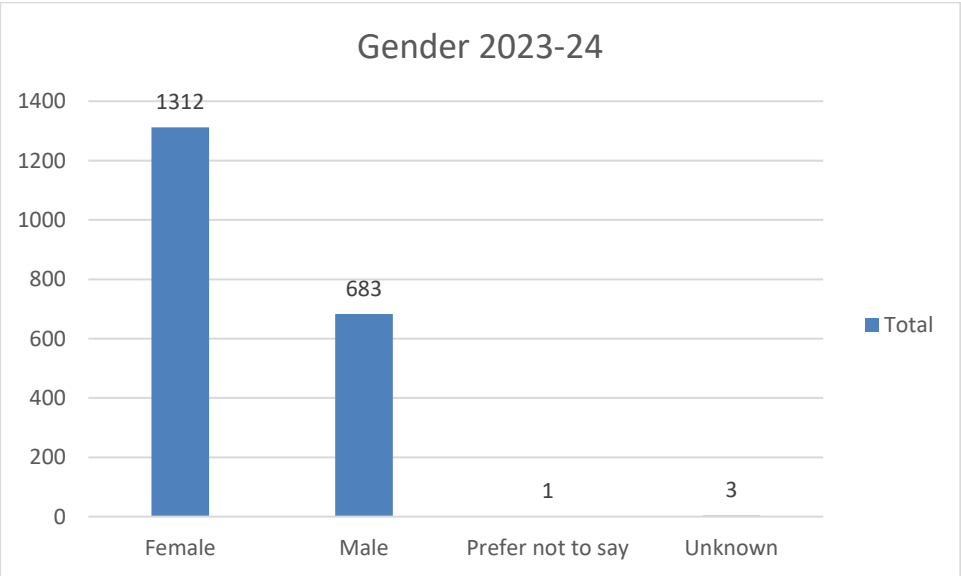
The PALS & Complaints team continue to cross-check diversity data through our patient information systems (Careflow and RiO), although the information is also requested through the PALS & Complaints leaflet. All data collected from Datix is shared with the Department of Health through the KO41 annual report.

Graphs 15 and 16 below show the demographic data for Ethnicity & Gender for 2023-24. The data for age and disability figures had too many "unknowns" to provide a meaningful breakdown.

Graph 15: Ethnicity



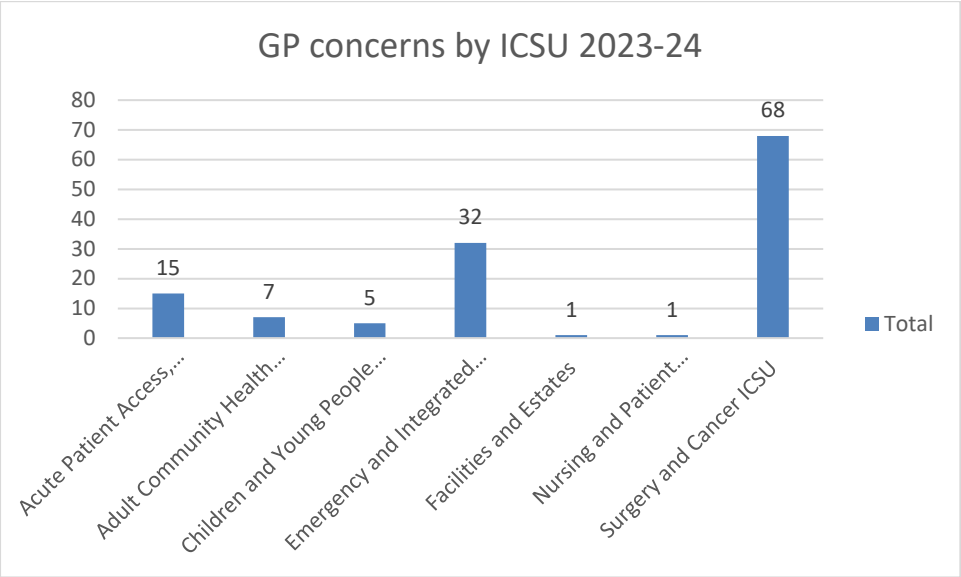
Graph 16: Gender



3.3 GP Concerns

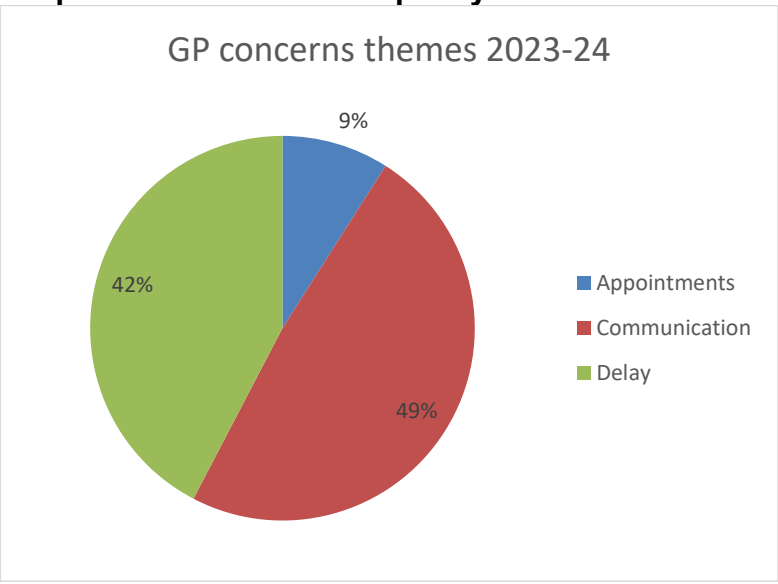
129 concerns were logged from GP Practices. This compares to 181 in 2022-23 a decrease of 52. The number of concerns by ICSUs & the main themes are shown in the graphs below, (graphs 17 & 18). A similar pattern to complaints can be seen in these data, with S&C being the subject of the highest number of concerns, followed by EIM and ACW.

Graph 17: GP concerns by ICSU 2023-24



The key concerns related to delay to treatment (47%), lack of or poor communication (42%) and failure to get an appointment (11%), (Table 20)

Graph 18: GP concerns top 5 by Theme 2023-24



In all cases the GP requests for help were shared with the appropriate service who were asked to resolve and contact the GP Practice directly.

3.4 NHS Choices

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

4.0 Support & Training

The PALS & Complaints team provides ongoing support to ICSUs by ensuring the availability of training sessions on demand that can be delivered across several sites. The team also provides a complaints introductory session as part of Trust Induction and ad hoc complaints management training for relevant new employees.

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

During 2023-24 bespoke PALS & Complaint handling training via TEAMS and face-to-face was delivered to 70 members of staff across all ICSUs.

5.0 PLANS FOR 2023-2024

5.1 To revisit the training provision for complaint handling to ensure a good understanding in the ICSUs. This should enable the ICSUs to increase the number of staff skilled to undertake investigators and improve the quality and timeliness of complaint investigations.

5.2 To review the learning from those complaints that are upheld in any way to ensure that the learning is embedded in the working practices of the team/area involved. The aim is to reduce the likelihood of a recurrence.

5.3 To include complaints and compliments data into the new Patient Safety Incident Response Framework (PSIRF), to ensure learning and provision of a better patient experience.

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Whittington Population Health Report

MAY 2024

Whittington Health NHS

Table of contents

Executive summary

Whittington Health NHS Trust

Our Communities

Most of our patients come from Islington and Haringey, which have very **diverse communities** with a **younger population.** The population in both boroughs has increased and aged slightly since the last population health report.

The percentage of people with **higher than average levels of deprivation has increased** with 26.7% of Islington and 34.7% of Haringey's population living in the 20% most deprived neighbourhoods in England.

There is **high prevalence of smoking and obesity**, which are significant risk factors for long-term conditions affecting the community. These risk factors increase with deprivation. However, more robust data on behavioural risk factors is needed.

Pressing Health Inequalities

There are significant **differences in health outcomes** (such as life expectancy) between those living in the most and least deprived deciles.

The **social determinants of health** such as housing, poverty, employment, and access to care have a significant effect on the ability of our residents to live healthy lives.

Whittington Health is improving the wellbeing of the local community and addressing the social determinants of health through its work as an **anchor institution.**

Long Term Conditions

Haringey and Islington have higher rates of **mental health problems and mortality due to cardiovascular disease** than the London average. Islington also has higher rates of mortality from respiratory diseases than Haringey.

The prevalence of long-term conditions such as hypertension and diabetes generally correlates with rates of smoking and obesity in most areas. The number of cancer diagnoses has increased in both boroughs since the last report.

By looking more deeply into **behavioural risk factors** and the intersection between demographic areas of interest (e.g.. **ethnicity, deprivation**), we can improve the **detection and treatment** for these LTC's.

Population Health Implications

In order to make the greatest impact on population health, we must focus on the **four pillars:** The wider determinants of health, our health behaviours and lifestyles, the places and communities we live in and with, and an integrated health and care system.

A population health approach emphasizes the need to **work with other public services** to address the interdependent issues that affect health and wellbeing, which is important for reducing health inequalities.

Population Health

NHS
Whittington Health
NHS Trust

Population Health

Population Health has been defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

To improve population health, we must tackle the key drivers of poor health affecting our local populations.
WH is working to improve the health of its local population through its role as an anchor institution and its health inequality programme.

Wider determinants of health

The communities we live in

Our behaviours and lifestyle

An integrated health and care system

Anchor Institution

Health Inequalities Programme

Our proposed approach

Whittington Health NHS Trust

Whittington's Strategic Objective:

To improve the health of our population and address health inequalities

We aim to do this by working:

- to make our **communities fairer** and to create a place where everyone, whatever their background, has the opportunity to reach their potential and enjoy a good quality of life.

- to involve and **engage residents** in our decision making and service design.
- to support people to look after their own health, including through **enabling access** to wellbeing and self-care opportunities.

- as an **Anchor institution**, deeply rooted in our local community, WH can have significant impact on the things that keep people healthy and reduce inequalities e.g. employment, procurement and sustainability.
- to take a **data driven** approach, looking at the drivers of ill health and which populations are most affected, can lead to better outcomes, reduce inequalities and reduce demand for hospital services.

- To Make Every Contact Count (MECC) and providing health advice

Population health data

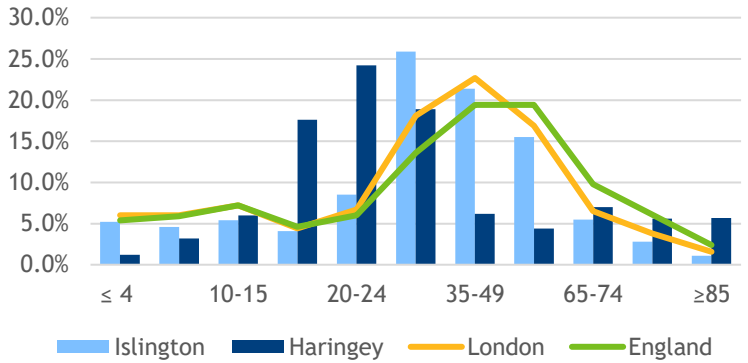
Demography- the people we serve

Whittington Health NHS Trust

Key Messages:

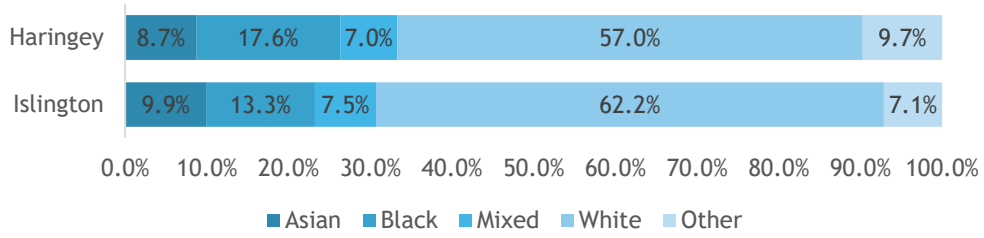
- Most of our patients come from Islington and Haringey, however we do get some patients from the entire NCL area including Camden, Barnet, and Enfield.
- Our patients are **increasingly ethnically and linguistically diverse.** Conscious efforts must be taken to ensure we are providing culturally competent services to meet these diverse needs.
- Haringey and Islington are dominated by a young working age population. This presents a significant opportunity for prevention of conditions that are significant contributors to death and disability.
- There are high levels of deprivation in Haringey and Islington. Areas with income deprivation are more likely to have a range of health conditions

Age (%)

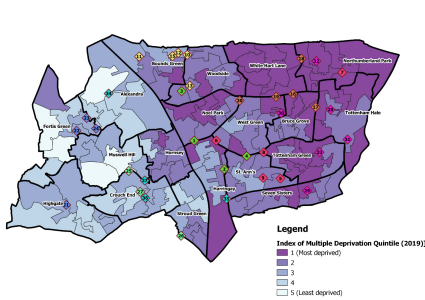


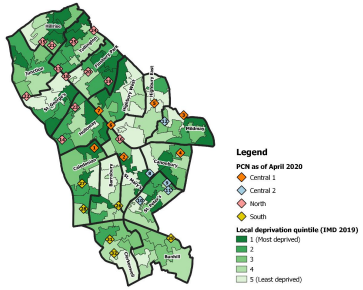
Haringey and Islington have higher populations of people aged 20-34 than London and England.

Ethnicity (% of population)



Areas of deprivation





33.1% of Haringey's and 23.4% of Islington population live in the 20% most deprived neighbourhoods in England

Top 5 languages spoken:

Haringey

1. English (70.3%)
2. Turkish (3.6%)
3. Spanish (3.4%)
4. Polish (3.0%)
5. Portuguese (2.2%)

Islington

1. English (78.4%)
2. Spanish (3.2%)
3. French (2.1%)
4. Italian (1.7%)
5. Turkish (1.7%)

Source: ONS census 2021

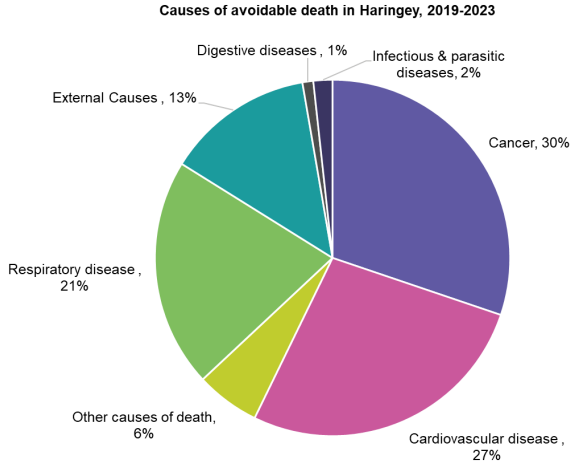
Population health data
Deprivation and avoidable deaths

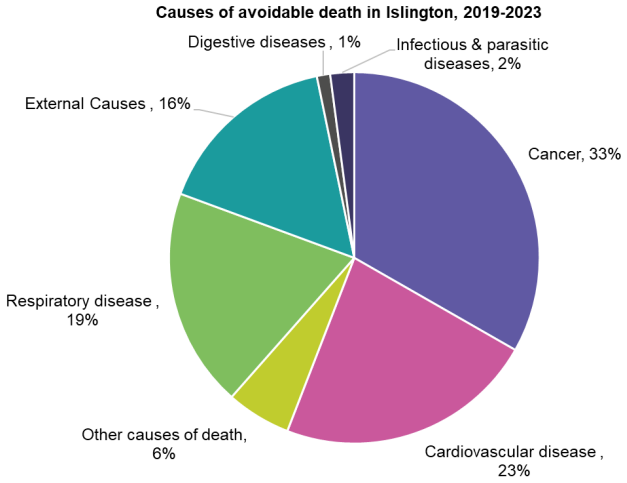
Whittington Health NHS Trust

Emergency Admissions by Deprivation

	Most Deprived: Deciles 1 and 2			Least Deprived: Deciles 9 and 10		
	% Population	% Emergency Admissions	Difference	% Population	% Emergency Admissions	Difference
Haringey	34.6%	38.2%	+3.6%	3.1%	2.6%	-0.5%
Islington	26.7%	31.5%	+4.8%	0.0%	0.0%	0.0%

Causes of avoidable deaths in Haringey and Islington





Key Messages:

Deprivation is associated with adverse health effects.

- 34.7% of Haringey's population live within the 20% most deprived areas in England- but account for 38.2% of Haringey emergency admissions.
- 26.7% of Islington's population live within the 20% most deprived areas in England- but account for 31.5% of Islington emergency admissions.
- The main causes of avoidable death in both Haringey and Islington are cancer, cardiovascular and respiratory disease.

Sources: Admissions data from SUS 2023; Population data from ONS Mid-2022 Population Estimates

Population health data

Overview - Long-term conditions

NHS Whittington Health NHS Trust

Area	Metric	Haringey	Change from last report*	Islington	Change from last report*	London
Diabetes	Estimated diabetes diagnosis rate (2018)	64.50%		63.70%		78%
COPD and respiratory	<75 mortality due to respiratory disease/100,000 (2021)	23.4	0.1	36.3	-1.1	22.5
	<75 mortality due to respiratory disease/100,000 considered preventable (2021)	10.8		24.7		12.1
Cancer	number diagnosed at stages 1 and 2	237		187		9,248
MSK	% reporting long-term MSK problems (2022)	12.10%	-1.3%	11.90%	-0.4%	12.70%
Cardiology	<75 mortality due to CVD/100,000 (2021)	91.9		85.2		74.3
	<75 mortality due to CVD/100,000 considered preventable (2021)	38.9		34.5		29.5
Mental health	Estimated prevalence of common mental disorders (% age 16+) (2017)	22.3		22.7		19.3
	Estimated prevalence of common mental disorders (% age 65+) (2017)	13.4		13.8		11.3

Key:
- Better than London average
- Similar to London average
- Worse than London average

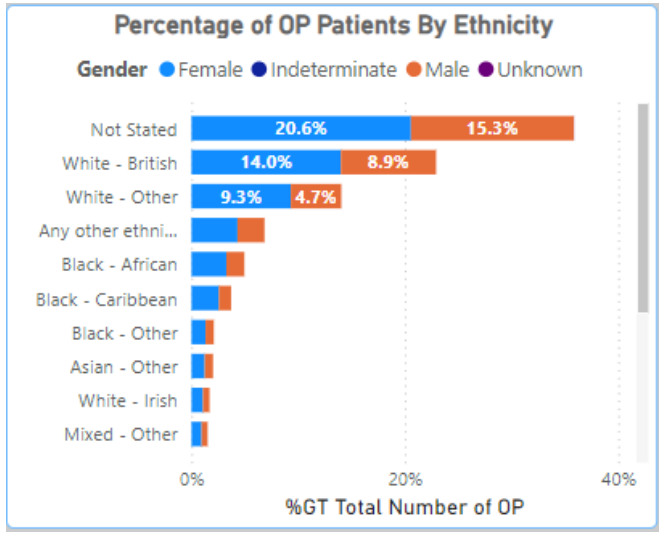
Respiratory disease, cardiovascular disease, and mental illness are key areas of concern for Haringey and Islington. Mortality due to respiratory disease is higher in Islington than in Haringey.

* Where comparable and updated statistics are available.

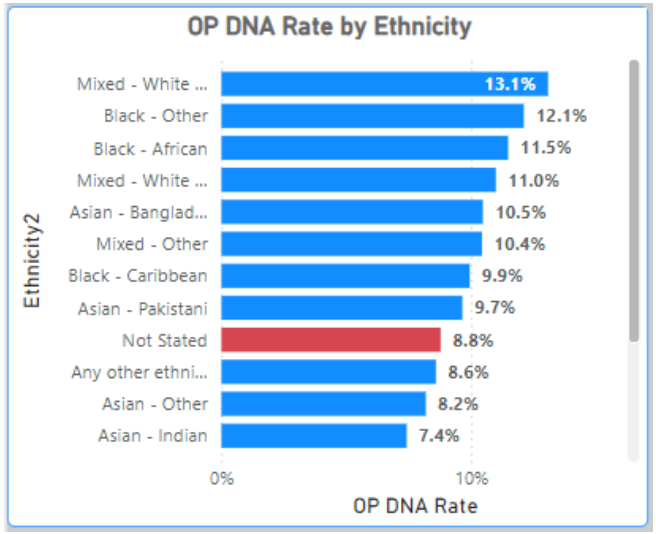
Whittington Health data
Outpatient attendances

Whittington Health NHS Trust

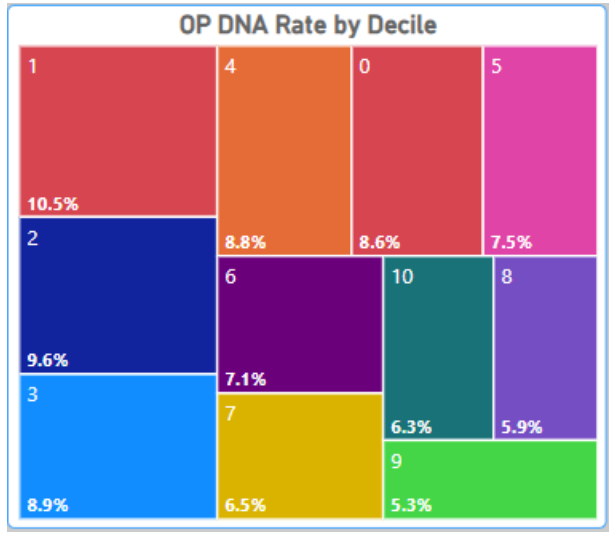
The recently created **Health Equity dashboard** is a tool for services to identify health inequalities that may exist across their areas of work. The data is segmented by ethnicity, age, gender and IMD deciles. This dashboard is still under development and currently covers Outpatients, Inpatients, ED, WG CDC.



A third of patients across all services do not have ethnicity stated on the EPR.



DNA rate greatest for Mixed - White and Black and Black – Other and African groups



Number of DNA rates in OP by IMD Decile is higher for most deprived

Data informs our programme of work

Whittington Health NHS Trust

The data shows us:		We will:
Our communities are more diverse	**Community**	Look at making patient communications more accessible to our local populations and track impact of CDC
There is an increase in disease burden, with priorities in heart, lung, cancer, and mental health	**Service provision**	Focus on the 5 clinical areas defined in the CORE20PLUS5 because our “plus” areas align with these (consider MECC)
Increase in the number of A&E attendances and large number of DNAs in outpatients	**Service provision**	Work with our partners to review access locally and undertake a QI project to address DNAs
We have limited datasets disaggregated by IMD and ethnicity	**Data quality**	Review our data dashboards and work on improving ethnicity recording
We need to work with the wider system to impact the wider determinants of health	**Anchor institution**	Work with our local partners to deliver against the 5 agreed priorities for the Anchor programme

Health inequalities

Population Health

The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

An integrated health and care system

Health Inequalities Programme

We have set up a Health Inequalities Steering Group to provide assurance to the Quality Assurance Committee on the monitoring, analysis and publication of health inequalities and population health data.

The objectives of the Steering Group include;

- Provide support and enable different services to address Health Inequalities
- Sharing work and learning opportunities
- Identify cross ICSU opportunities
- Report on progress in addressing Health Inequalities CORE 20 PLUS 5 through service delivery, access and improved data quality

Health Inequalities Programme

NHS Whittington Health NHS Trust

REDUCING HEALTHCARE INEQUALITIES

The National **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g.. inclusion health groups

Target population

CORE20 PLUS 5

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups

2. **SEVERE MENTAL ILLNESS (SMI)**
ensure annual Physical Health Checks for people with SMI to at least, nationally set targets

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on COPD, driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5. **HYPERTENCAS E-FINDINGSION**
and optimal management and lipid optimal management

SMOKING CESSATION
positively impacts all 5 key clinical areas

Health Inequalities Programme

Whittington Health NHS Trust

Programme Priority	Process
Oversight of Anchor work	Monthly update of progress against framework
Improve access to HI data and insights. Improve data quality	Weekly meetings to keep track of progress and link to other improvement programmes and trust priorities
Service delivery oversight including CORE20PLUS5	Work with MD to embed assessment of service against health inequalities criteria. Publish assessments on intranet page
Embed addressing health inequalities across all trust services	Implement a Health Inequalities Assessment Tool to undertake at the point of starting a service/project.
Address high number of DNAs for Outpatients	Outpatient DNA project will use data to stratify patients and identify methods to communicate with patients to improve attendance. Linked to outpatient improvement project
Patient information leaflets/letters	Identify some key letters to develop more pictorial equivalents and then trial

Health Inequalities Programme

NHS Whittington Health NHS Trust

CORE20PLUS5	Current projects
Core 20 24% of Islington and 34% of Haringey's population live in the 20% most deprived neighbourhoods in England	Dashboard created where service user data is disaggregated by ethnicity, IMD deciles, age and gender. This will help services to ensure they are able to identify areas of greatest disparity. Trust Board performance packs to be disaggregated by deprivation and ethnicity. This intelligence will then inform the development of action plans to narrow the health inequalities gap.
Plus Population groups experiencing poorer-than-average health access, experience and/or outcomes	We have multiple services which treat some of the most deprived patients in our communities, these include: • Sickle cell service • Integrated frailty service, proactive frailty service. • Prevention and Management of type 2 diabetes in a deprived community in West Haringey- this project improved outcomes for patients.
Maternity Ensuring continuity of care for women from BAME communities and from the most deprived groups	A Maternity dashboard has been curated which also segments data by ethnicity and deprivation. This is utilised in service meetings to monitor progress, including the Continuity of care service in Haringey and the Health visiting service. There is also a Peri-natal mental health project underway.
Severe Mental Illness 22.5% of people aged 16+ have a common MH condition. One-in-three out-of-work benefit claims are due to mental illness	WH provide medical input into the Highgate West site of the Mental Health Trust, to support physical health needs. Next steps are to expand support into Highgate East. WH collaborates with the C&I smoking cessation service to look at ways we can work together and continues to support C&I staff development with access to WH Library resources. A project to improve peri-natal mental health is underway in the Maternity department WH provides IAPT services in Haringey where there are high level of Mental Health need.
Chronic Respiratory Disease Islington has higher than average mortality from respiratory diseases.	ACS has undertaken projects in the community which include respiratory outreach work in Haringey via well-being events with Somali and Turkish communities and those living sheltered housing
Early Cancer Diagnosis The number of cancer diagnoses in Haringey and Islington have increased since 2022	Increased access to imaging through the Wood Green Community Diagnostic Centre Releasing capacity in the system through undertaking day cases at Whittington so complex cancers are treated at UCLH Commissioned HI survey for colposcopy with Haringey PH team.

Health Inequalities at the CDC

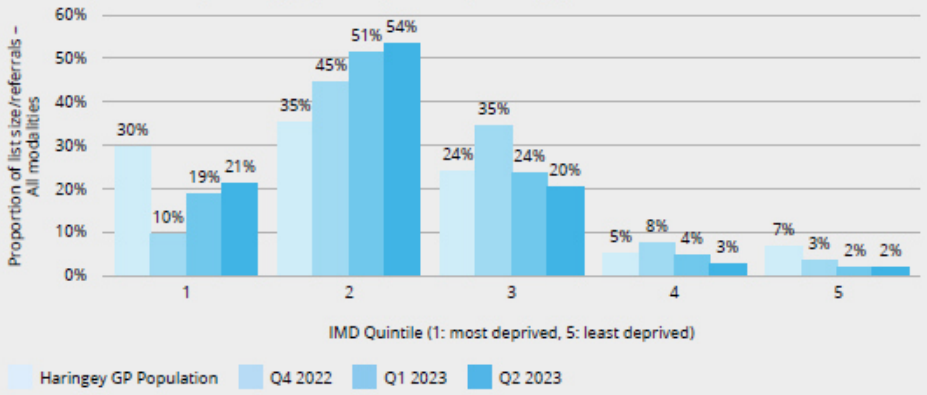
Whittington Health NHS Trust

In November 2023, a Health equity audit of services at the Wood Green Community Diagnostic Centre (CDC) was completed.

Changes in referrals over time

All modalities

Figure 19: Proportion of referrals received by the CDC for all modalities across IMD quintiles, presented in calendar quarters compared to proportion of list size for Haringey



Over time, there has been an increase in proportion of referrals received from GP practices in IMD Quintile 1 (Core 20), although there is still opportunity to close this gap (Figure 19).

Systematic comparison of expected referrals to actual referrals across demographic categories of age, gender, ethnicity and deprivation was undertaken.

The CDC has demonstrated its ambition to impact on healthcare inequalities by providing faster diagnostic testing to more patients across NCL, whilst also **improving access for Core20 populations and underrepresented groups.**

Comparing the population of Haringey, baseline referrals (to WH) and CDC referrals across all modalities, **referrals to CDC have shifted towards more deprived groups** and this pattern is more comparable to Haringey population.

Most recently 75% of referrals to the CDC were from the 40% most deprived groups.

Key recommendations which will form the basis of specific projects include:

- **Need to address referral gaps**
- **Improve and explore data**
- **Track impact**

Population Health

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Population Health

The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Wider determinants of health

The communities we live in

Our behaviours and lifestyle

An integrated health and care system

Anchor Institution

Our work as an anchor institution in partnership with local government, communities and local businesses aims to deliver improvements to the health and wellbeing of our population. The Anchor Network have agreed 5 strategic objectives that we are committed to delivering against.

Health Inequalities Programme

Anchor Institution

NHS Whittington Health NHS Trust

The Anchor Network have agreed 5 strategic objectives that we are committed to delivering in collaboration with our partner organisations.

Employment	Create local jobs paying the living wage, caring for the mental and physical health of our staff.
Procurement	Create social value through our procurement
Bricks and mortar	**Design vibrant community spaces that improve health and benefit the environment**
Corporate and civic	Lead, influence and partner with others using data to prioritise actions that reduce inequalities.
Service Provision	Be a positive presence and influence in the health of our communities through trusted advice and holistic approach. Co-design and deliver joined up services so they reach and benefit disadvantaged communities.

Anchor Institution – Current projects

Whittington Health NHS Trust

Priority	Current projects

Employment
 	
Create local jobs paying the living wage, caring for the mental and physical health of our staff.
	• Local outreach – work experience opportunities are being looked at as part of the Network and include:
	  - A work placement scheme for schools
	  - A supported internship scheme - for young persons (18-25) with special educational needs
	• Work is ongoing with the Health and Social Care Academy to tackle focus on enrolment and shared practice
	• Appraisals are in place with staff to look at professional development with internal ICARE leadership courses and apprenticeship schemes
	• Flexible working policy has been renewed.
	• Work is ongoing and is moving in the right direction for positive working environments, open communication and recognition on work including better connections for lower grade staff and management
	• The merger of City, University of London and St George's, University of London will create a powerful multi-faculty institution which is part of our Anchor Network will increase capability for population health monitoring, workforce development and leadership, policy, and advocacy.

Procurement Create social value through procurement	• On behalf of the Network WH will be hosting a procurement event for local partners in Mar 2024. • As an NHS trust WH will participate in the system led procurement programme.
Bricks and mortar Design vibrant community spaces that improve health and benefit the environment.	To reduce our carbon footprint: • Work is ongoing at WH regarding replacing gas boilers and finance options to pay this back over time • Ongoing discussions with Treasury regarding restrictions on power purchase agreements and team ready to look at solutions • Work ongoing with high street banks co-op and Natwest looking at zero fossil fuel banking • Work is ongoing with moving to seasonal/vegan based food options and consultancy in place to map changes and challenges. Information sharing with Guy's and St Thomas FT
Corporate and civic Lead, influence & partner with others using data to prioritise actions that reduce inequalities.	• External civic role and partnerships: Part of Islington Anchor network, Member of NHS London Anchor Strategy and Change Network. • Internal anchor ownership: We have allocated leads for each of the strategies within the local Anchor institute and track progress against these in our steering group.

Health Inequalities Self Assessment Tool

Whittington Health NHS Trust

As part of a bench-marking exercise we carried out a Health Inequalities self-assessment.
The self-assessment tool was designed by NHS Providers alongside the Reducing Health Inequalities Guide for NHS Trust Board Members. It provides a maturity rating for the Trust's position in 4 domains and helps establish a starting point for a high level discussions about the Health Inequalities programme of work. We will repeat this annually as a mechanism for benchmarking progress over time.

Domain	Percentage complete	Maturity level
Building public health capacity & capability	50%	Maturing
Data, insight, evidence and evaluation	43%	Developing
Strategic leadership & accountability	61%	Maturing
System partnerships	80%	Thriving

https://health-inequality-tool.net/reload/RwEEZTBUy

Next steps

The Health Inequalities Steering Group will continue to provide assurance to the Quality Assurance Committee and monitor progress on:

- Population Health
- Service Delivery
- CORE20PLUS5
- Anchor Institute

We will increase membership of the group to include representation from the Quality Improvement and Research teams to build public health capacity & capability in house.

Review our data by continuing to champion importance of improved data collection and reporting to drive a better understanding of local health inequities in access to services, experience of services and health outcomes. This will progress our maturity in the data, insight, evidence and evaluation domain.

Oversee the implementation of the **Health Inequalities Assessment tool** across services to identify any gaps in data and ensure that health inequality is systematically considered throughout the organisation.

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Appendix 1

Demographics

Trends and inequalities, mortality, burden of disease and risk factors

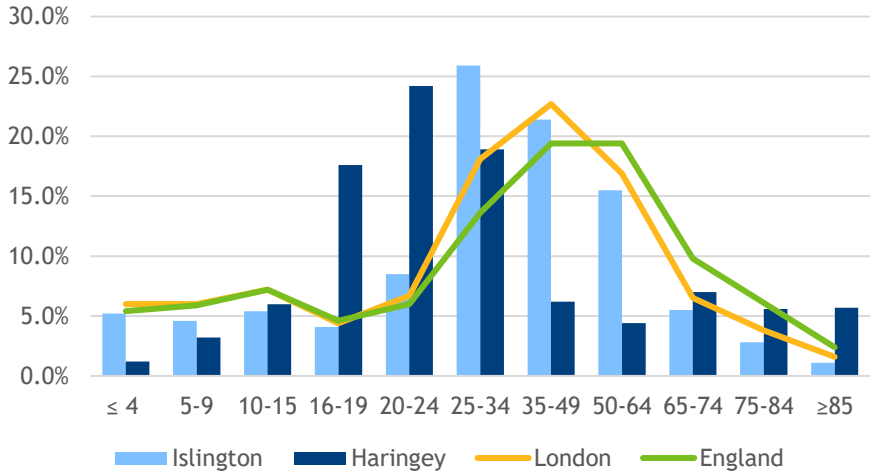
Demography- the people we serve

Whittington Health NHS Trust

Key Messages:

- Most of our patients come from **Islington and Haringey**, however we do get some patients from the entire NCL area including Camden, Barnet, and Enfield.
- Our patients are **increasingly ethnically and linguistically diverse.** The proportion of White people in Haringey and Islington has slightly decreased since the last population health report. Conscious efforts must be taken to ensure we are providing culturally competent services to meet these diverse needs.
- Haringey and Islington are dominated by a **young working age** population. This presents a significant opportunity for prevention of conditions that are significant contributors to death and disability.

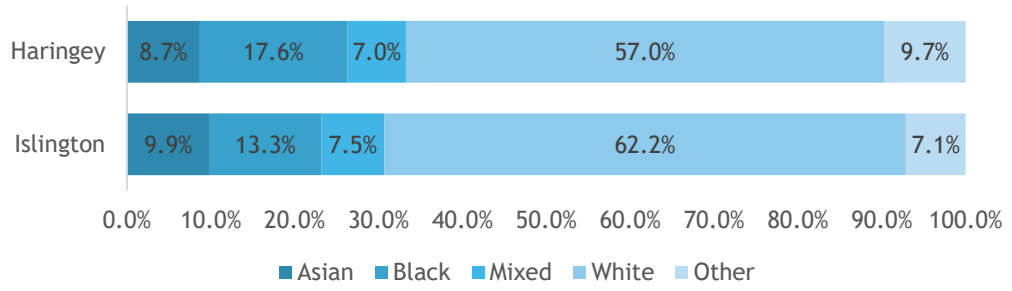
Age (%)



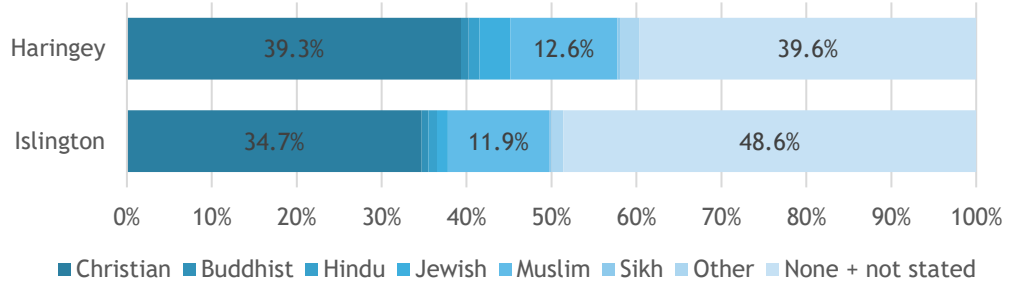
Haringey and Islington have higher populations of people aged 20-34 than London and England. Haringey has more young adults (16-24) and elderly (>65) than Islington, while Islington's population clusters in the 25-64 age range.

Source: ONS census 2021

Ethnicity (% of population)



Religion (% of population)



Top 5 languages spoken:

Haringey

1. English (70.3%)
2. Turkish (3.6%)
3. Spanish (3.4%)
4. Polish (3.0%)
5. Portuguese (2.2%)

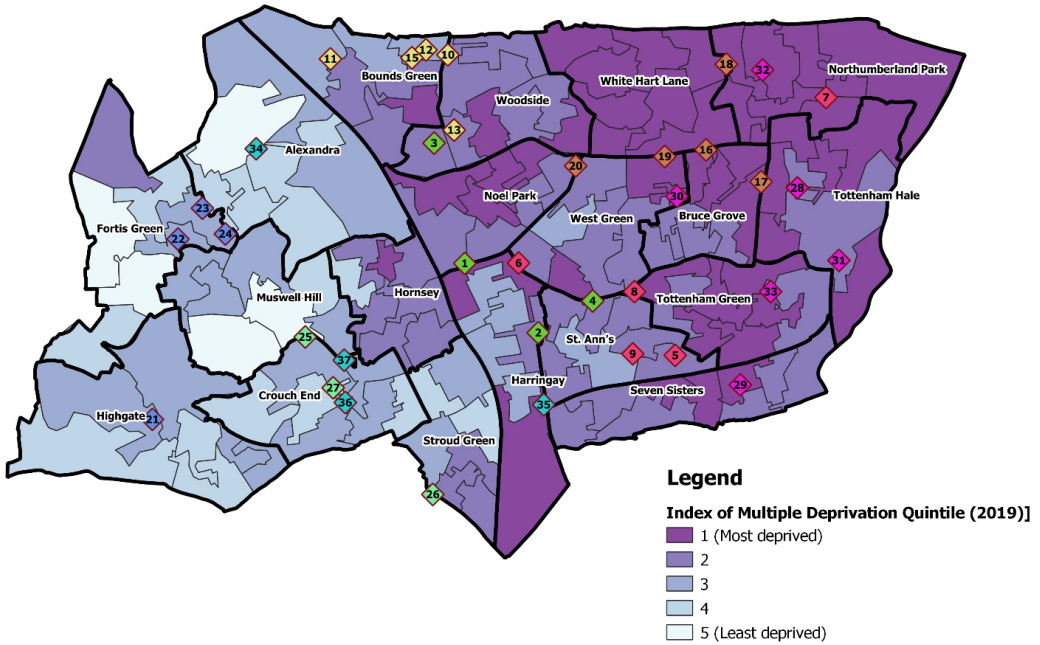
Islington

1. English (78.4%)
2. Spanish (3.2%)
3. French (2.1%)
4. Italian (1.7%)
5. Turkish (1.7%)

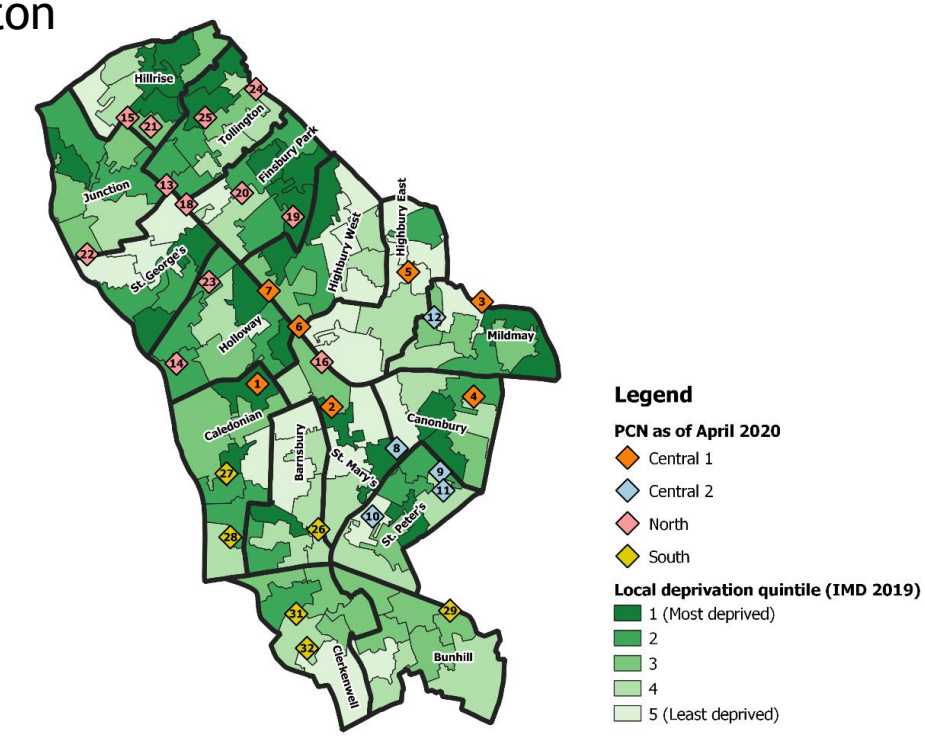
Areas of Deprivation

NHS Whittington Health NHS Trust

Haringey



Islington



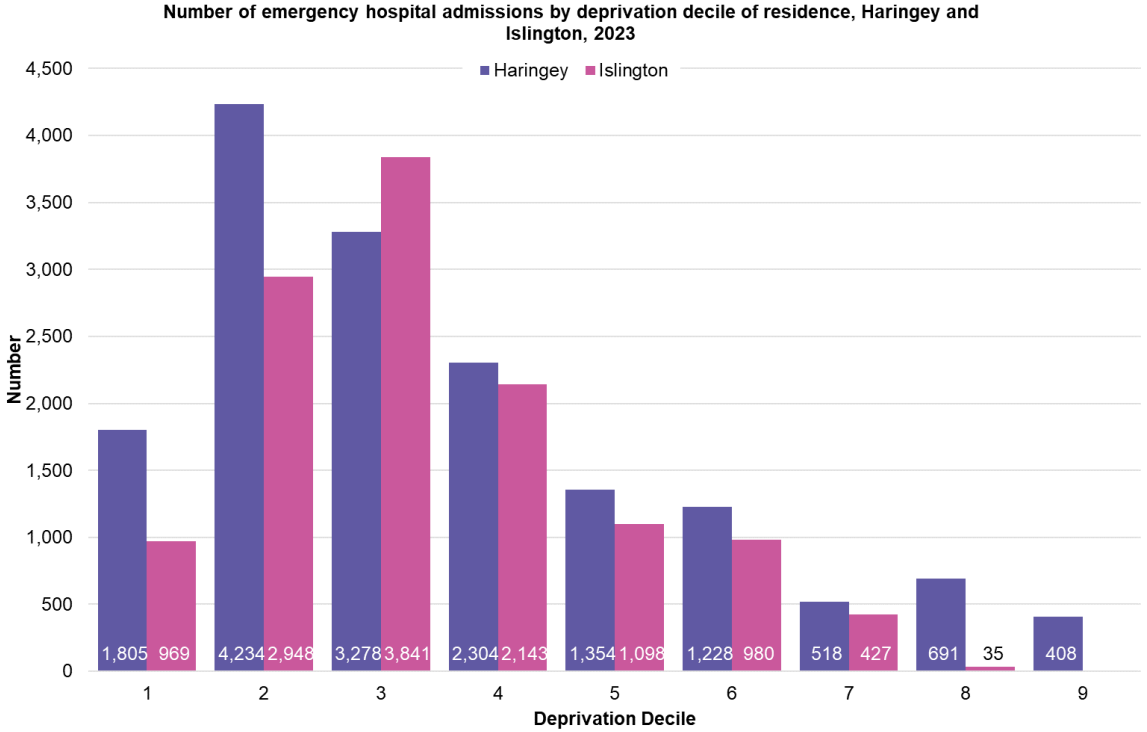
Key Messages:

- 23.4% of Islington and 33.1% of Haringey's population live in the 20% most deprived neighbourhoods in England, which is a slight decrease from 24% and 34% in the last population health report.
- Deprived neighbourhoods are concentrated in the East in Haringey, while Islington areas of deprivation are spread throughout the borough.
- Haringey and Islington are increasingly ethnically and linguistically diverse, with less than two thirds of the population being White in both boroughs. The proportion of White people has also decreased since the last report.

Emergency Admissions by Deprivation

NHS Whittington Health NHS Trust

	Most Deprived: Deciles 1 and 2			Least Deprived: Deciles 9 and 10		
	% Population	% Emergency Admissions	Difference	% Population	% Emergency Admissions	Difference
Haringey	34.6%	38.2%	+3.6%	3.1%	2.6%	-0.5%
Islington	**26.7%**	**31.5%**	**+4.8%**	**0.0%**	**0.0%**	**0.0%**



Sources: Admissions data from SUS 2023; Population data from ONS Mid-2022 Population Estimates

Key Messages:

Deprivation is associated with adverse health effects.

- **34.7%** of Haringey's population live within the 20% most deprived areas in England- but **account for 38.2%** of Haringey emergency admissions.
- Conversely, **3.1%** live in the 20% least deprived areas- but **account for 2.6%** of emergency admissions.
- **26.7%** of Islington's population live within the 20% most deprived areas in England- but **account for 31.5%** of Islington emergency admissions.

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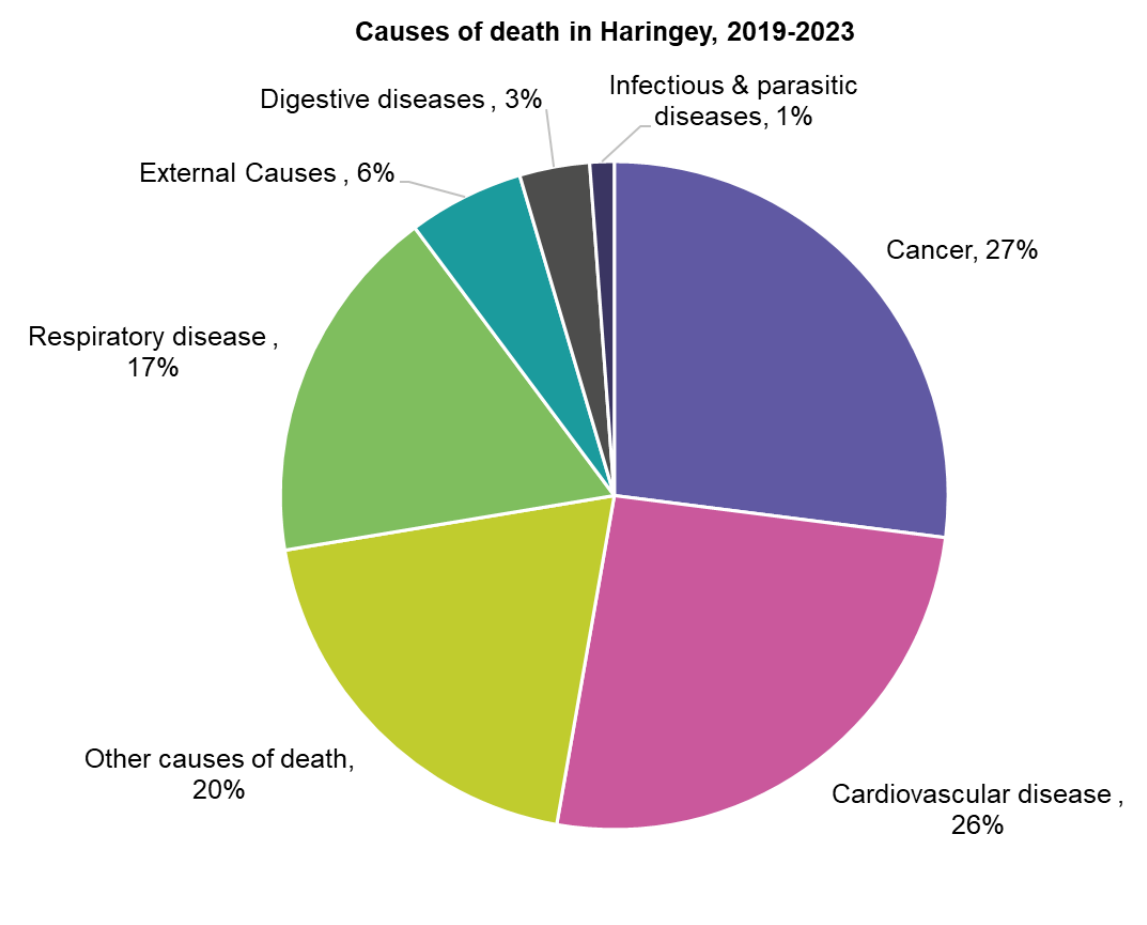
Appendix 1

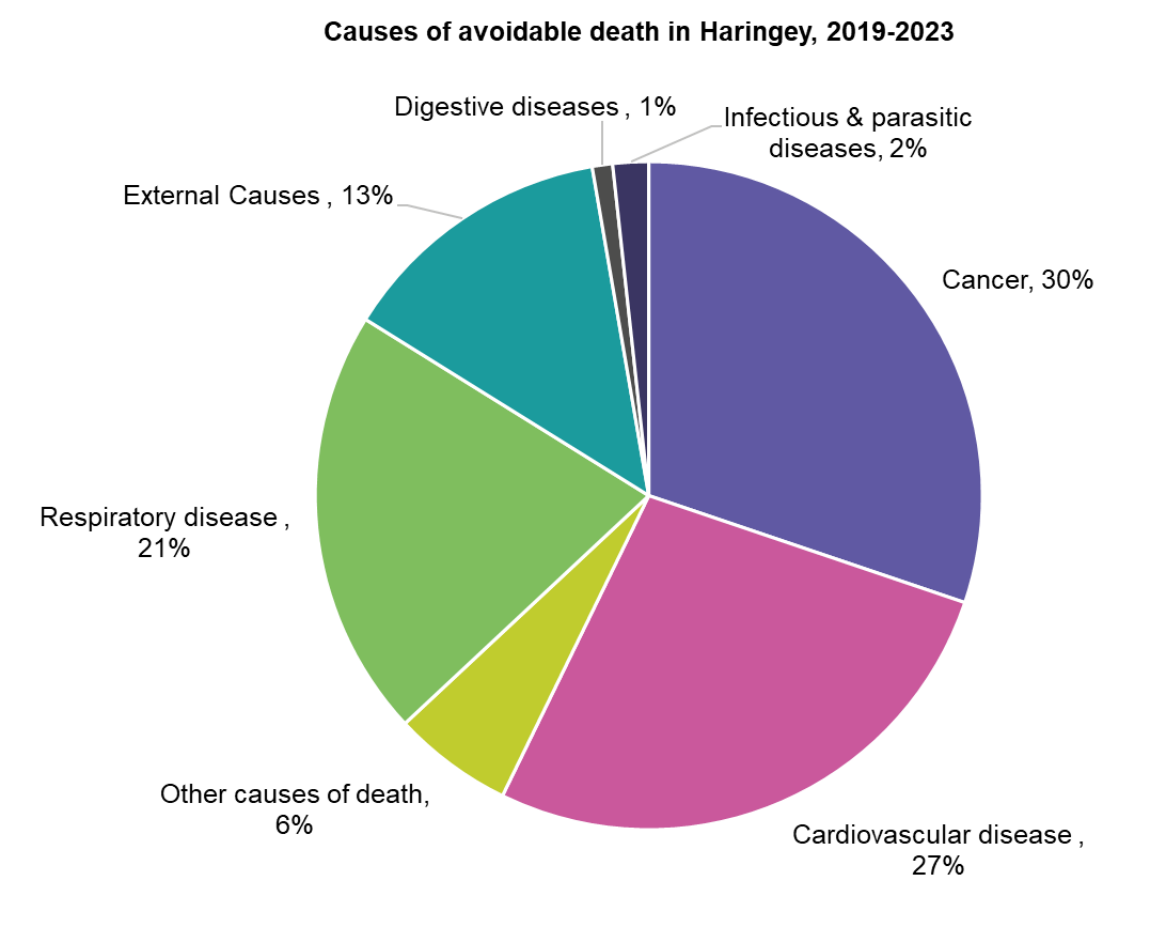
Population health needs

Mortality, burden of disease, and risk factors

Causes of death in Haringey (2019-2023)

Average annual number of deaths in Haringey: 1,393 (426 avoidable)

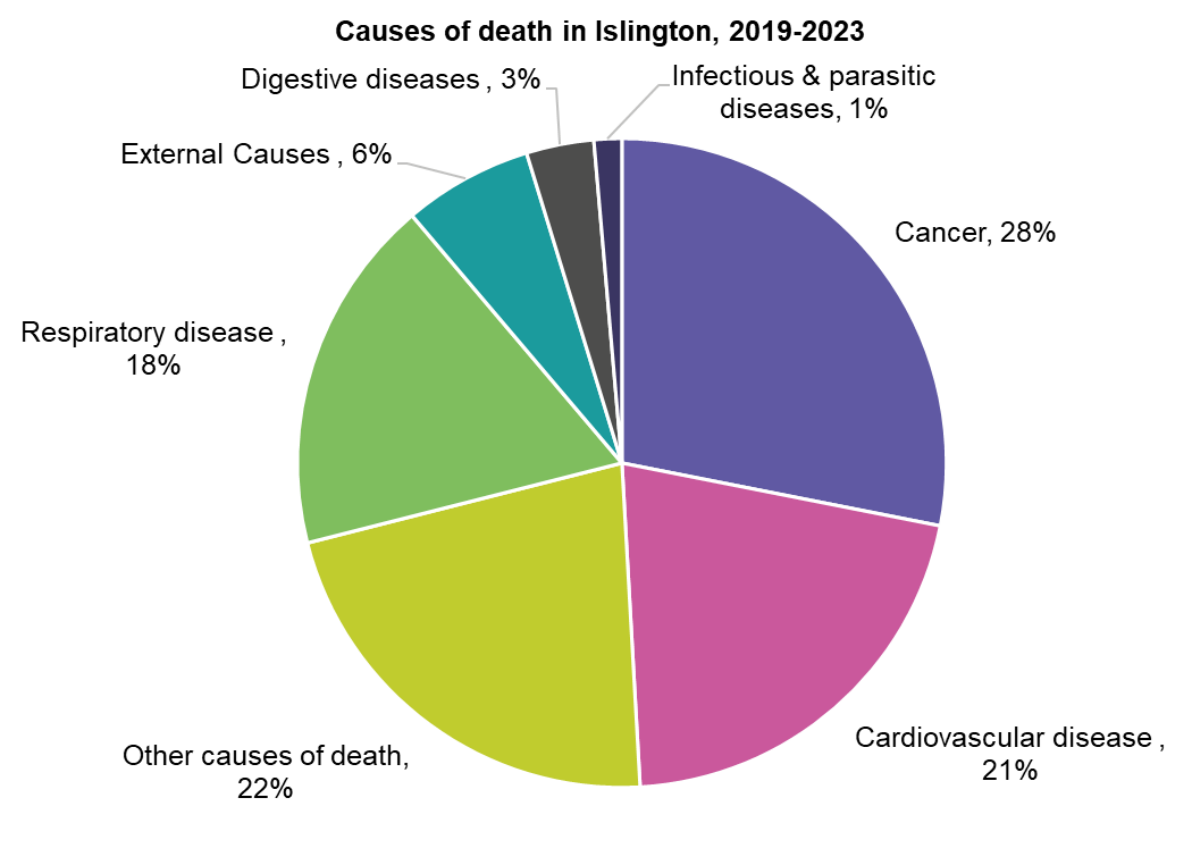


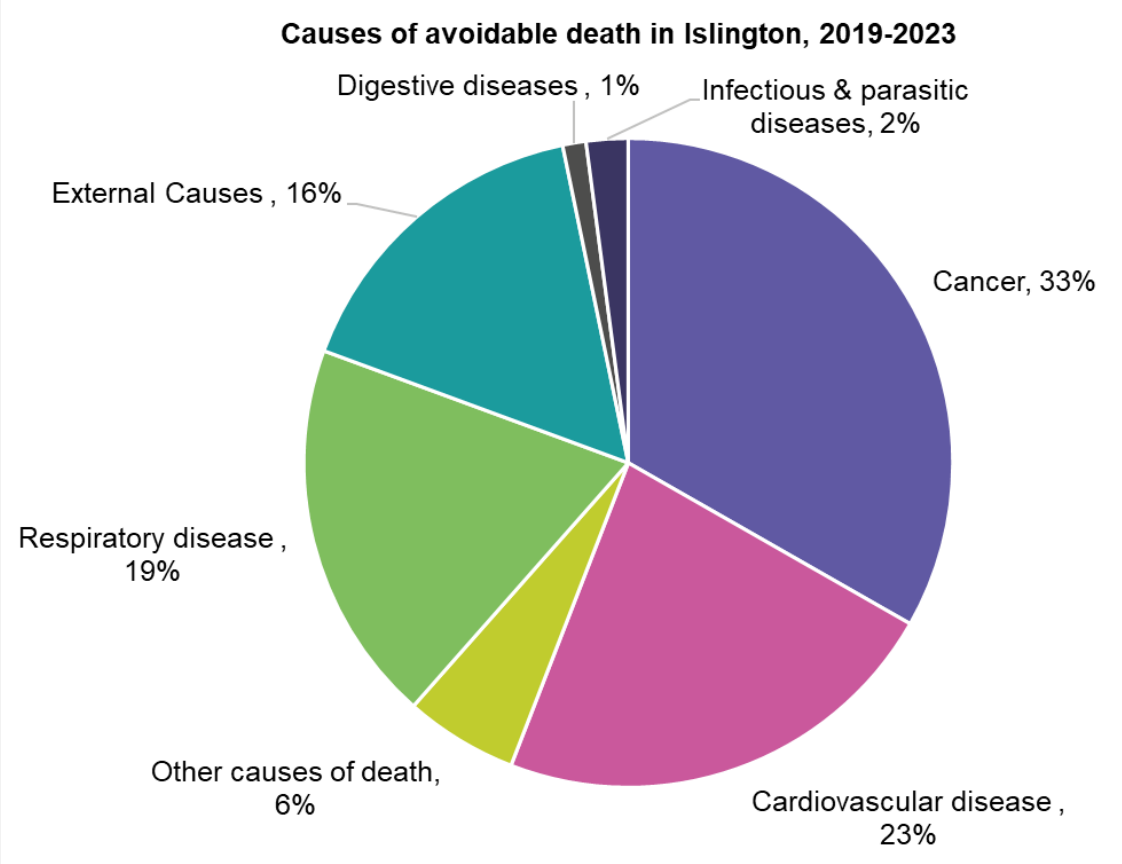


Causes of death in Islington (2019-2023)

Whittington Health NHS Trust

Average annual number of deaths in Islington: 1,142 (345 avoidable)





Overview - Life expectancy and deprivation

Whittington Health NHS Trust

Area	Metric	Haringey	Change from last report*	Islington	Change from last report*	London
Life expectancy	Life expectancy at birth (male) (2021)	78.2	-2.5	77.1	-2.6	78.8
	Life expectancy at birth (female) (2021)	83.3	-1.5	82.6	-0.8	82.8
	Healthy life expectancy at birth (male) (2018-20)	62.6	-1.6	63	-0.4	63.8
	Healthy life expectancy at birth (female) (2018-20)	65	1	63.8	4	63.9
	Life expectancy at 65 (male) (2021)	18.1	-1.5	16.2	-2.7	18.2
	Life expectancy at 65 (female) (2021)	21.4	-1.2	20.5	-0.9	21.2
	Inequality in life expectancy at birth (male) (2018-20)	8.1		11.3		7.5
	Inequality in life expectancy at birth (female) (2018-20)	4.2		5		7.9
Deprivation	% Children (<16) in relative low income families (2021/22)	18		18.5		16.4
	% people in employment (2021/22)	76.50%	-0.2%	79.30%	2.4%	75.4
	Deprivation score (2019)	28		27.5		21.8

Key:

- Better than London average
- Similar to London average
- Worse than London average

Life expectancy in Islington is generally lower than in Haringey. Life expectancy and healthy life expectancy for men is lower than for women.

Life expectancy and healthy life expectancy have decreased in Haringey and Islington from the last population health report (data from 2017-2019), except healthy life expectancy at birth for females. This could reflect the impact of COVID-19 (?)

* Where comparable and updated statistics are available.

Overview - Long-term conditions

Whittington Health NHS Trust

Area	Metric	Haringey	Change from last report*	Islington	Change from last report*	London
Diabetes	Estimated diabetes diagnosis rate (2018)	64.50%		63.70%		78%
COPD and respiratory	<75 mortality due to respiratory disease/100,000 (2021)	23.4	0.1	36.3	-1.1	22.5
	<75 mortality due to respiratory disease/100,000 considered preventable (2021)	10.8		24.7		12.1
Cancer	number diagnosed at stages 1 and 2	237		187		9,248
MSK	% reporting long-term MSK problems (2022)	12.10%	-1.3%	11.90%	-0.4%	12.70%
Cardiology	<75 mortality due to CVD/100,000 (2021)	91.9		85.2		74.3
	<75 mortality due to CVD/100,000 considered preventable (2021)	38.9		34.5		29.5
Mental health	Estimated prevalence of common mental disorders (% age 16+) (2017)	22.3		22.7		19.3
	Estimated prevalence of common mental disorders (% age 65+) (2017)	13.4		13.8		11.3

Key:
- Better than London average
- Similar to London average
- Worse than London average

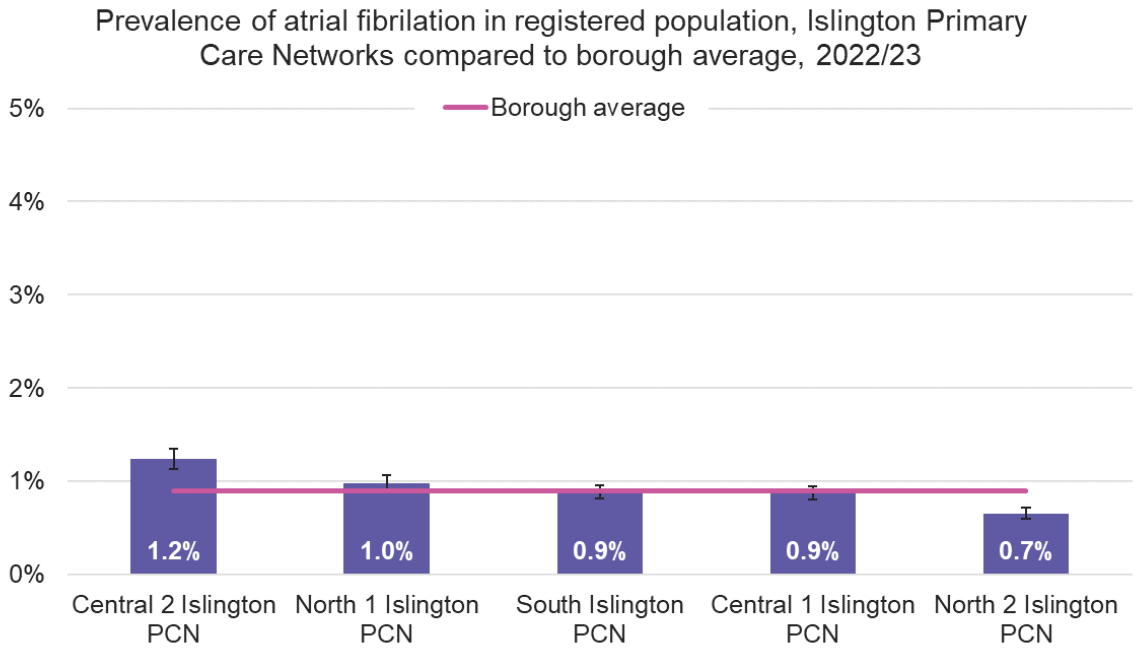
Respiratory disease, cardiovascular disease, and mental illness are key areas of concern for Haringey and Islington. Mortality due to respiratory disease is higher in Islington than in Haringey.

* Where comparable and updated statistics are available.

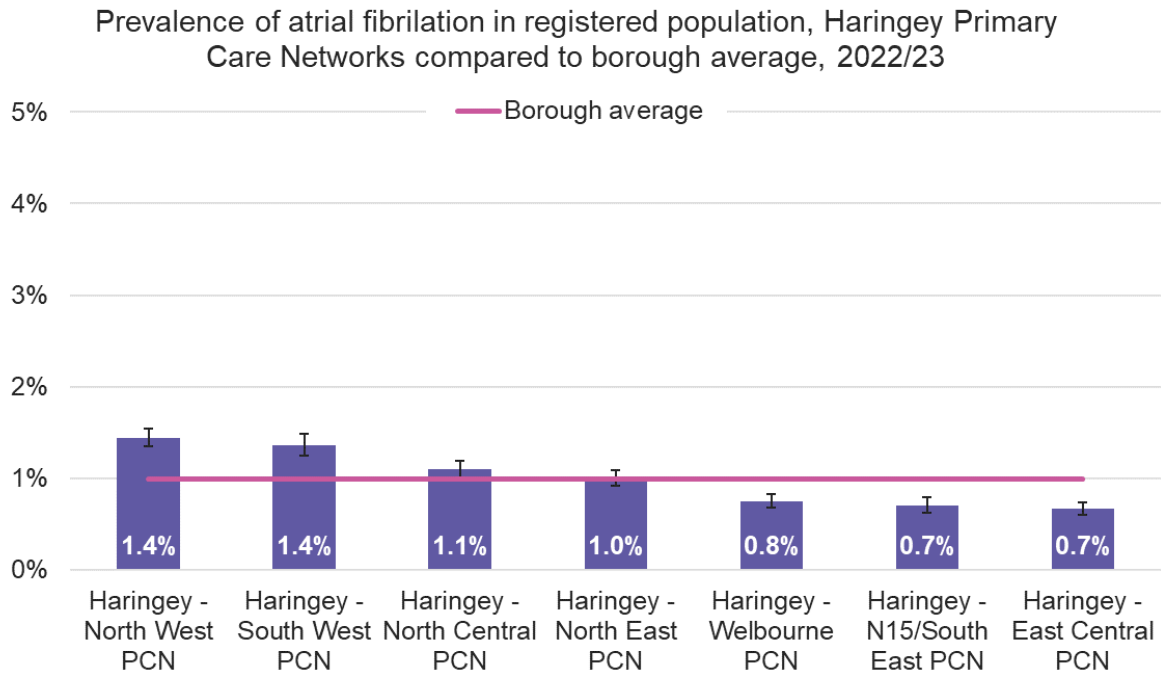
Long Term Conditions

Diagnosed Prevalence of atrial fibrillation (2022/23)

Whittington Health NHS Trust



Source: QOF 2022/23



Source: QOF 2022/23

In **Islington**, there are 2,636 people with diagnosed atrial fibrillation (Afib). This is an increase from an estimated 2,491 since the last population health report (2021/22).

The % population with AFib has remained the same at 1.2% in Central 2 PCN, which is still significantly above borough average.

In **Haringey**, there are 3,348 people with diagnosed atrial fibrillation (Afib). This is an increase from an estimated 3,186 since the last population health report (2021/22).

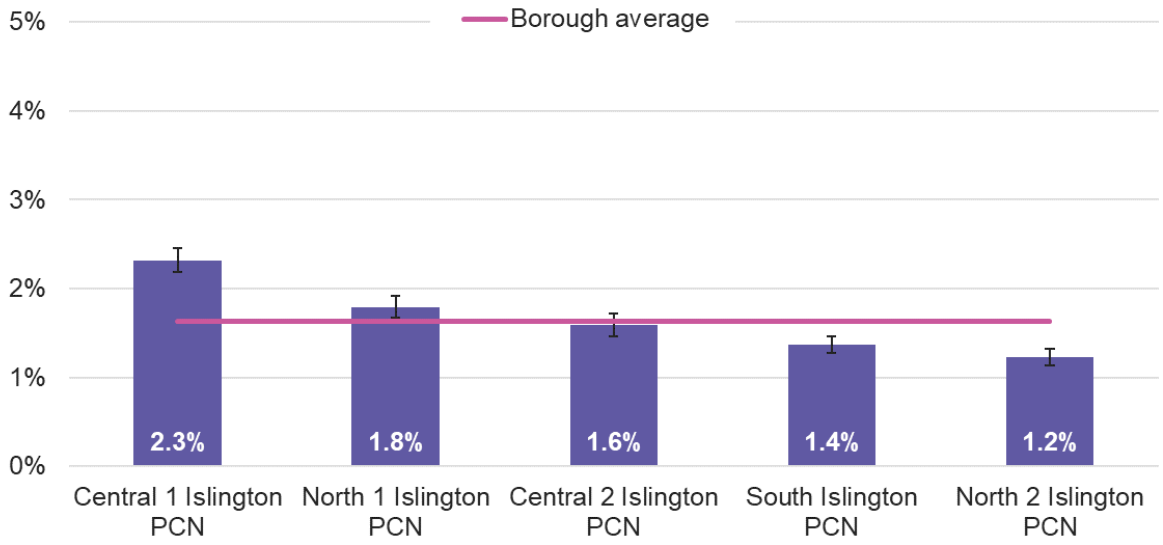
The % population with AFib remained the same at 1.4% in North West PCN and increased from 1.3% to 1.4% in South West PCN (formerly Crouch End PCN). Both PCNs remain significantly above the borough average.

Long Term Conditions

Diagnosed Prevalence of chronic kidney disease (2022/23)

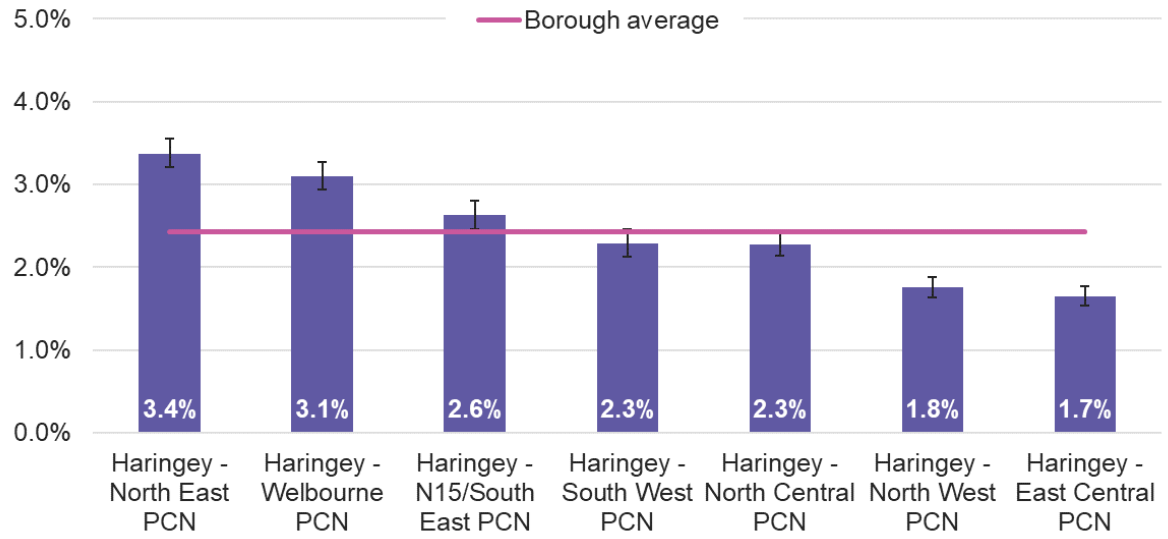
Whittington Health NHS Trust

Prevalence of chronic kidney disease in registered population, Islington Primary Care Networks compared to borough average, 2022/23



Source: QOF 2022/23

Prevalence of chronic kidney disease in registered population, Haringey Primary Care Networks compared to borough average, 2022/23



Source: QOF 2022/23

In **Islington**, there are 4,110 people with diagnosed Chronic Kidney Disease (CKD). This is an increase from an estimated 3,887 since the last population health report (2021/22).

The % population with CKD has stayed the same at 2.3% in Central 1 PCN, which is still significantly above the borough average.

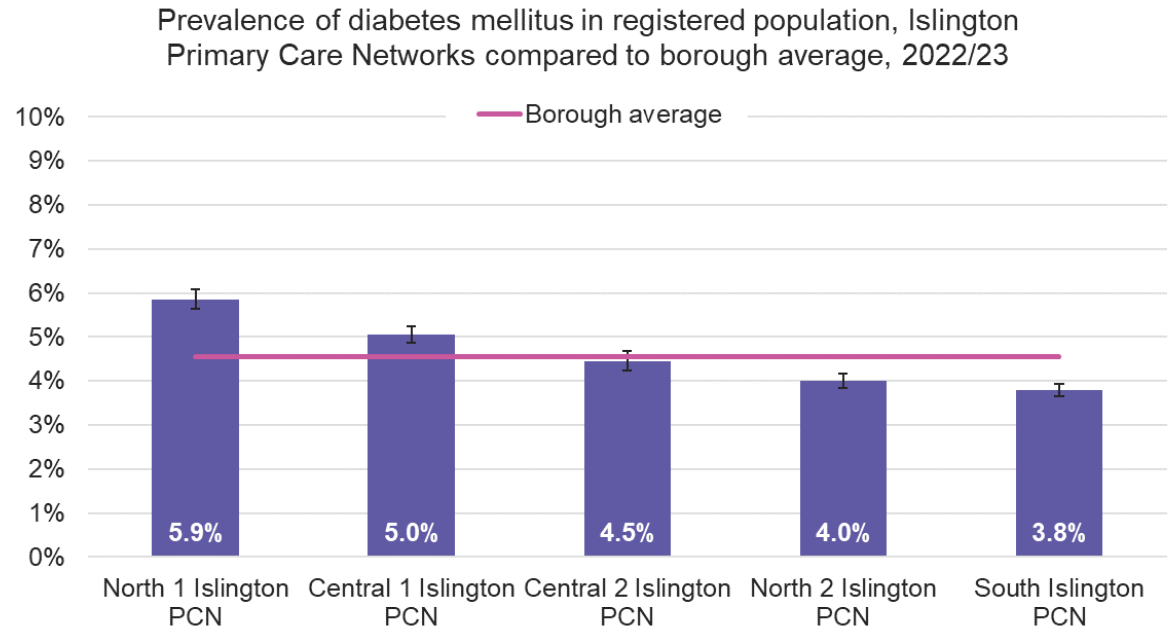
In **Haringey**, there are 6,729 people with diagnosed Chronic Kidney Disease (CKD). This is an increase from an estimated 5,589 since the last population health report (2021/22).

The % population with CKD has increased in North East (2.7% to 3.4%), Welbourne (2.5% to 3.1%), and N15/South East PCNs (2.2% to 2.6%). In North East PCN and Welbourne PCN this is significantly above the borough average.

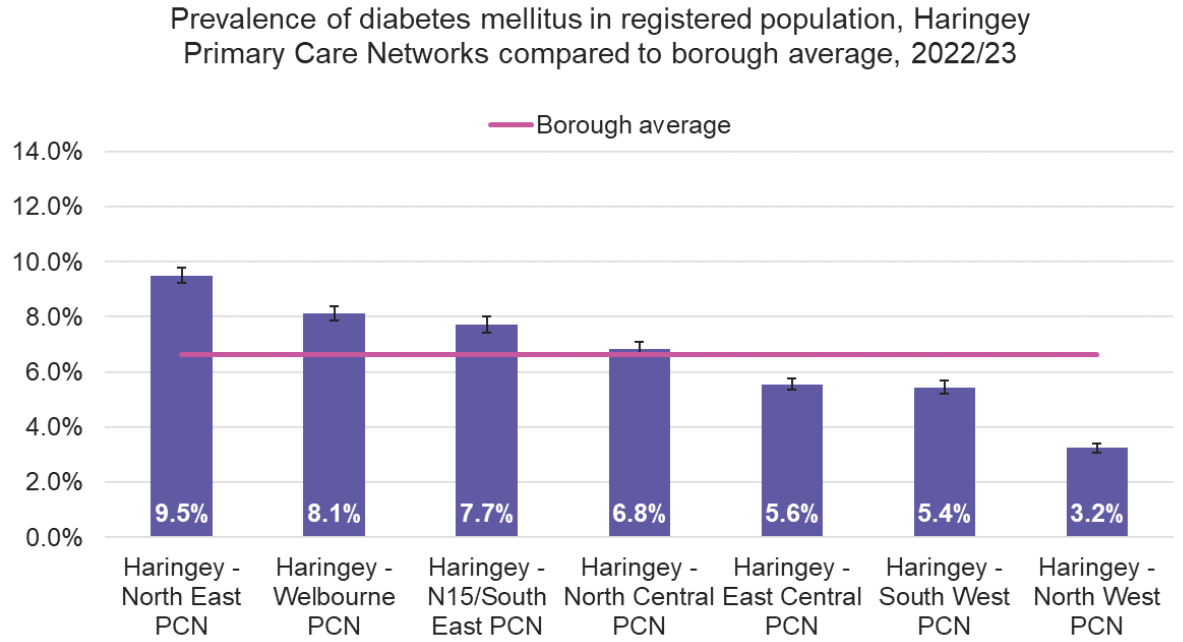
Long Term Conditions

Diagnosed Prevalence of diabetes (2022/23)

Whittington Health NHS Trust



Source: QOF 2022/23



Source: QOF 2022/23

In Islington, there are 11,571 people with diagnosed diabetes. This is an increase from an estimated 11,065 since the last population health report (2021/22).

The % population with diabetes has increased slightly in North 1 PCN (5.8% to 5.9%) and Central 1 PCN (4.9% to 5.0%), which is significantly above the borough average.

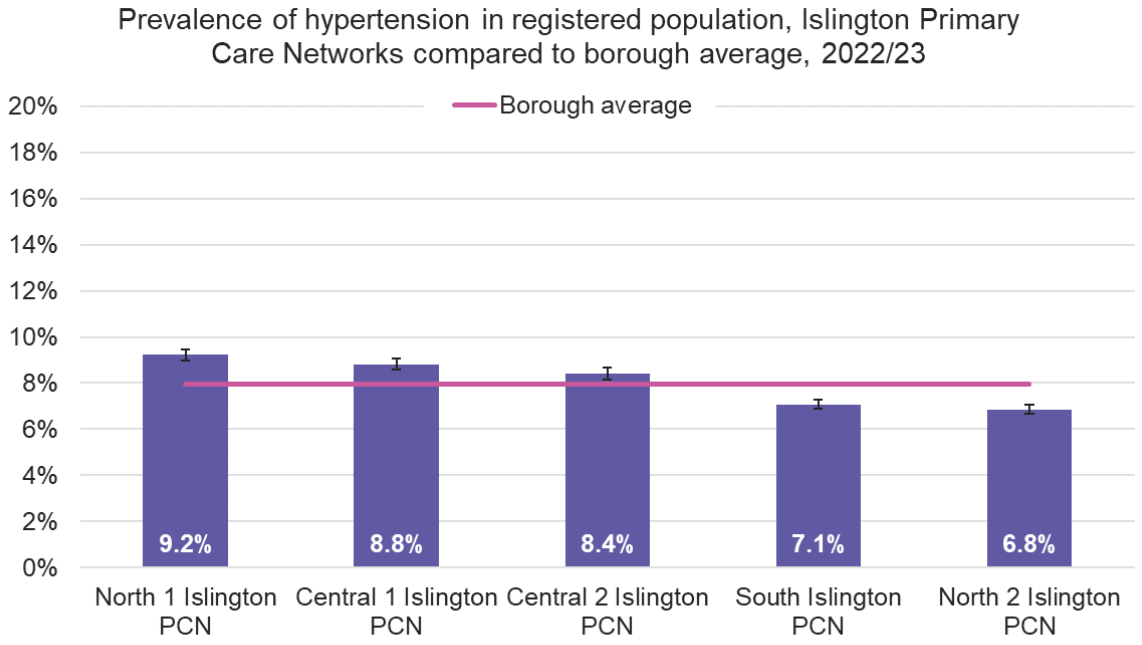
In Haringey, there are 18,577 people with diagnosed diabetes. This is an increase from an estimated 17,170 since the last population health report (2021/22).

The % population with diabetes has increased in North East (9.1% to 9.5%) and Welbourne (7.9% to 8.1%). It has stayed the same at 7.7% in N15/South East PCN. All three PCNs remain significantly above the borough average.

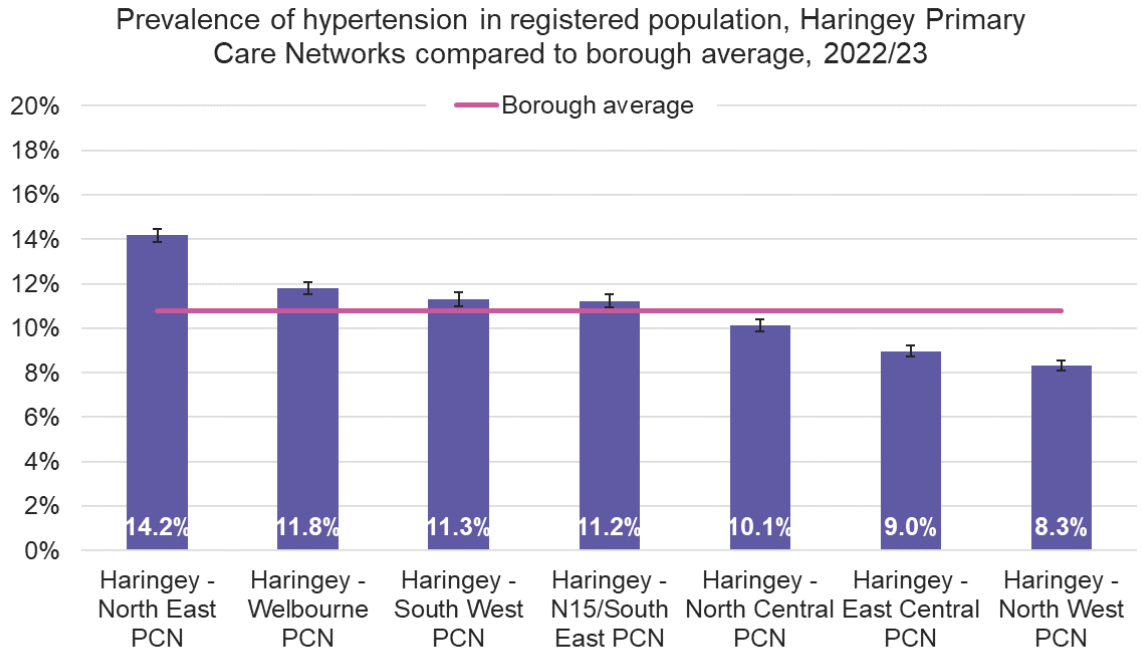
Long Term Conditions

Diagnosed Prevalence of hypertension (2022/23)

Whittington Health NHS Trust



Source: QOF 2022/23



Source: QOF 2022/23

In Islington, there are 23,351 people with diagnosed hypertension. This is an increase from an estimated 22,430 since the last population health report (2021/22).

The % population with hypertension has increased in Central 1 PCN (8.5% to 8.8%) and Central 2 PCN (8.2% to 8.4%). The % has remained the same at 9.2% in North 1 PCN. All three PCNs are significantly above the borough average.

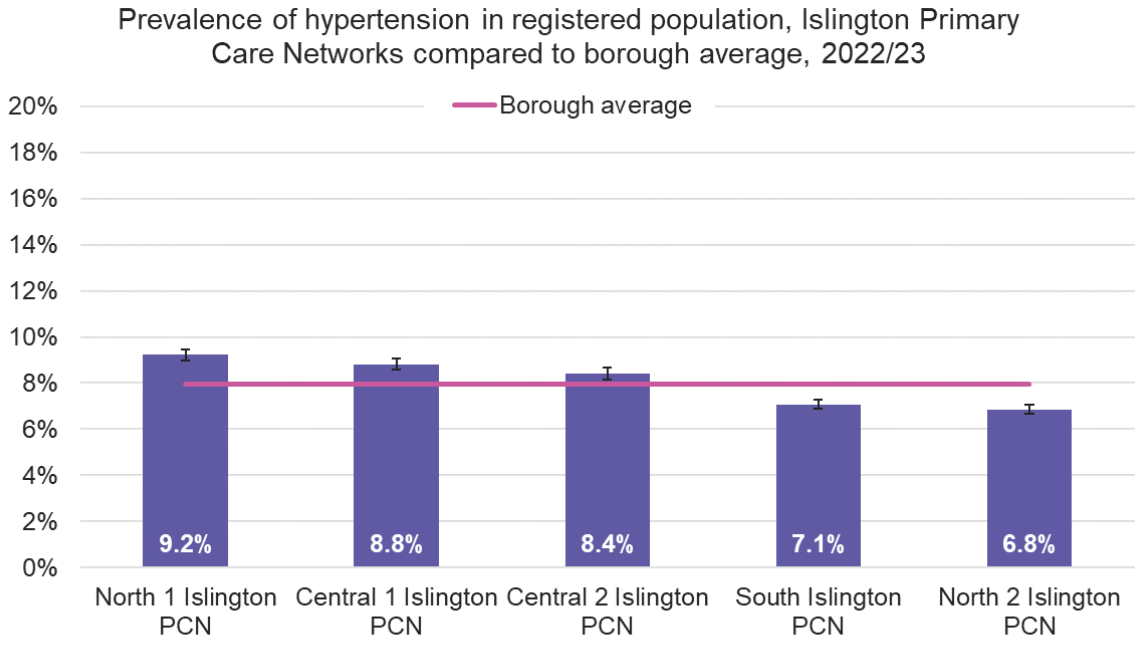
In Haringey, there are 36,660 people with diagnosed hypertension. This is an increase from an estimated 34,082 since the last population health report (2021/22).

The % population with hypertension has increased in North East (13.9% to 14.2%), Welbourne (11.3% to 11.8%), and South West (10.9% to 11.3%) PCNs. It has stayed the same at 11.2% in N15/South East PCN. All four PCNs remain significantly above the borough average.

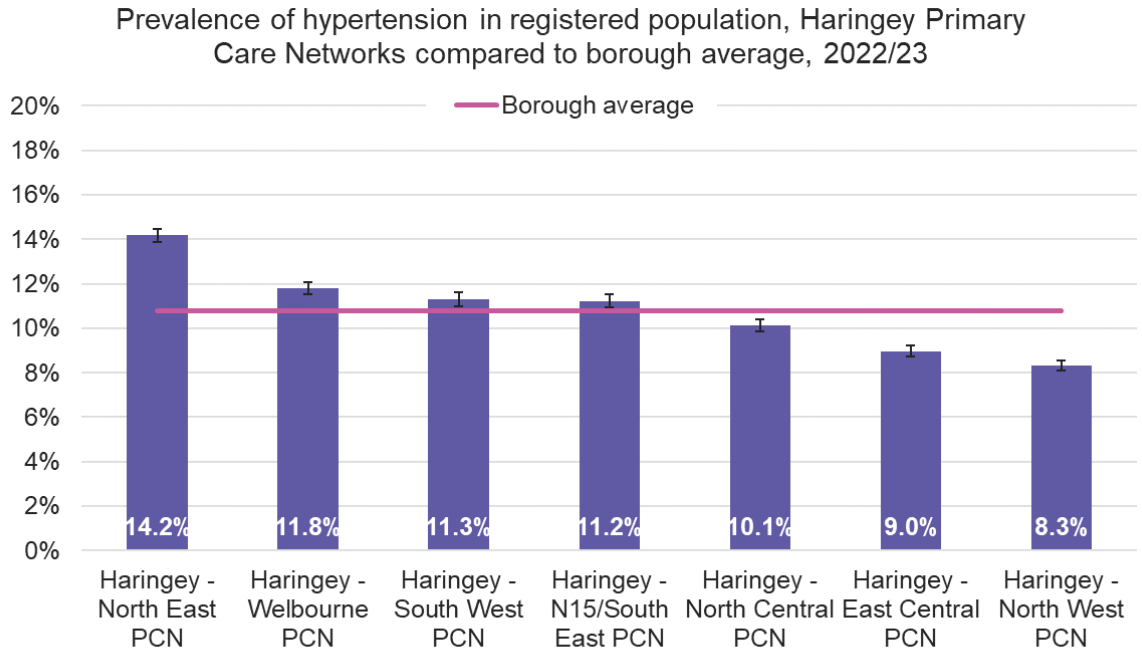
Long Term Conditions

Diagnosed Prevalence of hypertension (2022/23)

Whittington Health NHS Trust



Source: QOF 2022/23



Source: QOF 2022/23

In Islington, there are 23,351 people with diagnosed hypertension. This is an increase from an estimated 22,430 since the last population health report (2021/22).

The % population with hypertension has increased in Central 1 PCN (8.5% to 8.8%) and Central 2 PCN (8.2% to 8.4%). The % has remained the same at 9.2% in North 1 PCN. All three PCNs are significantly above the borough average.

In Haringey, there are 36,660 people with diagnosed hypertension. This is an increase from an estimated 34,082 since the last population health report (2021/22).

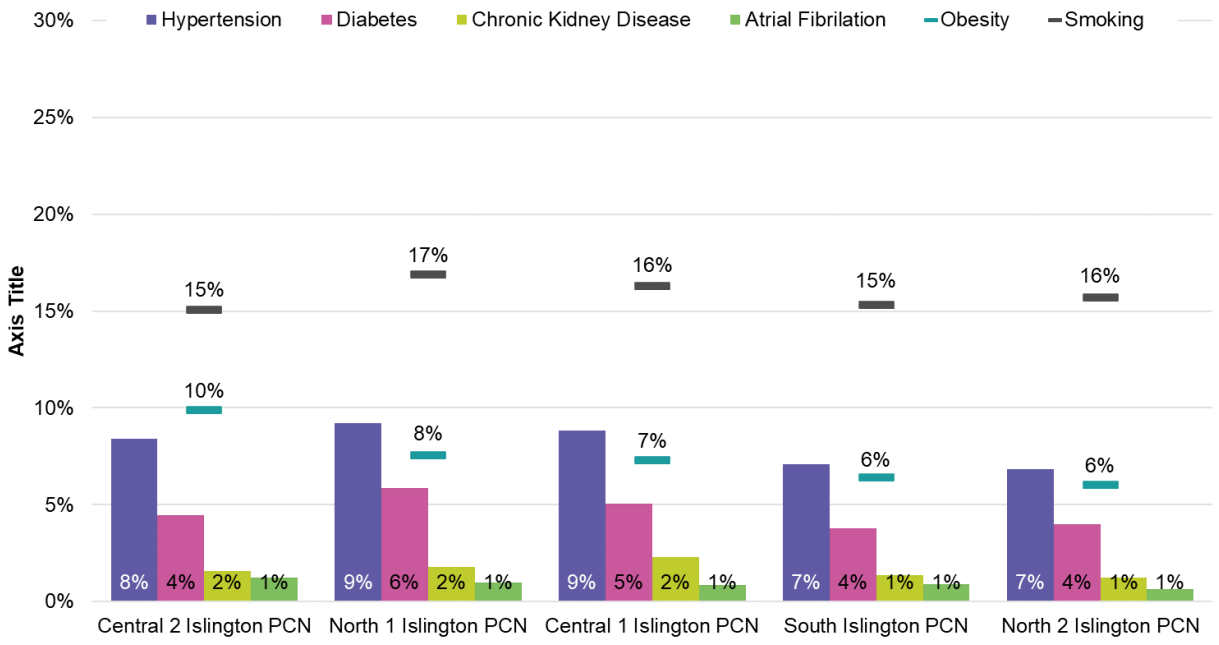
The % population with hypertension has increased in North East (13.9% to 14.2%), Welbourne (11.3% to 11.8%), and South West (10.9% to 11.3%) PCNs. It has stayed the same at 11.2% in N15/South East PCN. All four PCNs remain significantly above the borough average.

Long Term Conditions

Risk factors of atrial fibrillation, hypertension, CKD, diabetes

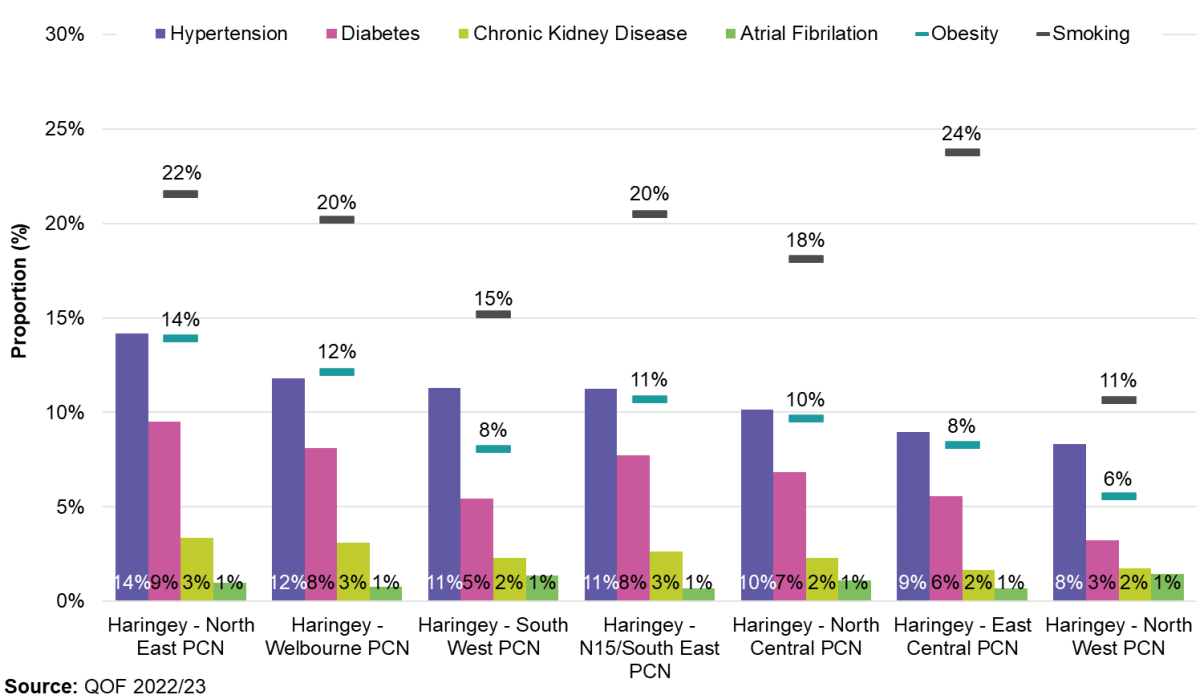
NHS Whittington Health NHS Trust

Prevalence of hypertension, diabetes, chronic kidney disease,atrial fibrillation, obesity, and smoking in registered population, Islington Primary Care Networks, 2022/23



Source: QOF 2022/23

Prevalence of hypertension, diabetes, chronic kidney disease,atrial fibrillation, obesity, and smoking in registered population, Haringey Primary Care Networks, 2022/23



Source: QOF 2022/23

AFib, hypertension, diabetes and CKD tend to co-occur. They also share risk factors:

Being overweight is a risk factor for Afib, hypertension and diabetes.

Smoking is a risk factor for AFib and hypertension.

Overall, Islington has a lower prevalence of AFib, hypertension, CKD, and obesity than Haringey.

The Islington – North 2 PCN has the lowest prevalence of these conditions, while Haringey – North East PCN has the highest.

AFib, hypertension, CKD, and obesity seem to generally correlate with their risk factors. Haringey – East Central PCN is an exception, as it has a relatively low prevalence of the LTCs compared to smoking and obesity.

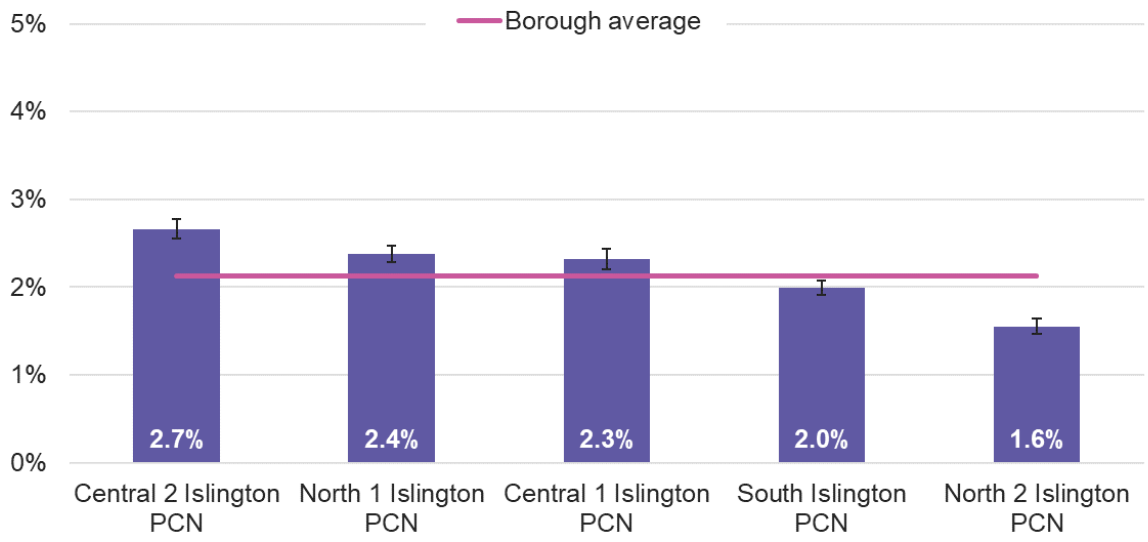
In Haringey, the rates of smoking and obesity broadly increase from west to east, following the pattern of deprivation in the borough.

Long Term Conditions

Diagnosed Prevalence of cancer (2022/23)

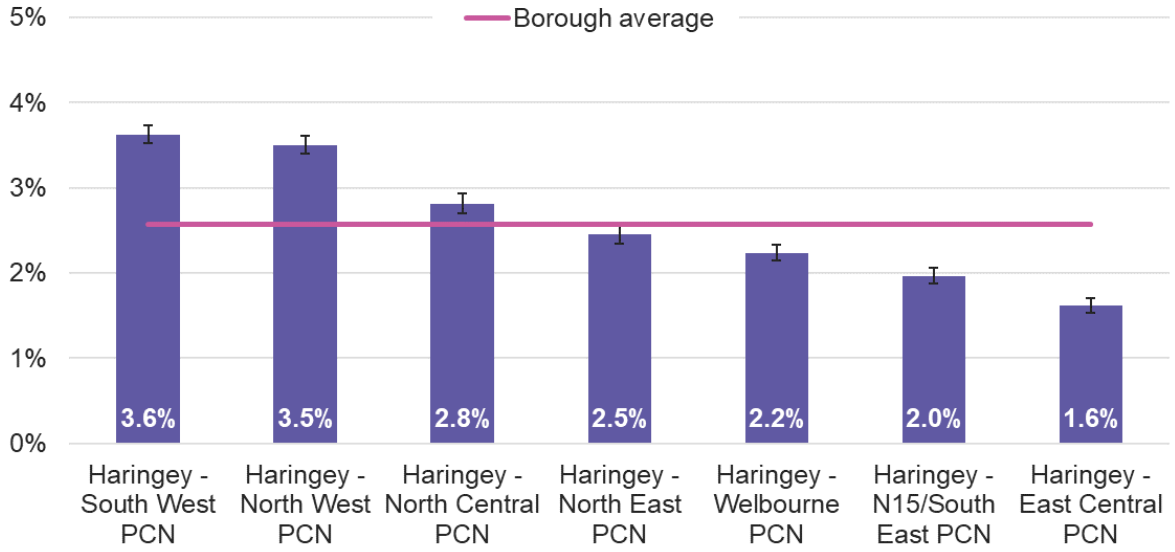
NHS Whittington Health NHS Trust

Prevalence of cancer in registered population, Islington Primary Care Networks compared to borough average, 2022/23



Source: QOF 2022/23

Prevalence of cancer health in registered population, Haringey Primary Care Networks compared to borough average, 2022/23



Source: QOF 2022/23

In Islington, there are 6,229 people with diagnosed cancer. This is an increase from an estimated 5,795 since the last population health report (2021/22).

The % population with cancer has increased in Central 2 (2.5% to 2.7%), North 1 (2.3% to 2.4%), and Central 1 (2.2% to 2.3%) PCNs. All three PCNs are significantly above the borough average.

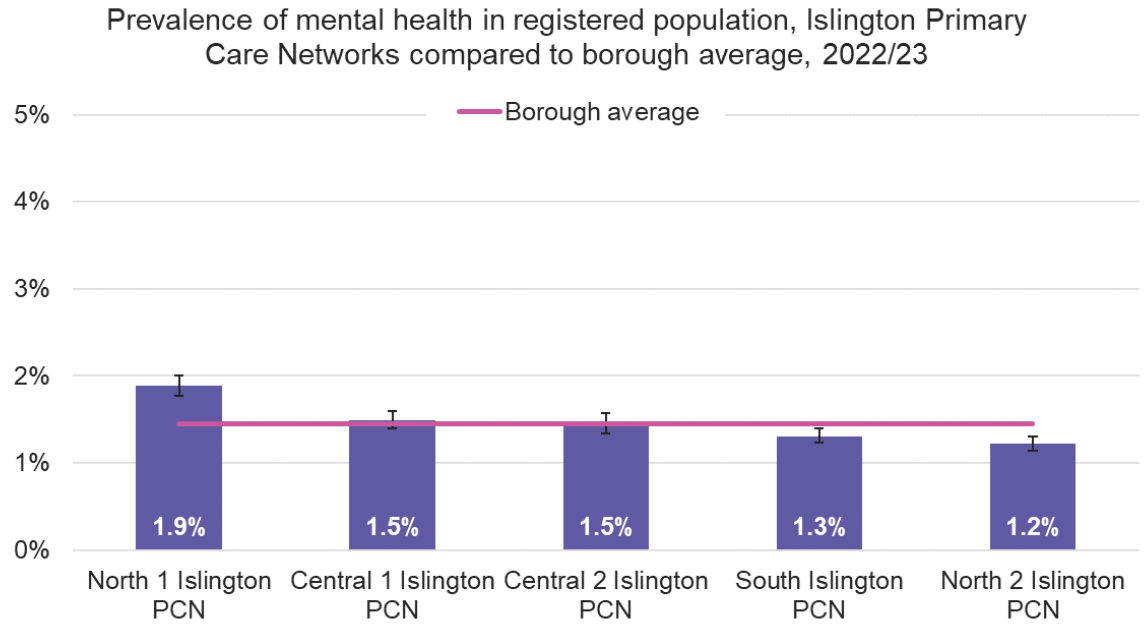
In Haringey, there are 8,728 people with diagnosed cancer. This is an increase from an estimated 7,747 since the last population health report (2021/22).

The % population with cancer has increased in South West (3.3% to 3.6%), North West (3.2% to 3.5%), and North Central (2.5% to 2.8%) PCNs. All three PCNs remain significantly above the borough average.

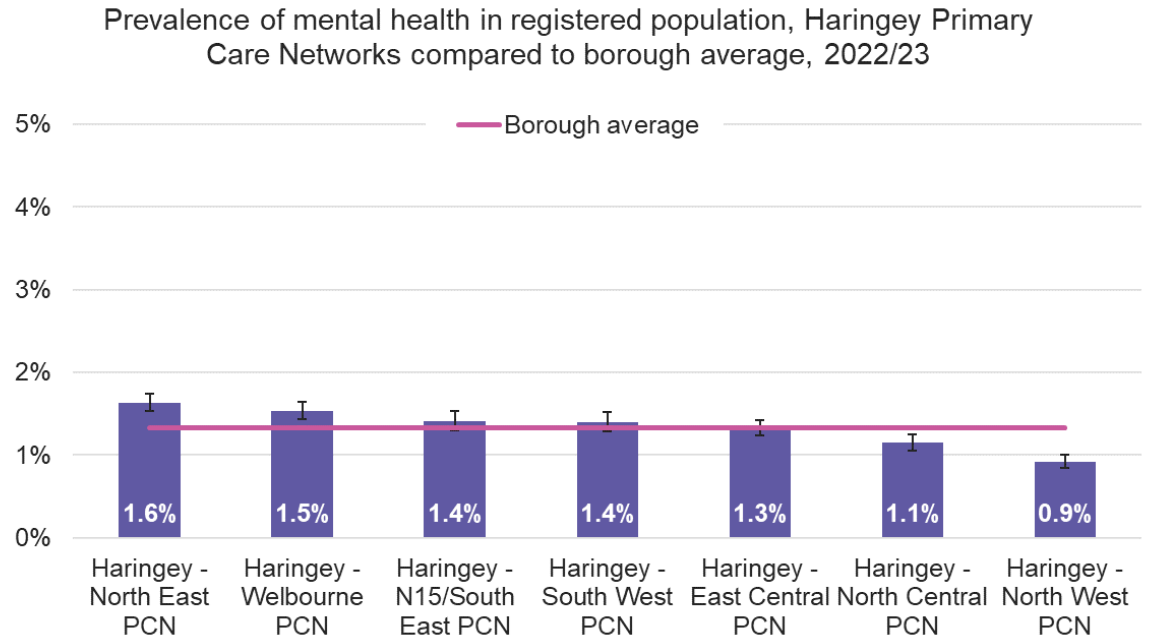
Long Term Conditions

Diagnosed Prevalence of mental health (2022/23)

Whittington Health NHS Trust



Source: QOF 2022/23



Source: QOF 2022/23

In Islington, there are 4,255 people with diagnosed mental health. This is an increase from an estimated 3,173 since the last population health report (2021/22).

The % population with mental health has increased in North 1 PCN from 1.7% to 1.9% which is still significantly above the borough average.

In Haringey, there are 4,525 people with diagnosed mental health. This is an increase from an estimated 4,206 since the last population health report (2021/22).

The % population with mental health has increased slightly in North East PCN from 1.5% to 1.6% and remains significantly above the borough average. The % has stayed the same at 1.5% in Welbourne PNC. However, this PCN has moved to significantly above the borough average.

Children's health
In Islington and Haringey

NHS Whittington Health NHS Trust

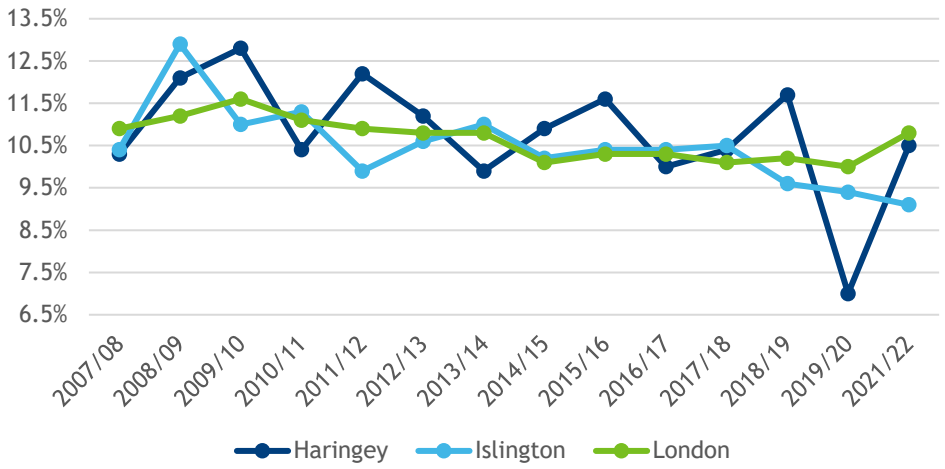
The prevalence of obesity in Haringey and Islington has fluctuated from 2007-2022.

In particular, obesity in Haringey sharply decreased in 2019/20.

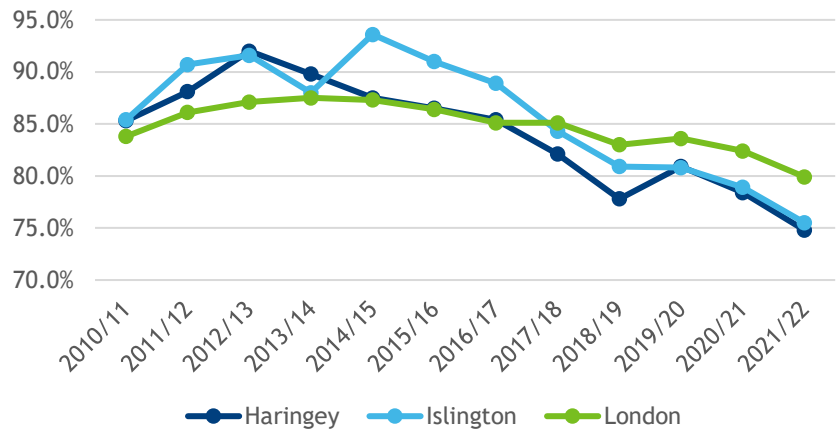
Overall, obesity has remained the same at reception but increased at year 6 in Islington, Haringey, and London.

This could indicate potential for school-based interventions in reducing obesity.

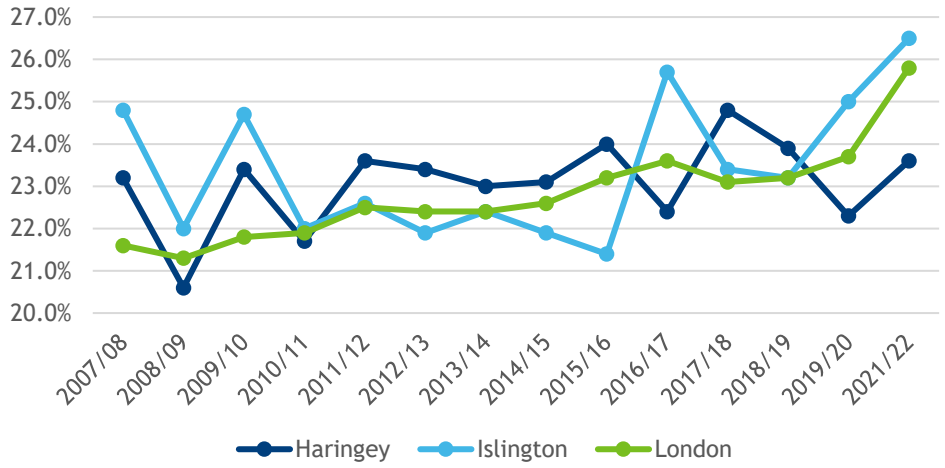
Prevalence of obesity at reception (2007-2022)



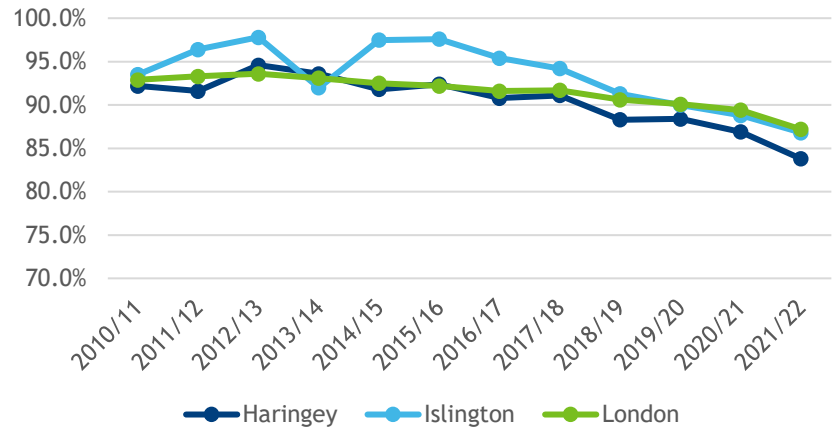
MMR coverage at 2 years old (2010-2022)



Prevalence of obesity at year 6 (2007-2022)



Dtap IPV Hib coverage at 2 years old (2010-2022)



Childhood vaccine coverage for both MMR and DTaP-IPV-Hib vaccines have decreased from 2010-2022 in Haringey and Islington.

This reflects a similar downward trend of childhood vaccine coverage in London, but not in England.

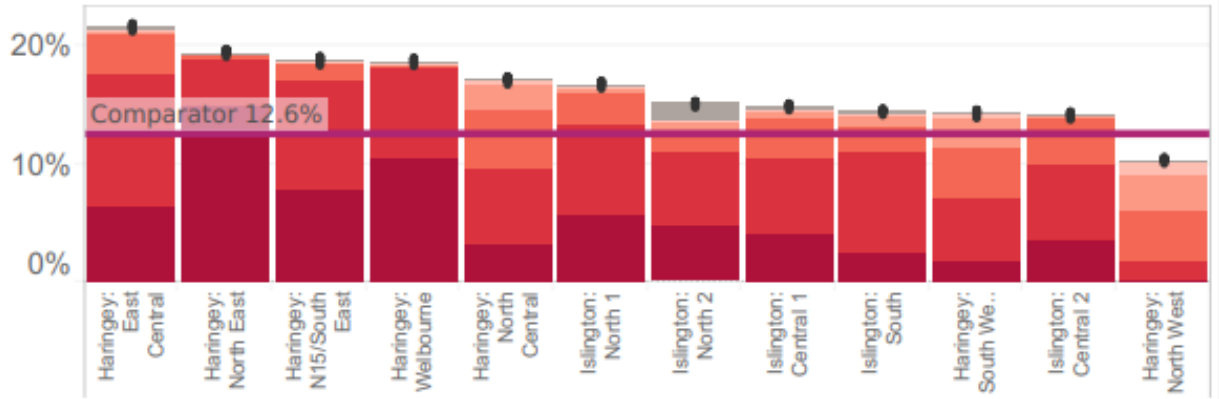
Vaccine coverage is now below national and London levels in both boroughs.

Health behaviours and lifestyles

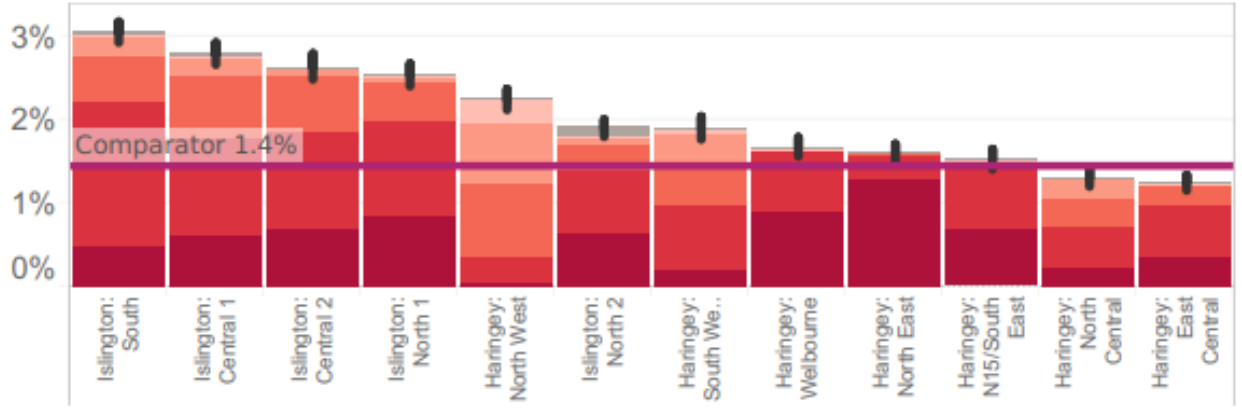
Alcohol dependency, smoking, obesity

Whittington Health NHS Trust

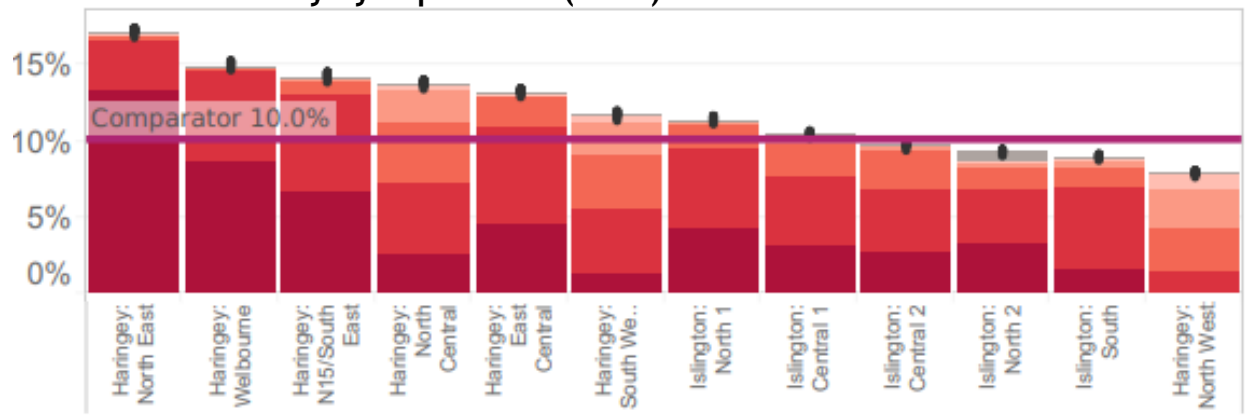
Prevalence of smoking (current smokers) by deprivation (2022)



Prevalence of alcohol dependency by deprivation (2022)



Prevalence of obesity by deprivation (2022)



Prevalence of smoking, obesity, and alcohol dependency are generally higher in Haringey and Islington than the NCL average. Smoking and obesity are higher in Haringey than Islington, particularly in East Haringey. The reverse is true for alcohol dependency.

In most PCNs, people in the most and second most deprived quintiles make up the bulk of prevalence for all 3 behavioural risk factors. Haringey North West, South West, and North Central PCNs are exceptions to this, being in areas which are less deprived.

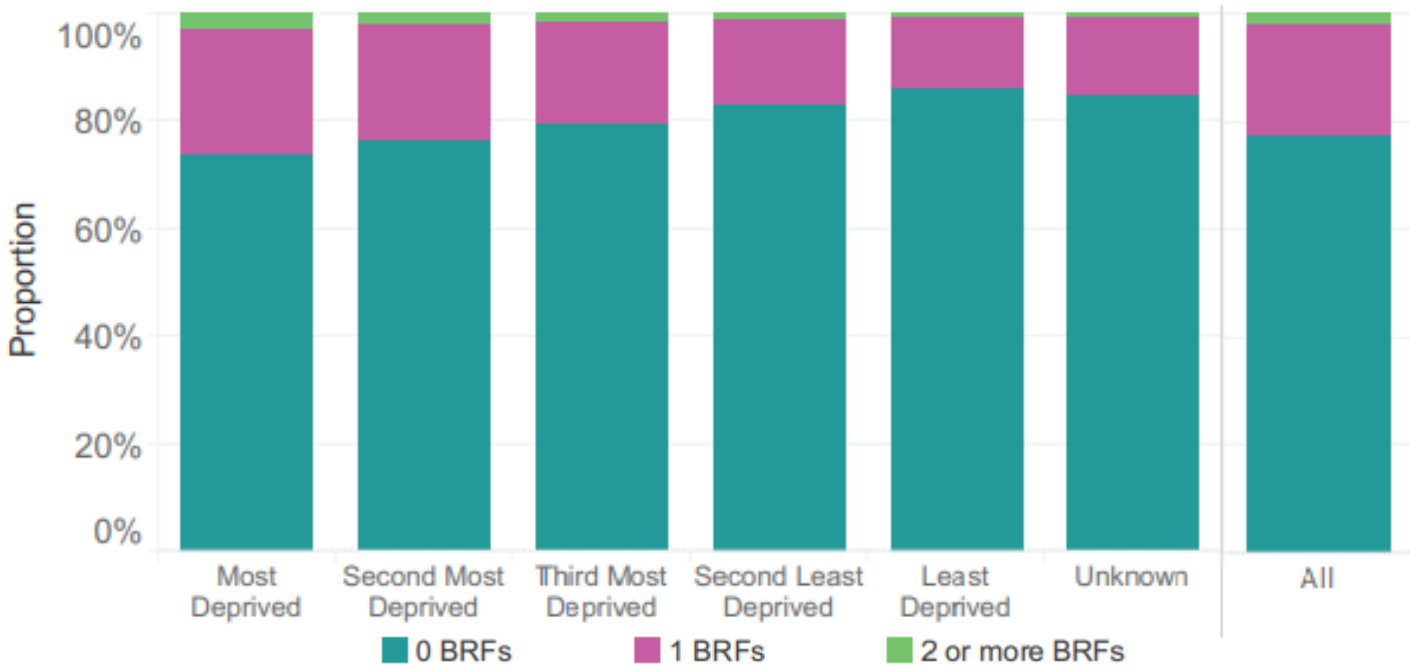
Source: HealthEIntent (2023)

Health behaviours and lifestyles

% of population with 1 or more behavioural risk factor

Whittington Health NHS Trust

Prevalence of behavioural risk factors in Haringey and Islington (2022)



Prevalence of alcohol dependency
Haringey: 5,500 (1.6%) | Islington: 7,530 (2.6%)

Prevalence of obesity
Haringey: 44,797 (13.3%) | Islington: 28,647 (9.9)

Prevalence of smoking (current smokers)
Haringey: 58,269 (17.2%) | Islington: 43,686 (15.0%)

Most people in Haringey and Islington are not reported to have any behavioural risk factors.

The prevalence of behavioural risk factors increase with deprivation.

Data quality may be a concern, as smoking, obesity, and alcohol use are reported as “unknown” for 22%, 25%, and 74% of the population in Haringey and Islington. Therefore, there is likely underreporting of behavioural risk factors.

Whittington Health
NHS Trust

Appendix 1

Whittington Data

Dashboards and CDC

Meeting title	**Trust Board – public meeting**	**Date: 25 July 2024**
Report title	**Finance Report May (Month 3) 2024/25**	**Agenda item: 7**
Executive lead	Terry Whittle, CFO	
Report authors	Finance Team	
Executive summary	The Trust is reporting a deficit of £9.5m at the end of June which is £4.3m worse than plan. Trust delivered £2.7m of savings against a year-to-date target of £4.1m for June. Capital expenditure at end of June was £1.86m. Capital plan for 2024-25 is £10.2m. The Trust's cash balance at end of June was £62.84m, which is £9.82m favourable to Plan. Trust has submitted a revised financial plan of £10.9m deficit for 2024-25.	
Purpose:	To discuss M3 financial performance.	
Recommendation(s)	To note the financial performance for June	
Risk Register or Board Assurance Framework	BAF risks S1 and S2	
Report history		
Appendices	None	

CFO Message

Finance Report M3

Trust is reporting a deficit of £9.5m at end of June. This is £4.3m worse than plan.

The Trust is reporting a year-to-date deficit of £9.5m at the end of June which is £4.3m worse than plan (£3.2m excluding industrial action impact).

Key drivers of the year to date adverse performance are:

- Industrial action costs (£0.65m) and income losses (£0.45m) totalling £1.1m, included in June's financial performance. July will also include the impact of one strike day.
- Pay overspends relating to:
  - Enhanced care - 0.4m
  - General wards overspends (sickness/annual leave and supernumerary backfill) - £0.4m
  - Domestics overspend - 0.4m
  - Unfunded pay pressures of - 0.2m
- Trust delivered £2.7m (66%) of CIP savings against a year-to-date target of £4.1m. The annual CIP target is £16.6m.
- Non-Pay overspends on increased pathology tests (£0.4m), clinical supplies (£0.6m), legal fees (£0.2m) and reactive maintenance (£0.6m).
- Income was £2m above plan including £1.1m NHS clinical income and £0.7m non-NHS clinical income. NHS clinical income included extra funding for consultant pay awards, pass through drugs and miscellaneous ICB and FT income, all offset by additional expenditure.
- The Trust spent £4.4m on agency staff for the three-month period. This is 5.2% of total pay costs and £0.6m above the agency cap. There has been no material run-rate reduction since 2023/24.
- The Trust spent £1.4m on additional UEC bed capacity that continues to be open since April. Funding for additional UEC capacity will be fully utilised by month 4 (2024/25 winter allowance).

Cash of £62.84m as at end of M3

The Trust's cash balance on 30th June was £62.84m, which is £9.82m favourable to plan.

Capital expenditure allocation for 2024-25 is £10.2m

Capital expenditure to the end of June was £1.86m vs, a plan of £1.02m. The capital allocation for 2024-25 is £10.2m, however the Trust has received notification of potential additional allocation of £2.01m.

Better Payment Practice Performance

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 97.3% by volume and 94.9% by value. The BPPC for non-NHS invoices is 97.5% by volume and 95.9% by value.

Financial Plan for 2024-25	The Trust submitted a revised deficit income and expenditure plan of £10.9m for 2024-25. The deficit plan includes a CIP target of £16.6m.

Summary of Income & Expenditure Position – Month 3

	In Month			Year to Date			
	Plan	Actual	Variance	Plan	Actual	Variance	Annual Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income							
NHS Clinical Income	26,071	26,410	339	78,542	79,438	896	314,146
High Cost Drugs - Income	948	962	14	2,866	3,111	244	11,488
Non-NHS Clinical Income	1,657	2,070	413	4,972	5,622	650	19,888
Other Non-Patient Income	2,189	2,478	289	6,568	6,994	426	26,272
Elective Recovery Fund	4,971	4,650	(322)	15,042	14,842	(200)	60,167
	35,837	**36,570**	**733**	**107,990**	**110,006**	**2,016**	**431,962**
Pay							
Agency	(216)	(1,296)	(1,080)	(577)	(4,446)	(3,869)	(577)
Bank	(417)	(2,635)	(2,218)	(1,258)	(7,657)	(6,399)	(3,102)
Substantive	(26,371)	(24,943)	1,427	(78,949)	(73,324)	5,625	(319,319)
	(27,003)	**(28,874)**	**(1,871)**	**(80,784)**	**(85,427)**	**(4,642)**	**(322,998)**
Non Pay							
Non-Pay	(7,899)	(7,693)	206	(23,936)	(25,587)	(1,651)	(86,000)
High Cost Drugs - Exp	(883)	(1,004)	(120)	(2,650)	(2,913)	(262)	(10,602)
	(8,782)	**(8,696)**	**86**	**(26,586)**	**(28,499)**	**(1,913)**	**(96,602)**
EBITDA	**52**	**(1,001)**	**(1,052)**	**620**	**(3,920)**	**(4,540)**	**12,362**
Post EBITDA							
Depreciation	(1,546)	(1,647)	(101)	(4,647)	(4,961)	(314)	(18,471)
Interest Payable	(69)	(64)	6	(208)	(191)	17	(830)
Interest Receivable	177	345	168	531	1,075	543	2,125
Dividends Payable	(506)	(506)	0	(1,517)	(1,517)	0	(6,068)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(1,944)	**(1,871)**	**73**	**(5,840)**	**(5,594)**	**246**	**(23,244)**
Reported Surplus/(Deficit)	**(1,893)**	**(2,871)**	**(979)**	**(5,221)**	**(9,514)**	**(4,293)**	**(10,882)**
Impairments	0	0	0	0	0	0	0
IFRS & Donated	(5)	(5)	0	(15)	(14)	1	(60)
Reported Surplus/(Deficit) after Impairments and IFRIC12	**(1,898)**	**(2,876)**	**(979)**	**(5,236)**	**(9,528)**	**(4,293)**	**(10,942)**

- The Trust is reporting a deficit of £9.5m (excluding donated asset depreciation and impairments) against a planned deficit of £5.2m. This is £4.3m worse than plan.

Key drivers for this adverse performance are continuing pay overspends (enhanced care - £0.4m), other pay overspends including domestics and wards of (£0.8m), non-pay overspends (pathology - £0.4m, planned and reactive maintenance - £0.6m, consumables - £0.7m, legal fees - £0.2m) and slippage on CIPs of £1.4m.

2.0 Income and Activity Performance

2.1 Income Performance – June

Income	In Month Income Plan £000's	In Month Income Actual £000's	In Month Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Variance £000's
A&E	1,674	1,943	269	5,078	5,828	749
Elective	2,192	2,069	(123)	6,794	6,782	(12)
Non-Elective	4,781	4,638	(142)	14,501	14,191	(310)
Critical care	451	454	3	1,369	1,291	(78)
Outpatients	4,225	3,958	(267)	13,061	13,137	76
Direct access	1,148	1,386	239	3,558	4,181	623
Community	6,538	6,538	0	19,613	19,613	0
Other clinical income NHS	6,010	6,385	375	17,434	17,525	91
NHS Clinical Income	**27,019**	**27,371**	**352**	**81,408**	**82,548**	**1,140**
Non NHS clinical income	1,657	2,070	413	4,972	5,622	650
Elective recovery fund (ERF)	4,971	4,650	(322)	15,042	14,842	(200)
Income From Patient Care Activities	**33,647**	**34,090**	**443**	**101,422**	**103,012**	**1,590**
Other Operating Income	**2,189**	**2,479**	**290**	**6,568**	**6,994**	**426**
Total	35,837	36,570	733	107,990	110,006	2,016

- Income was £2m over plan. £1.1m NHS clinical income, £0.7m non-NHS clinical income, £0.2m ERF underperformance and £0.4m other operating.
- £1.1m NHS clinical income is driven mainly by £0.3m consultant pay award, £0.2m drugs overperformance, £0.2m miscellaneous ICB income and £0.3m foundation trust income. (Foundation Trust income includes assumed receipt of £0.6m for Simmons House).
- £0.7m non-NHS clinical income is driven by £0.5m local authority income. Mainly CYP, such as 0.2m start for life, 0.1m barnet therapies.
- £0.4m other operating income is driven by £0.2m HSL pathology, £0.1m education & training income and £0.1m research & development.

2.2 Elective recovery fund (ERF) – June

- Trust is estimated to have underperformed by £0.2m against an estimated elective income target of 104% of 2019/20 performance. The position is based on early data and an adjustment for outpatient un-outcome estimate. The estimated loss due to cancelled outpatient and day case activity due to Industrial Action is £0.45m. EIM divisional overperformance in gastroenterology and respiratory medicine is offsetting S&C divisional underperformance in day-case activity.

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	7,180	698	654	(45)	1,795	1,752	(43)
CYP	6,148	496	564	68	1,537	1,726	189
EIM	19,813	1,598	1,622	24	4,953	5,384	431
S&C	27,028	2,180	1,885	(295)	6,757	5,994	(763)
Corp	(1)	(0)	(75)	(75)	(0)	(15)	(15)
Grand Total	60,167	4,971	4,650	(322)	15,042	14,842	(200)

ERF Income by POD

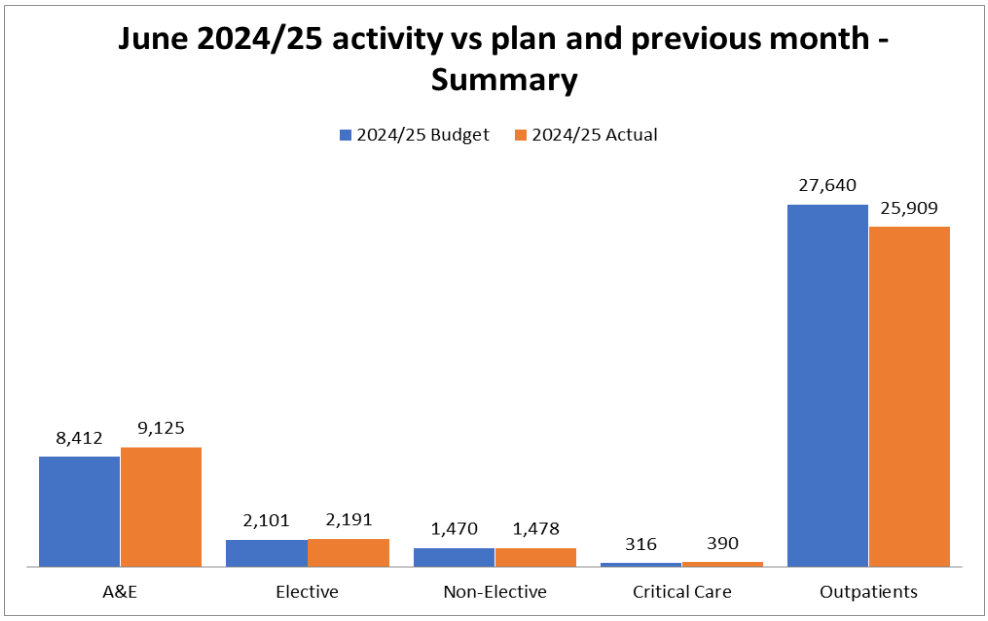
POD	Annual Plan £000's	In Month Income Plan £000's	In Month Income Actual £000's	In Month Income Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Income Variance £000's
DC	19,072	1,538	1,490	(48)	4,768	4,798	30
EL	7,785	628	593	(35)	1,946	1,843	(103)
OP First	23,122	1,802	1,791	(11)	5,780	5,870	90
OP Procedure	10,188	1,004	776	(228)	2,547	2,331	(217)
Grand Total	60,167	4,971	4,650	(322)	15,042	14,842	(200)

2.3 Activity Performance – June

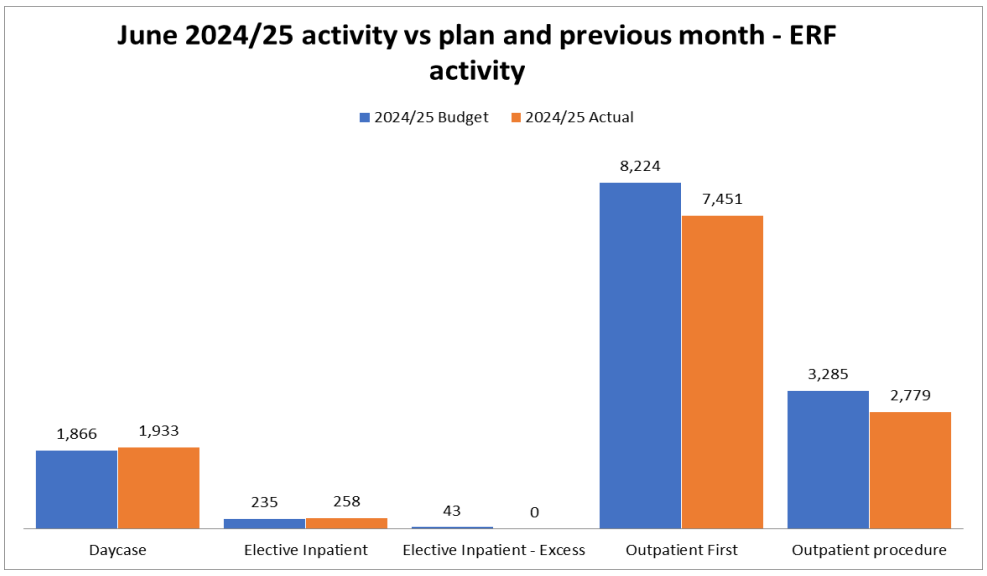
- Activity overperformed against plan in all areas, except for outpatients.

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	9,125	713	8%	25,515	27,606	2,091	8%
Elective	2,101	2,192	91	4%	6,513	7,148	635	10%
Non-Elective	1,470	1,478	8	1%	4,459	4,533	74	2%
Critical care	316	390	74	24%	958	1,028	70	7%
Outpatients	27,331	25,598	(1,733)	(6%)	84,547	85,105	558	1%
Imaging	6,705	6,853	148	2%	20,784	20,022	(762)	(4%)
Direct Access	116,623	143,777	27,155	23%	361,530	431,798	70,268	19%

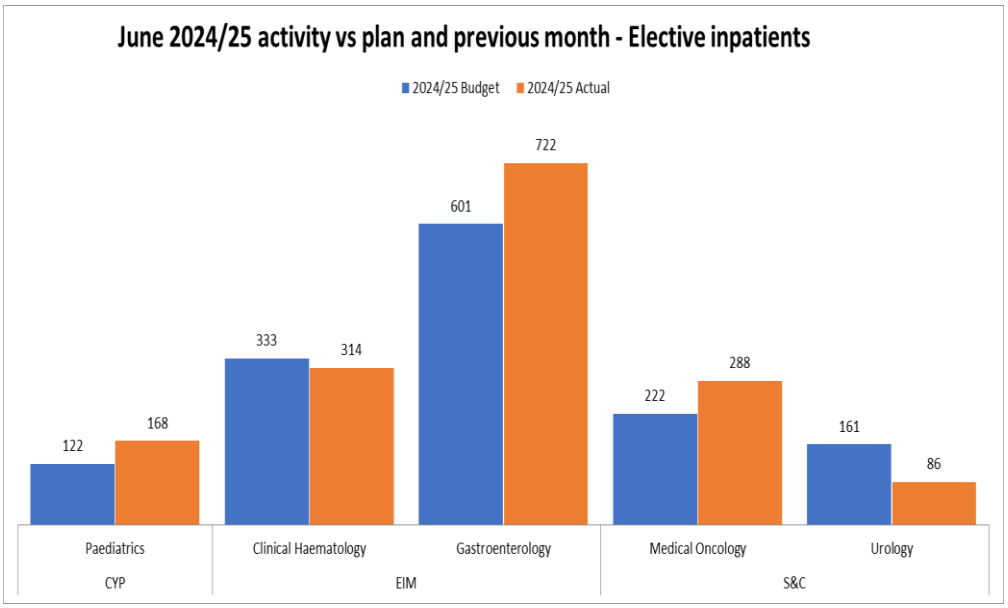
- Activity is slightly higher than May (adjusted for working/calendar days) across all points of delivery, except for outpatients (due to late outcoming impact and industrial action). Industrial Action impacted both inpatients and outpatients.



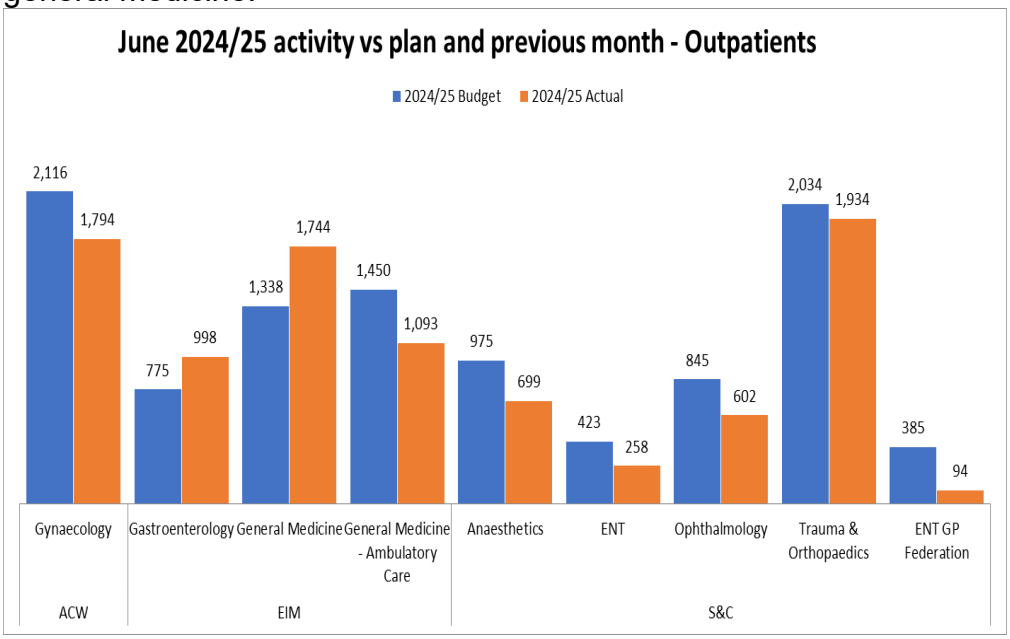
- ERF inpatient activity is slightly over plan, with underperformance in outpatients. Although outpatient underperforming, performance will be improved when late outcoming activity coded. Expected to be under plan due to industrial action.



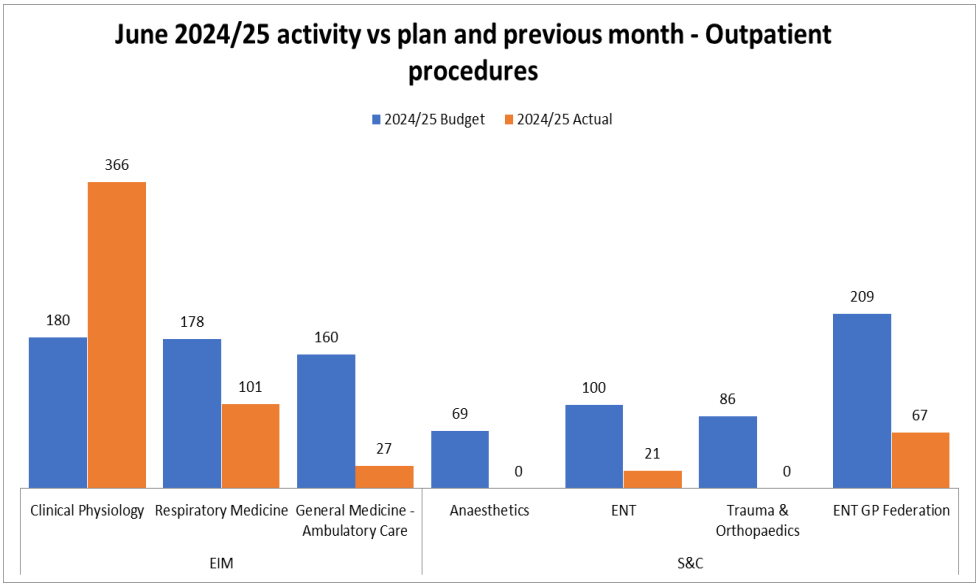
- Elective inpatient overperformance driven by gastroenterology, medical oncology and paediatrics.



- Outpatients underperforming across specialities, offset by gastroenterology and general medicine.



- Outpatient underperformance in outpatient procedures.



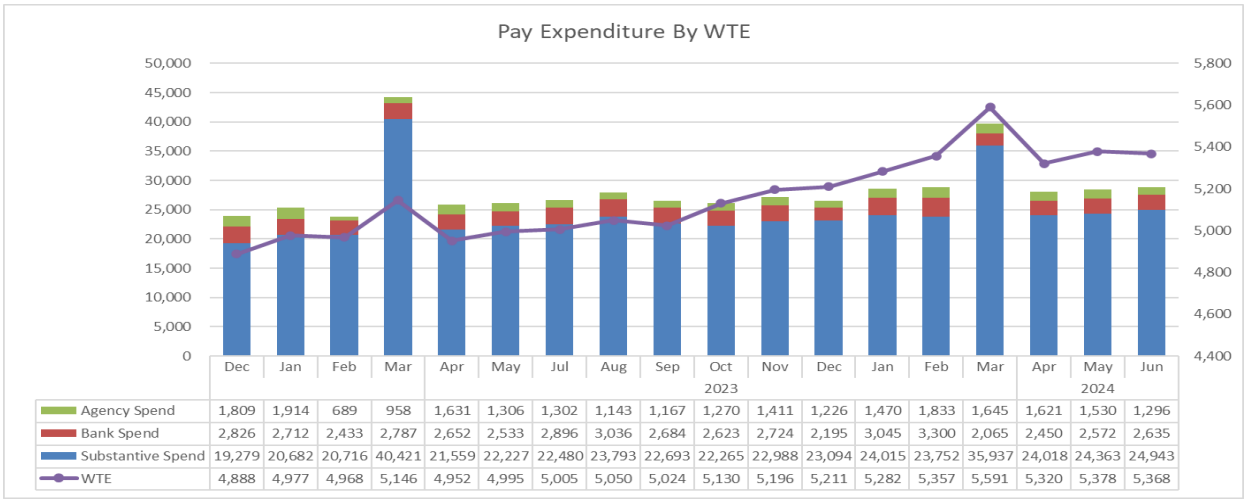
3. Expenditure – Pay & Non-pay

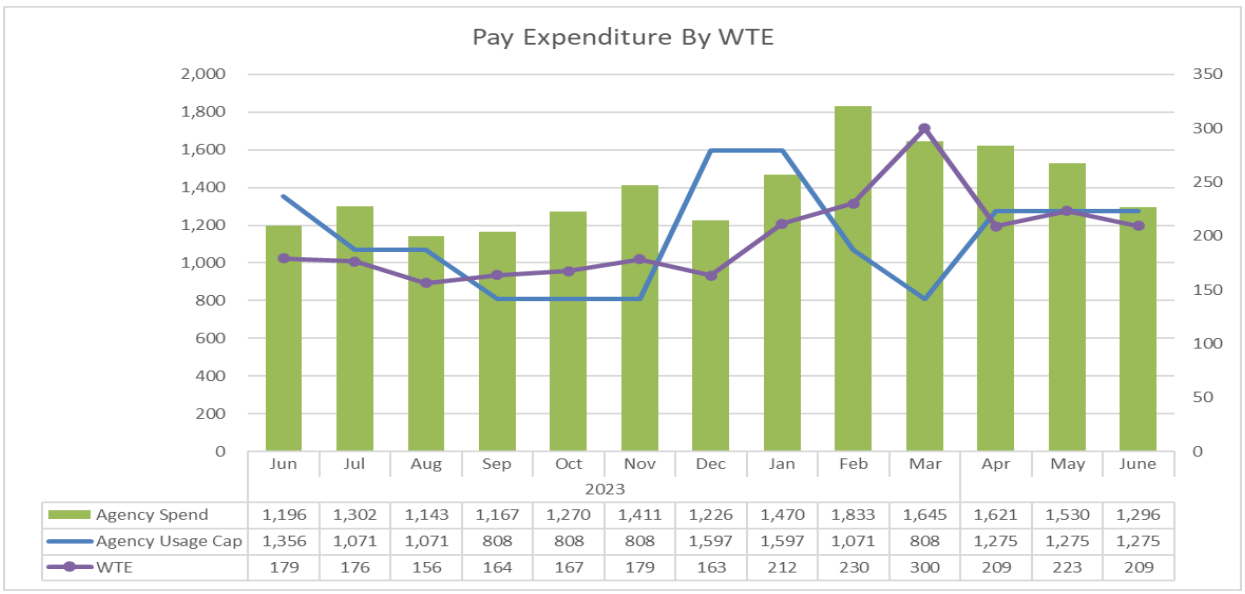
3.1 Pay Expenditure

Pay expenditure for June was £28m, an increase of £0.4m from the May position. The increase is due to

- Industrial action costs of £0.65m.
- There was a reduction in agency spend of £0.4m compared to prior months. The Trust is still breaching the agency cap by £0.6m at end of June.
- There was a corresponding increase in bank and substantive staffing with the overall WTE for the Trust decreasing by 1%.

	2023-24			2024-25			
	Jan	Feb	Mar	Apr	May	Jun	Mov^t
Agency	1,470	1,833	1,883	1,581	1,569	1,196	(374)
Bank	3,079	3,308	2,039	2,442	2,579	2,740	161
Substantive	23,906	23,844	24,353	23,407	23,748	24,211	463
Total Operational Pay	**28,456**	**28,985**	**28,275**	**27,430**	**27,897**	**28,147**	**250**
Non Operational Pay Costs	74	(100)	11,372	658	567	727	160
Total Pay Costs	**28,530**	**28,885**	**39,647**	**28,089**	**28,464**	**28,874**	**410**





3.2 Non-pay Expenditure

Non-pay spend for June was £7.7m, a £1.4m decrease from May spend. The decrease was on a reduction in bad debt provision of £0.5m and a VAT rebate of £0.5m.

	2023-24												2024-25			
Non-Pay Costs	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**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	4,170	4,063	(106)
Supplies & Servs - Gen	333	376	442	310	440	341	391	332	456	585	294	356	394	417	390	(28)
Establishment	263	240	284	237	273	324	320	334	293	517	278	(6)	291	295	354	59
Healthcare From Non Nhs	95	79	85	76	80	75	75	56	75	78	45	(85)	82	115	99	(16)
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	2,411	1,780	(631)
Ext Cont Staffing & Cons	193	388	265	13	169	218	127	16	152	114	146	117	140	230	192	(38)
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	1,409	804	(605)
Chairman & Non-Executives	9	9	9	9	9	9	9	11	11	11	11	11	11	11	11	0
Non-Pay Reserve	42	388	(251)	(178)	(5)	5	0	0	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**	**9,058**	**7,693**	**(1,365)**

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**	**May**	**Jun**	**Mov^t**
Ambulance Contract	175	206	185	172	199	139	207	137	174	213	75	138	190	171	189	18
Other Expenditure	155	85	166	100	(483)	66	92	60	120	(289)	144	(10,306)	125	162	(472)	(634)
Audit Fees	15	12	(17)	11	13	11	11	11	11	12	12	0	9	12	15	3
Provision For Bad Debts	65	94	(238)	250	(596)	(212)	57	(34)	34	188	(997)	(15)	(54)	(112)	(190)	(79)
Cnst Premium	821	821	821	821	821	577	780	778	765	827	810	827	765	674	765	91
Fire Security Equip & Maint	5	5	6	10	7	13	4	47	2	11	16	14	9	5	12	7
Interpretation/Translation	27	8	31	21	14	21	10	102	36	15	5	47	42	12	31	19
Membership Subscriptions	125	159	117	161	135	146	146	149	61	119	131	166	141	144	121	(23)
Professional Services	355	354	115	288	495	399	387	389	374	408	162	(73)	354	263	228	(34)
Research & Development Exp	(1)	(1)	(1)	4	12	(1)	8	6	286	124	7	312	3	2	1	(1)
Security Internal Recharge	10	11	14	13	(0)	12	10	7	10	10	10	12	10	11	10	(1)
Teaching/Training Expenditure	66	77	92	89	49	84	152	73	124	30	155	633	62	62	94	32
Travel & Subs-Patients	2	4	4	1	4	0	5	7	0	3	7	3	3	4	1	(3)
Work Permits	0	0	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	23	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**	**1,671**	**536**	**(8,221)**	**1,660**	**1,409**	**804**	**(605)**

3.3 Cost Improvement Programme (CIP)

The CIP target for 2024-25 is £16.6m. As at month 3, £9.2m has been identified (55% of the target). This is an improvement of £2.5m since month 2. Identified CIP value includes now 80% of ideas in progress, i.e. schemes that Divisions are working on, but have not yet been fully signed-off. This accounts for £1.3m of improvement.

70% of the identified schemes are non-recurrent, a review of scheme classification (recurrent to non-recurrent) will be completed during July and August. The 2025/26 full year effect of the identified recurrent schemes is £3.2m (20% of the target).

		2024/25 IN YEAR EFFECT					2025/26 FULL YEAR EFFECT		
Divisions	24/25 CIP Target '£000	Recurrent '£000	Non-Recurrent '£000	**Total '£000**	Variance to target '£000	% of target	Full Year Effect '£000	Variance to target '£000	% of target
ADULT COMMUNITY	**2,086**	65	421	**486**	(1,600)	23%	124	(1,962)	6%
CHILDREN & YOUNG PEOPLE	**3,073**	409	889	**1,297**	(1,776)	42%	455	(2,618)	15%
EMERGENCY & INTEGRATED MEDECINE	**2,729**	493	176	**669**	(2,060)	25%	694	(2,035)	25%
SURGERY & CANCER	**2,565**	33	40	**73**	(2,492)	3%	66	(2,499)	3%
ACW	**2,928**	230	325	**556**	(2,372)	19%	294	(2,634)	10%
DIVISIONS TOTAL	**13,381**	**1,230**	**1,851**	**3,081**	**(10,300)**	**23%**	**1,633**	**(11,748)**	**12%**
ESTATES AND FACILITIES	**1,547**	718	180	**898**	(649)	58%	767	(780)	50%
CENTRAL	**0**	440	3,914	**4,354**	4,354	0%	440	440	0%
CORPORATE	**1,671**	334	523	**856**	(815)	51%	400	(1,271)	24%
TRUST TOTAL	**16,599**	**2,722**	**6,467**	**9,189**	**(7,410)**	55%	**3,239**	**(13,360)**	20%
CORPORATE									
CHIEF OPERATING OFFICER	87	0	0	**0**	(87)	0%	0	(87)	0%
FINANCE	270	0	513	**513**	243	190%	0	(270)	0%
IM&T	426	182	0	**182**	(244)	43%	248	(178)	58%
MEDICAL DIRECTOR	119	50	0	**50**	(69)	42%	50	(69)	42%
NURSING & PATIENT EXPERIENCE	295	0	0	**0**	(295)	0%	0	(295)	0%
TRUST SECRETARIAT	166	102	10	**111**	(55)	67%	102	(64)	61%
WORKFORCE	308	0	0	**0**	(308)	0%	0	(308)	0%
CORPORATE TOTAL	**1,671**	**334**	**523**	**856**	**(815)**	**51%**	**400**	**(1,271)**	**24%**

Trust is reporting actual CIP delivery of £2.7m against a YTD target of £4.1m, i.e. a YTD shortfall of £1.5m (35% of the YTD target).

Divisions	24/25 CIP Target '£000	2024/25 YTD DELIVERY: YTD CIP target '£000	YTD Actuals Recurrent '£000	YTD Actuals Non-Recurrent '£000	YTD Actuals Total '£000	YTD Variance to target '£000	24/25 FORECAST DELIVERY: Forecast '£000	Forecast Variance	% of target
ADULT COMMUNITY	**2,086**	522	0	**105**	**105**	(416)	486	(1,600)	6%
CHILDREN & YOUNG PEOPLE	**3,073**	768	49	**219**	**268**	(500)	1,297	(1,776)	15%
EMERGENCY & INTEGRATED MEDECINE	**2,729**	682	11	**87**	**98**	(584)	669	(2,060)	25%
SURGERY & CANCER	**2,565**	641	0	**0**	**0**	(641)	73	(2,492)	3%
ACW	**2,928**	732	38	**184**	**223**	(509)	556	(2,372)	10%
DIVISIONS TOTAL	**13,381**	**3,345**	**98**	**595**	**694**	**(2,652)**	**3,081**	**(10,300)**	**12%**
ESTATES AND FACILITIES	**1,547**	387	153	**180**	**333**	(54)	898	(649)	58%
CENTRAL	**0**	0	0	**1,103**	**1,103**	1,103	4,354	4,354	0%
CORPORATE	**1,671**	418	50	**513**	**563**	145	856	(815)	51%
TRUST TOTAL	**16,599**	**4,150**	**301**	**2,391**	**2,692**	**(1,458)**	**9,189**	**(7,410)**	55%
CORPORATE									
CHIEF OPERATING OFFICER	87	22	0	**0**	**0**	(22)	0	(87)	0%
FINANCE	270	68	0	**513**	**513**	446	513	243	190%
IM&T	426	107	12	**0**	**12**	(95)	182	(244)	43%
MEDICAL DIRECTOR	119	30	13	**0**	**13**	(17)	50	(69)	42%
NURSING & PATIENT EXPERIENCE	295	74	0	**0**	**0**	(74)	0	(295)	0%
TRUST SECRETARIAT	166	42	25	**0**	**25**	(16)	111	(55)	67%
WORKFORCE	308	77	0	**0**	**0**	(77)	0	(308)	0%
CORPORATE TOTAL	**1,671**	**418**	**50**	**513**	**563**	**145**	**856**	**(815)**	**51%**

4.0 Statement of Financial Position (SoFP)

The net Statement of Final Position as of 30th June 2024 is £226.99m, £2.89m lower than May 31st, 2024, as shown in the table below.

Statement of Financial Position as at 31st May 2024	2023/24 M12 Balance	2024/25 M02 Balance	2024/25 M03 Balance	Movement in Month
	£000	£000	£000	£000
NON-CURRENT ASSETS:				
Property, Plant And Equipment	219,465	223,485	222,435	(1,050)
Intangible Assets	5,701	5,608	5,411	(198)
Right of Use Assets	43,136	42,375	41,994	(381)
Assets Under Construction	40,916	34,838	36,226	1,387
Trade & Other Rec -Non-Current	561	533	572	39
TOTAL NON-CURRENT ASSETS	**309,779**	**306,839**	**306,637**	**(202)**
CURRENT ASSETS:				
Inventories	1,090	1,130	1,088	(42)
Trade And Other Receivables	27,135	14,565	17,944	3,378
Cash And Cash Equivalents	68,549	75,394	62,852	(12,542)
TOTAL CURRENT ASSETS	**96,774**	**91,090**	**81,884**	**(9,206)**
CURRENT LIABILITIES				
Trade And Other Payables	(92,997)	(91,022)	(86,334)	4,688
Borrowings: Finance Leases	235	406	492	86
Borrowings: Right of Use Assets	(4,370)	(4,370)	(4,370)	0
Borrowings: Dh Revenue and Capital Loan - Current	(116)	(116)	(116)	0
Provisions for Liabilities and Charges	(661)	(650)	(650)	0
Other Liabilities	(5,470)	(6,361)	(4,987)	1,374
TOTAL CURRENT LIABILITIES	**(103,379)**	**(102,112)**	**(95,964)**	**6,148**
NET CURRENT ASSETS / (LIABILITIES)	**(6,605)**	**(11,023)**	**(14,080)**	**(3,057)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**303,174**	**295,817**	**292,557**	**(3,259)**
NON-CURRENT LIABILITIES				
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,508)	(1,508)	(1,508)	0
Borrowings: Finance Leases	(3,498)	(3,498)	(3,498)	0
Borrowings: Right of Use Assets	(38,824)	(38,090)	(37,723)	367
Provisions for Liabilities & Charges	(22,827)	(22,838)	(22,838)	0
TOTAL NON-CURRENT LIABILITIES	**(66,657)**	**(65,935)**	**(65,568)**	**367**
TOTAL ASSETS EMPLOYED	**236,516**	**229,882**	**226,990**	**(2,892)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	137,948	137,948	137,948	0
Retained Earnings	16,743	10,109	7,216	(2,892)
Revaluation Reserve	81,826	81,826	81,826	0
TOTAL TAXPAYERS EQUITY	**236,516**	**229,882**	**226,990**	**(2,892)**

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

NON-CURRENT ASSETS

Non -Current assets closed at £306.64m in June 2024, a net decrease of £0.20m from previous month due to the monthly depreciation exceeding the Month 2 Asset addition of £1.39m.

CURRENT ASSETS

Current assets closed at £81.88m in June 2024, a net decrease of £9.21m from the previous month. Principal movements comprised Trade and other receivables (increase of £3.38m partly due to an

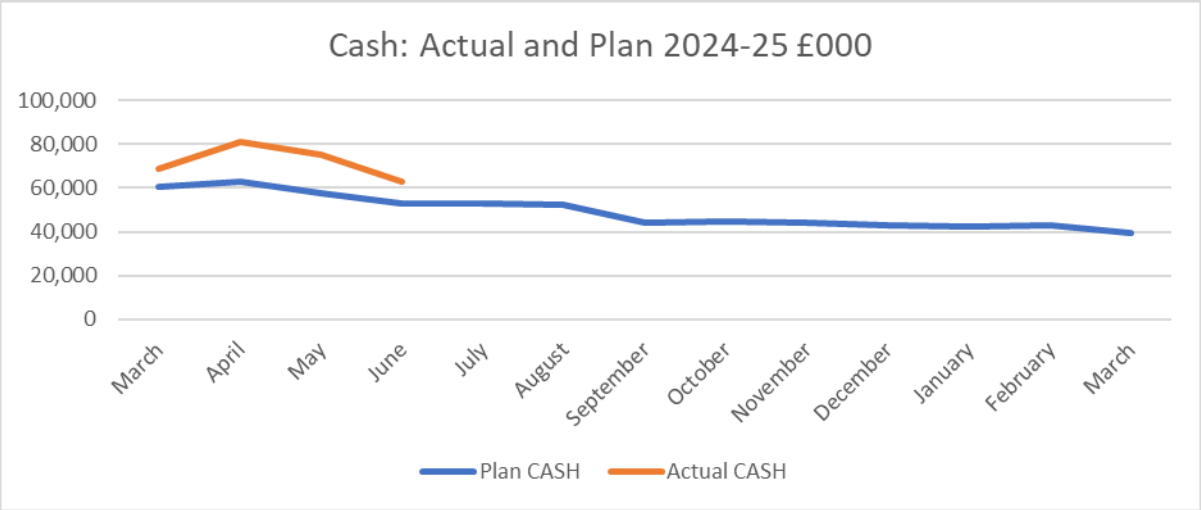
increase in prepayments of £1.46m, trade debtors increase £0.43m, local authorities accrued income £1.35m) and Cash (decrease of £12.54m as analysed below).

CURRENT LIABILITIES

Current liabilities decreased by £6.15m in month. Trade and other payables decreased by £4.69m in month and other liabilities increased by £1.37m in month.

CASH

The Trust's cash balance on 30th June was £62.84m, which is £9.82m favourable to Plan.



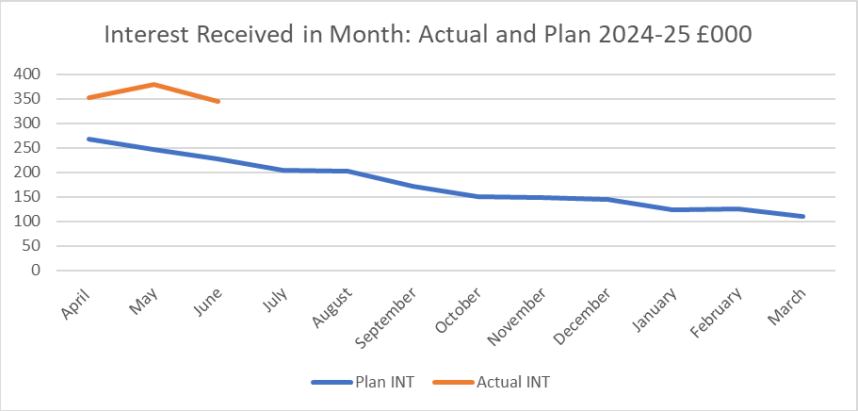
The closing cash balance on 30th June was £12.54m lower in-month due to the following factors:

- Reported deficit of £2.89m in month.
- Increase in Trade and other Receivables £3.38m
- Decrease in Trade and other Payables £6.15m

The 2024/24 Plan as revised encompasses a reduction of £20.60m of cash over the 12 months to 31st March 2025. Accordingly, the Trust continues to monitor its actual and forecast cash position against Plan.

Interest Received

Year-to-date interest received of £1.075m is favourable to Plan by £0.33m. The Plan was set in anticipation of interest rates peaking around Month 6-7 of the 2024-25 financial year, with anticipated rate reductions factored in for July, October, and January.



5.0 Capital Expenditure

The core capital allocation for 2024-25 has been confirmed as £10.236m, which is significantly reduced from previous years' totals. The Trust has received notification of potential additional allocation of £2.01m comprising of:

Bonus allocation	£0.81m
Ventilation project	£1.20m
Total	£2.01m

However, as the plan remains significantly overprogrammed against the allocation, this effectively reduces the amount of the over-commitment.

The phasing of the Plan is as follows:
Q1 10%
Q2 20%
Q3 30%
Q4 40%
Total 100%.

Capital Expenditure 2024/25: M03 Month to 30th June 2024

	Original allocation £000	*Overprogrammed at risk £000*	*Total Budget M1-12 £000*	*YTD M03 Actuals £000*
Internally Funded:				
Estates Capital 2425	2,836	964	3,800	143
Strategy Capital 2425	5,800		5,800	1,634
Ligature Risks		500	500	
Fire Remediation BC		500	500	
ICSUs 2425	200		200	33
ICT 2425	400		400	
Equipment 2425	400		400	
Capitalised salaries	600		600	49
Total Internally Funded	***10,236***	***1,964***	***12,200***	***1,859***
Externally funded (PDC):				
DDC: Image Sharing	72		72	
Total Externally Funded	***72***	***0***	***72***	***0***
ROU funded (Leases):				
IFRS16 Remeasurement	5,479		5,479	
Total ROU	***5,479***	***0***	***5,479***	***0***
Total Capital Expenditure : Actuals	***15,787***	***1,964***	***17,751***	***1,859***

In-month capital expenditure totalled £1.447m. The current year to date expenditure at 30th June is £1.859m against cumulative plan of £1.02m and is comprised of Estates, ICSUs and Capitalised salaries £0.23m, and Strategic Projects £1.63m. The Strategic Projects expenditure of £1.634m is comprised of: Mortuary £0.46m, Power Upgrade £0.73m, Fire £0.37m and Salaries £0.08m.

The following additional risks were identified in the setting of the Trust's 2024/25 Capital Plan:

- Over-allocation

As shown above, there is an acknowledged risk of £1.97m in the Trust's core capital plan in excess of the notified core capital allocation.

- C Block LV intake panel

Capital cost of £0.4m relating to LV intake panel. This is currently on the risk register at a score of 20.

- Further expenditure for 2023/24 projects

A significant risk to the 2024-25 plan exists in the form of capital projects which were uncompleted in 2023-24 with expenditure being incurred in 2024-25.

- PACS procurement project

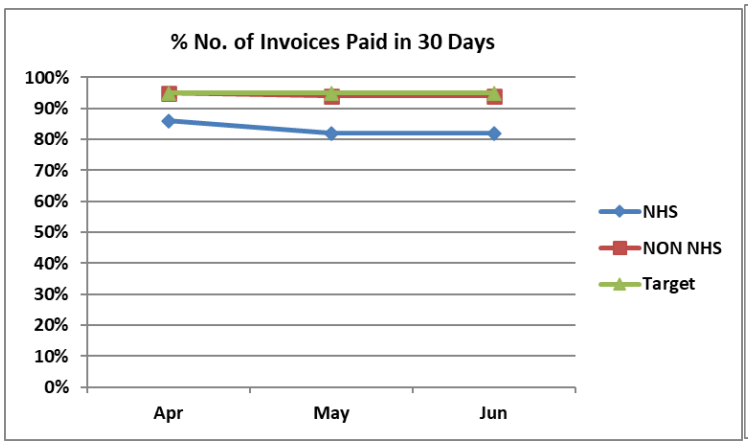
The Trust has been asked to earmark £0.4m of its capital allocation for this NCL-wide project. This project does not carry a separate allocation, hance is a further risk against core allocation.

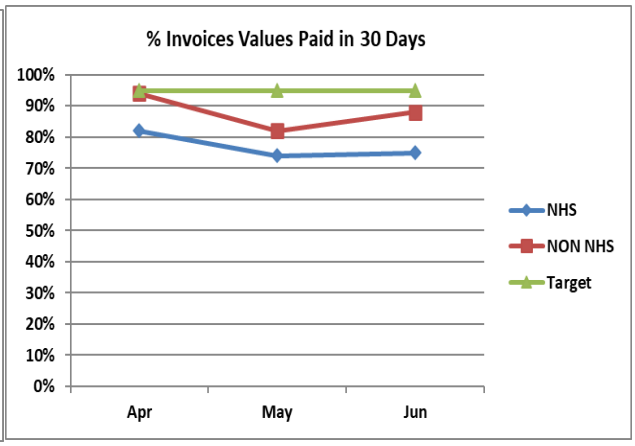
- Right of Use lease remeasurement

Each time a lease undergoes a rent review, the revised rent must be remodelled over the remaining term of the lease and the resulting net present value increase charged to CDEL. In addition to the core allocation, the Trust receives additional allocation for IFRS16 lease remeasurement of £5.479m. This is effectively ringfenced on the basis that remeasurements are expected for at least a proportion of the Trust's 24 finance-leased premises. During 2023-24, the remeasurement requirement was £3.4m for seven premises. During a subsequent reassessment of remeasurement liabilities, the Trust identified an actual requirement for £7.056m in 2024/25. Remeasurements over and above the allocation form an additional requirement against core CDEL.

In June 2024, the ICB announced an additional capital allocation of £2.01m which is derived as follows:
Bonus allocation £0.812m
Ventilation £1.200m
Total £2.012m
However, as the Trust's capital programme is already over-programmed at risk by upwards of £2m, the additional allocation addresses the risk and cannot be counted as additional resource.

Better Payments Practice Code – Monitoring for 2024/25





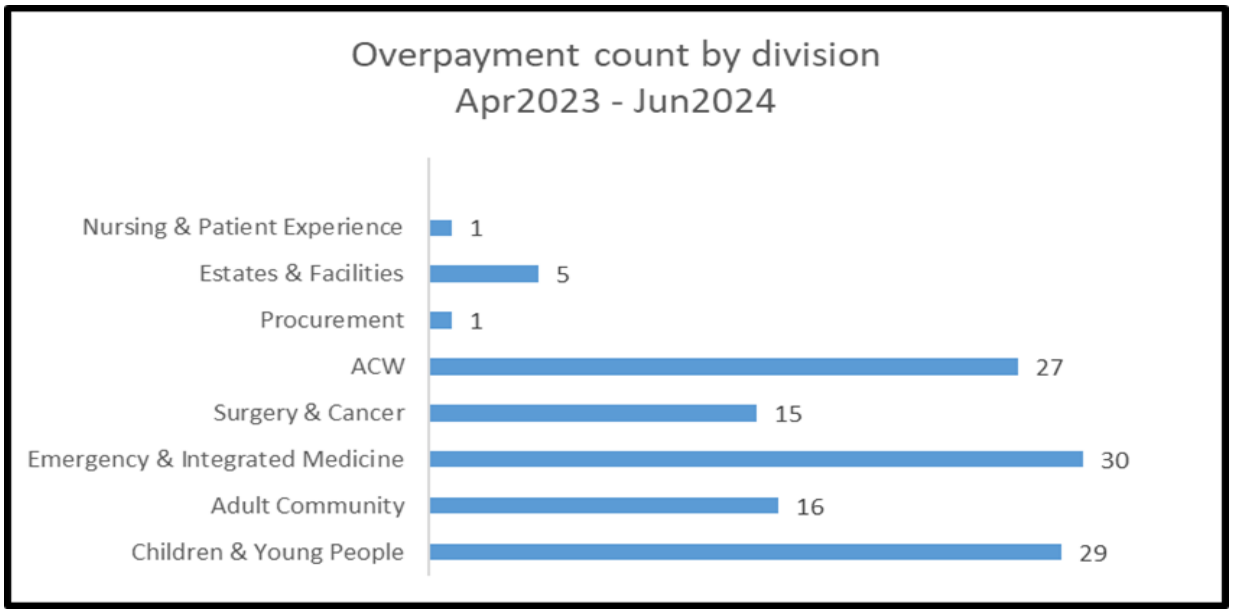
Salary Overpayments

Salary overpayments occur when a member of staff is inadvertently paid more than they are entitled to receive. If the individual is in post when the overpayment comes to light, it is normally deducted from subsequent salary payments. If the individual has left the Trust's employment, it is necessary for the Trust to invoice the individual and pursue the debt in the same way as any other debtor. All of these scenarios are to be avoided as they consume resource which would otherwise be available to the Trust to spend on patient care.

Total overpayments to employees present and former

For the period 1.4.2023 to 31.3.2024, there were a total of 97 overpayments totalling £282,522. For the period 1.4.2024 to 30.6.2024 the numbers are 27 overpayments totalling £25,538.

Overpayment instances by Staff Group and by Division are as follows:



Meeting Title	**Trust Board – public meeting**	**Date: 25 July 2024**
Report Title	**Integrated Performance Report**	**Agenda Item: 8**
Executive lead	Jonathan Gardner, Chief Strategy, Digital and Improvement Officer	
Report Owners	Paul Attwal, Head of Performance, and 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 despite the time of year. Also, the June figures are affected by the industrial action. The organisation has put considerable effort at every level to mitigate these issues, where possible. **Infection Prevention and Control** During June 2024, there was 1 MRSA Bacteraemia bringing the total to 2 MRSA Bacteraemia's against a target of 0 for the year (April 2024 – March 2025), **Emergency Care Flow** During June 2024, performance against the 4-hour access standard was 71.5%, which is lower than the NCL average of 72.79%, lower than the London average of 76.24%, and the national average of 74.59%. There were 339 12-hour trolley breaches in June 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 71.4% in May 2024 against the standard of 75%. This is an improvement of 6.1% compared to 65.3% in April 2024. 62-day Combined Treatments performance was at 64.1% for May 2024 against a target of 85%. This is an improvement of 7.7% compared to 56.4% in April 2024. At the end of June 2024, the Trusts position against the 62-day backlog was 80 patients. **Referral to Treatment: 52+ Week Waits** Performance against 18-week standard for June 2024 was 69%, this is an improvement of 0.3% from Mayl's performance of 68.7%. The Trust position against the 52-week performance has worsened from 452 patients waiting more than 52-weeks for treatment in April 2024 to 556 in May 2024. This is predominantly in General Surgery and is under review. The Trust had 1 patient over 78-weeks at the end of May 2024 against a target of 0. This patient was treated in the first week of June 2024.	

	Workforce Appraisal rates for June 2024 were at 77%, this is an improvement of 0.9% from May's performance of 76.1%. Work continues to support service areas to improve overall compliance. **Complaints** Complaints Responded to Within 25 or 40 Working Days has improved from 72.7% in May 2024, to 75.7% in June 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
BAF	The following BAF entries are linked: Quality 1; Quality 2; People 1; People 2
Report history	Trust Management Group

Whittington Health NHS Trust

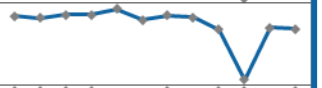
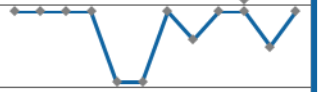
Performance Report

July 2024

Month 3 (2024-2025)

Community - Performance Dashboard

Whittington Health NHS Trust

Indicator	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	2024-2025	Activity
IAPT Moving to Recovery	50.0%	44.5%	43.8%	46.8%	45.5%	45.2%	52.5%	48.1%	51.9%	54.9%	49.2%	48.1%		48.6%	
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	90.9%	93.1%	90.7%	91.9%	90.4%	96.6%	91.9%	93.8%	93.0%	95.7%	94.4%		95.1%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	77.5%	79.8%	84.7%	79.5%	74.8%	72.0%	83.3%	84.7%	75.6%	87.4%	79.1%	79.6%	81.9%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	78.3%	81.8%	66.7%	81.8%	94.1%	83.3%	76.1%	88.2%	85.4%	84.2%	90.0%	100.0%	90.0%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	70.9%	71.6%	72.0%	71.2%	73.9%	70.4%	70.3%	71.3%	72.8%	43.8%	76.3%	72.4%	67.1%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	91.1%	89.7%	91.7%	91.7%	95.3%	88.9%	91.5%	90.3%	83.1%	53.6%	84.1%	83.5%	79.1%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	100.0%	100.0%	100.0%	100.0%	50.0%	50.0%	100.0%	80.0%	100.0%	100.0%	75.0%	100.0%	85.7%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 weeks	>45%			54.1%			56.1%			54.5%					

Community Performance Dashboard

IAPT: Recovery target is for 50% of depression and anxiety patients to have had two or more appointments. There was a drop in performance in January 2024 due to national changes in guidance, where IAPT accept higher severity. Performance dipped in April and May 2024, this is as a result of delays in data being reported by the team. However, there has been continuous improvement since July 2023. Data quality work is taking place, and it is anticipated that compliance will be achieved in subsequent months.

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. The service have been meeting their target since the unexplained drop in April 2024.

All other services continue to meet their targets and are on track to remain compliant on an ongoing basis.

ICARE EQUITY

Adult Community - Waiting Times

Whittington Health NHS Trust

Indicator (Routine Appointments)	Target	Target Weeks	Apr-24	May-24	Jun-24	Average Wait (Latest Month)	No. of Patients Seen
Community Matron	>95%	6	100.0%	100.0%	100.0%	1.3	13
Adult Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	1.8	57
Community Rehabilitation (CRT)	>95%	12	65.4%	68.3%	80.6%	10.9	31
ICTT - Other	>95%	12	100.0%	100.0%	98.2%	4.2	112
ICTT - Stroke and Neuro	>95%	12	22.2%	11.1%	16.7%	14.9	18
Home-based Intermediate Care Service	>95%		89.5%	79.2%	60.9%	5.1	46
Paediatric Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	7.1	4
Bladder and Bowel - Adult	>95%	12	44.8%	54.1%	27.5%	17.1	131
Musculoskeletal Service - CATS	>95%	6	30.8%	27.2%	30.7%	10.7	450
Musculoskeletal Service - Routine	>95%	6	37.2%	28.6%	32.1%	14.1	1311
Nutrition and Dietetics	>95%	6	96.2%	97.2%	90.2%	2.9	122
Podiatry (Foot Health)	>95%	6	22.2%	21.6%	20.0%	11.9	406
Lymphodema Care	>95%	6	34.8%	32.0%	45.7%	7.4	35
Tissue Viability	>95%	6	100.0%	100.0%	100.0%	1.3	42
Cardiology Service	>95%	6	95.0%	100.0%	100.0%	1.9	41
Diabetes Service	>95%	6	50.4%	52.4%	67.9%	4.9	196
Respiratory Service	>95%	6	57.6%	64.1%	83.6%	3.3	61
Spirometry Service	>95%	6	100.0%	91.9%	100.0%	2.8	70
Integrated MDT	>95%	6	94.2%	84.0%	89.2%	2.7	130
Self-Management	>95%	6	32.1%	72.2%	45.5%	6.6	11
Covid	>95%	6	78.8%	93.3%	92.3%	3.1	26
Indicator (Urgent Appointments)							
Adult Wheelchair Service	>95%	2		75.0%	100.0%	0.2	2
Community Rehabilitation (CRT)	>95%	2	41.7%	45.2%	8.3%	17.6	24
ICTT - Other	>95%	2	0.0%	6.3%	16.7%	5.4	6
ICTT - Stroke and Neuro	>95%	2	11.1%	20.0%	0.0%	7.9	7
Home-based Intermediate Care Service	>95%	2	92.1%	90.3%	83.7%	0.9	92
Musculoskeletal Service - CATS	>95%	2	33.3%	23.5%	14.3%	4.3	14
Musculoskeletal Service - Routine	>95%	2	59.4%	65.7%	54.5%	2.6	101

Adult Community Waiting Times

Podiatry: There has been a slight increase in the waiting times from June, from 10 weeks on average to 11.9 weeks. However, their activity remains to be the same. The team have been successfully working through the backlog, clearing the list from those waiting the longest this has increased this month's average timing time. The team has reduced the backlog with the longest waiters being now 30 weeks or less from 52 weeks.

Islington Community Neuro-Rehabilitation (Formally CRT/ICTT): Recovery in this area has been slow. The backlog has been in Speech and Language Therapy (SLT) and Occupational Therapy (OT), both professions have had long standing vacancies and long-term sickness. OT and SLT capacity is being managed by the agency cover, with a primary focus of managing long waiters. Whilst ongoing recruitment efforts are taking place for the vacancies. The team are being supported with finding ways to manage and support the waiting list and demand. We are seeing gradual improvement with both teams showing improvement this month.

Bladder and Bowel Service: Bladder and Bowel remains a fragile service, however, recovery plans are underway. A nurse lead has started this month and additional operational support in place to support the team in addressing the current waiting list and case load.

MSK Routine: The service was showing significant improvement in addressing the backlogs, with the longest waits now being 18 weeks, and we can see the average waiting times has decreased from last month. As they continue to clear the backlog, we anticipate the overall waiting times to come down further.

MSK CATS: There has been an improvement in overall backlog numbers and continues to be on a steady trajectory of improvement. We have seen the average waiting time has come down from 11.5 weeks to 10.7 weeks.

ICARE EQUITY

Children's Community – Waiting Times

NHS Whittington Health NHS Trust

Indicator (Routine Appointments)	Target	Target Weeks	Apr-24	May-24	Jun-24	Average Wait (Latest Month)	No. of Patients Seen
CAMHS	>95%	4	47.0%	50.4%	45.9%	10.4	218
Community Children's Nursing	>95%	6	78.9%	82.1%	82.3%	2.8	62
Community Paediatrics - Haringey	>95%	18	48.9%	70.5%	76.3%	9.5	38
Community Paediatrics - Islington	>95%	18	85.7%	100.0%	95.7%	6.1	23
Haringey - SCT	>95%	20	0.0%	0.0%	0.0%	63.8	25
Islington SCT (0-5s)	>95%	20	26.1%	30.4%	9.1%	51.4	22
CLA Initial Assessments - Haringey	>95%	4	100.0%	100.0%	100.0%	2.0	11
CLA Initial Assessments - Islington	>95%	4	53.8%	80.0%	30.0%	5.4	10
Occupational Therapy - Barnet	>95%	18	100.0%	100.0%	100.0%	6.1	19
Occupational Therapy - Haringey	>95%	18	100.0%	100.0%	100.0%	9.3	19
Occupational Therapy - Islington	>95%	18	38.5%	40.0%	68.4%	16.7	19
Paediatrics Nutrition and Dietetics - Haringey	>95%	12	100.0%	81.3%	100.0%	3.8	9
Paediatrics Nutrition and Dietetics - Islington	>95%	12	100.0%	100.0%	91.7%	7.2	12
Physiotherapy - Barnet	>95%	18	100.0%	100.0%	100.0%	4.2	29
Physiotherapy - Haringey	>95%	18	97.2%	100.0%	100.0%	4.1	70
Physiotherapy - Islington	>95%	18	98.4%	100.0%	98.6%	2.9	70
PIPS	>95%	12	100.0%	100.0%	100.0%	4.6	12
SALT - Barnet	>95%	18	75.8%	67.9%	73.3%	14.4	86
SALT - Camden	>95%	6	53.5%	56.1%	51.9%	7.9	77
SALT - Haringey	>95%	13	62.0%	77.4%	26.6%	23.0	64
SALT - Islington	>95%	13	90.6%	77.8%	79.4%	9.8	34
SALT - MPC	>95%	18	96.2%	100.0%	88.5%	7.2	26
School Nursing - Haringey	>95%	12	89.0%	94.1%	95.0%	3.6	161
School Nursing - Islington	>95%	12	94.3%	83.9%	93.4%	2.9	61
Indicator (Urgent Appointments)							
CAMHS	>95%	2	100.0%	100.0%	100.0%	0.3	9
Community Children's Nursing	>95%	1	100.0%	100.0%	100.0%	0.0	3
SALT - Barnet	>95%	6	100.0%	85.7%	100.0%	3.1	9
SALT - Haringey	>95%	2		0.0%	14.3%	7.1	7

Children's Community Waits

Haringey Speech and Language Therapy (SLT): The mainstream SLT service continues to have long waits for assessment. Most capacity in this team is allocated to delivering statutory Education Health and Care Plan (EHCP) provision for children which limits time available to provide assessments and other interventions. The launch of the graduated response for children with speech, language and communication needs in Haringey in September 2023 has resulted in more children having their initial needs met by school interventions. Referrals have reduced and the numbers on the waiting lists are reducing.

In Early Years SLT there continue to be high levels of referrals and high complexity on the caseload. The service has developed group assessments for most children referred to the service and this approach has supported a reduction in waiting times over the last quarter.

The development of the Universal SLT service is enabling parents to get support earlier and through different pathways. Additional one-off funding allocated by the ICB will help further reduce waiting times across the SLT service.

Islington Occupational Therapy (OT): In Islington OT waiting times for assessment and the waiting times for intervention have reduced recently. This is in part linked to short term additional funding. The service still has some staffing gaps and this impacts on provision – recruitment is underway. We continue to work with local partners, including Islington Council on plans for potential additional investment, in particular to support children and young people with an EHCP.

Barnet SLT: In Barnet, SLT referrals continue to exceed capacity every month. All families waiting are now sent details of relevant online training, parent workshops and 'virtual drop-ins' to give earlier access to support and potentially reduce the need to wait for formal assessment.

The SLT service in Barnet, as in other boroughs, is complex. The service works across multiple teams, service areas and settings. A range of services are provided including Universal Support for all children, Targeted support for some children, and individualised input for children with complex/specific needs. It is challenging to meet need and ensure children and young people are seen within a reasonable timeframe.

Additional recurrent and one-off investment over the past 2 years has supported a reduction in waiting times and improved the service offer. Improvements include:

- Provision of a training/advice programme for educational professionals and parents.
- Integrated therapy assistants to support delivery of provision.
- Improved recruitment and retention of staff

ICARE EQUITY

Safe

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
HCAI C Difficile	<13	Jun	0	1	1		
Actual Falls	400	Jun	41	42	111		
Category 3 or 4 Pressure Ulcers	64	Jun	16	27	63	H	
Medication Errors causing serious harm	0	Jun	0	0	0	L	
MRSA Bacteraemia Incidences	0	Jun	1	1	2	H	
Patient Safety Incident Investigations	N/A	Jun	1	0	1		
VTE Risk Assessment %	>95%	Jun	95.4%	96.1%	95.7%		P
Mixed Sex Accomodation Breaches	0	Jun	20	13	47	H	
Summary Hospital Level Mortality Indicator (SHMI)	1.14	Jan 2023 - Dec 2023	1.02				

Category 3 or 4 Pressure Ulcers - *Target 0*

June Performance – 16 Pressures on 16 Patients

This is an improvement of 11 compared to 27 in June 2024.

Category 3 = 16 Category 4 = 0

Issues: There were no category 4 pressure ulcers in June 2024. In the hospital setting, four category 3 ulcers developed in three clinical areas. In the community setting, twelve category 3 pressure ulcers occurred in five District Nursing teams, with a higher proportion in the Islington borough.

Actions: Work continues implementing the patient safety incident review framework (PSIRF) for pressure ulcers support improvement changes at local, directorate and Trust process level. The Trust Pressure Ulcer Group has updated it is reporting structure and reviewed the Trust pressure ulcer action plans to ensure the governance is focused and robust.

Significant work being undertaken in the Adult Community Services division following it is pressure ulcer review, with the new improvement plan focused on improving systems working, with senior leadership oversight and engagement.

MRSA Bacteraemia

MRSA June Performance – 1

This is a the same as in May 2024 when there was also 1 MRSA Bacteraemia.

Issues: Despite zero tolerance on MRSA blood stream infections, there was one hospital attributed case in June 2024. MRSA #2 for the trust was a complex case who acquired MRSA colonisation in hospital. Vulnerable to infection due to a lack of a protective skin barrier, skin was the likely source of the bacteraemia. The case was deemed avoidable.

Actions: The Trusts' patient safety incident response framework was followed. An after-action review found new learning that would have good impact on future case management through reinstating the Lewisham Isolation Priority System (LIPS) for bed management out of hours to prioritise patients whose isolation is essential in reducing high risk of transmission.

Responsive - Access

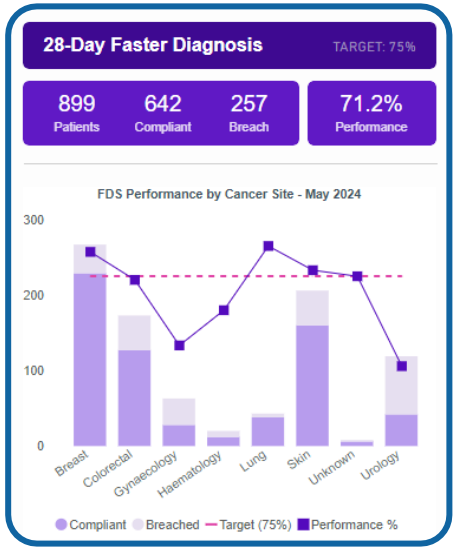
Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Cancer - 62 Days Combined Treatments	>85%	May	64.1%	56.4%	60.4%	H	F
Cancer - % Pathways Received a Diagnosis Within 28 Days of Referral	>75%	May	71.4%	65.3%	68.4%	H	F
Cancer - 31 Days to First & Subsequent Treatment	>96%	May	97.7%	93.0%	95.3%	H	F
DM01 - Diagnostic Waits (<6 Weeks)	>99%	Jun	92.2%	92.4%	92.1%		F
RTT - Incomplete % Waiting <18 Weeks	>92%	Jun	69.0%	68.7%	67.8%		F
Referral to Treatment 18 Weeks - 52 Week Waits	0	Jun	514	556	1008		F
% Seen <=48 Hours of Referral to District Nursing Service	>95%	Jun	96.7%	98.1%	97.8%		P
% Of Rapid Response Urgent Referrals Seen Within 2 Hours of Referral		Jun	78.9%	76.5%	74.3%		

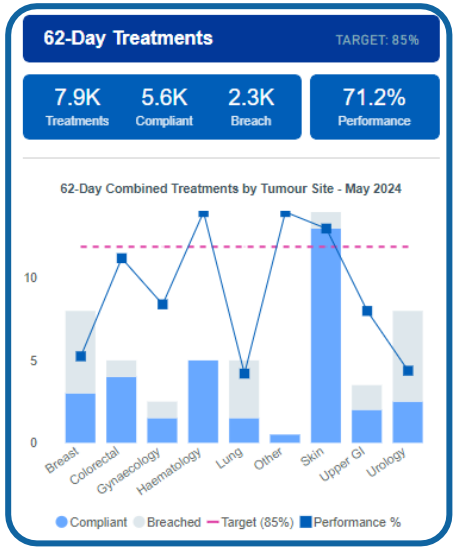
What the Data Tells Us	Issues	Actions and Mitigations
Referral to Treatment Incomplete % Waiting <18 Week – *Target 92%* **June Performance – 69%** This is an improvement of 0.3% compared to May's performance of 68.7%.	• Compliance against 18 weeks remains static in June 2024. However, there is a reduction in the overall backlog of patients waiting over 52-weeks. • All services are now working towards achieving the 65-week target for September 2024. • There were no over 78-week waiters at the end of June 2024	• Risks have been identified in the delivery of Lower Urinary Tract Syndrome, General Surgery, and Orthopaedics. Service lines have developed plans to mitigate capacity risks and achieve compliance.
Referral to Treatment 18 Weeks - 52 Week Waits – *Target 0* **June Performance – 514** This is an improvement of 42 compared to May's performance of 556. At the end of June there was 0 patient 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.* **June Performance – 92.2%** This is a worsening of 0.2% improvement of 0.92% compared to May's performance of 92.42%.	• Concerns still remain around the neurophysiology test service however performance for June was 30.4%. • Imaging overall remains positive achieving 99.1% compliance in June 2024.	• The Neurophysiology service is showing early signs of progress for July 2024 and is in line with action plan to achieve compliance by the end of August.

Responsive - Access

Whittington Health NHS Trust

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.* **May Performance – 71.4%** This is an improvement of 6.1% compared to 65.3% in April 2024.	The Trust performance improved by 6.1% in May 2024 compared to April 2024. • Gynaecology, Haematology, Upper GI and Urology were non-compliant for the month of May. • Delays in Haematology primarily resulted from some incidental findings and some particularly complex patients. This is not expected to be an on-going issue and performance is anticipated to improve in June. • Urology had some shortfalls in capacity to meet demand and workforce challenges	• The business case for Gynaecology has 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. A funding bid to NCL Cancer alliance to cover waiting list initiative rates while waiting for recruitment is an option this is being discussed • Urology performance continued to be challenged due to capacity constraints within the workforce • Demand and capacity modelling currently being undertaken within dermatology to provide additional capacity and improve 1st appointment wait time and FDS performance. The service is booking at a minimum of 28-days for first appointment.
Cancer: 62-Day Combined Treatments - *Target >85%* *No. of pts receiving their first treatment for cancer within 62 days of referral.* **May Performance – 64.1%** This is an improvement of 7.7% compared to 56.4% in April 2024.	May's combined performance improved to 64.1% from 56.4% in April • 70% of 62-Day breaches in May occurred in the Lung, Prostate and Breast pathways. Compliance with these three tumour/sub-tumours was 50% or lower. • Breast performance declined by 7.5% in May to 37% from 45% in April • Lung performance was impacted by capacity constraints at UCLH for the radiotherapy/chemo-radiotherapy pathway	• The Breast service, reviewed surgical theatre capacity and made alterations, in March 2024, so that capacity now matches the available consultant/surgeon establishment. Additional outpatient capacity was also provided throughout January to May. This has started to improve 62-day performance (January 2024 = 14%; March 2024 = 55%, with a slight decline in May to 33% due to some complex patients). • The joint urology surgical and oncology pathway with UCLH, went live on the 8th May 2024. There remain some challenges within the pathway, which are being worked through to improve throughput and patient pathways



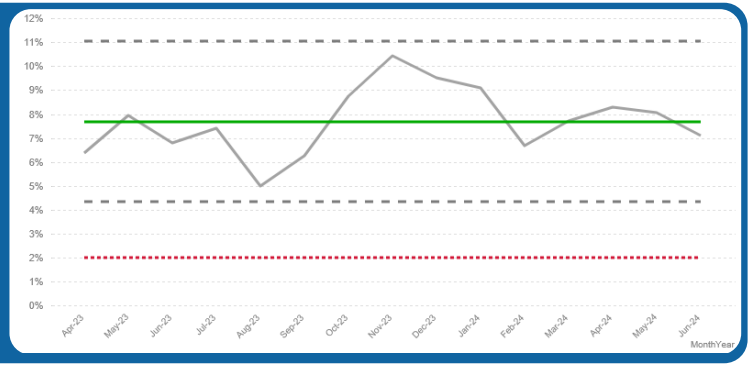


ICARE EQUITY

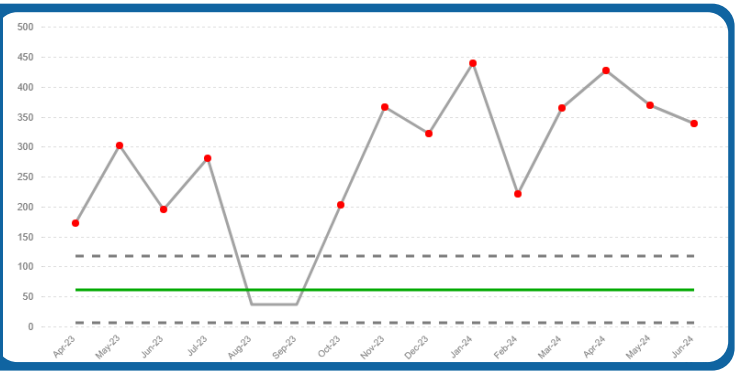
Responsive - Emergency Care

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Las Patient Handover Times - 30 Mins	0	Jun	78	88	285		
Las Patient Handover Times - 60 Mins	0	Jun	6	5	20		
% Streamed to an Onsite Service	>7.5%	Jun	2.8%	2.8%	3.3%		
Median Wait for Treatment (Minutes)	< 60 min	Jun	92 Mins	95 Mins	91 Mins		
% Of ED Attendance Seen by Clinician Within 60 Mins of Arrival		Jun	35.8%	34.9%	36.5%		
Median Time From Arrival to Decision to Admit		Jun	04:26	04:41	04:30		
12 Hour Trolley Waits in ED	0	Jun	339	369	1136		
Total ED Attendances in Dept for More Than 12 Hours (Arrival to Dept)		Jun	648	743	2158		
% Of ED Attendances Over 12 Hours From Arrival to Departure	<2%	Jun	7.1%	8.1%	7.8%		
ED Waits (4 Hrs Wait)	>95%	Jun	71.5%	69.2%	70.8%		
% Left ED Before Being Seen		Jun	8.5%	8.8%	8.6%		
% ED Re-Attendance Within 7 Days		Jun	9.7%	9.2%	9.8%		

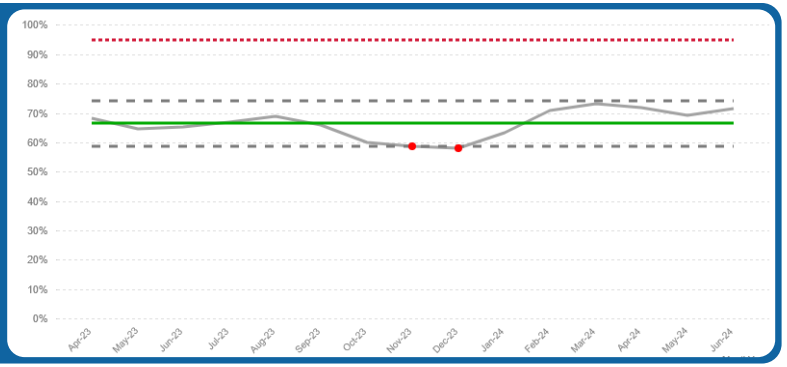
ED Attendances Over 12 Hours



12-Hour Trolley Waits in ED



ED 4-hour Waits



Responsive - Emergency Care

Whittington Health NHS Trust

What the Data Tells Us

% of ED Attendances Over 12 Hours - *Target <2%*
June Performance – 7.1%
This is an improvement of 1% from May's performance of 8.1%

12-Hour Trolley Waits in ED - *Target 0*
No. of patients who waited longer than 12 hours to be admitted to the ward following decision to admit.
June Performance – 339 (Average 11.3 per day)
This is an improvement of 30 from May's performance of 369

Emergency Department Waits (4 hrs wait) - *Target >95%*
No. of patients treated within 4 hours of arrival in ED.
June Performance – 71.5%
This is an improvement of 2.3% from May's performance of 69.2%

LAS Handovers - *Target 0*
Number of Ambulance Handover delays of greater than 30 minutes and 60 minutes.
June Performance (30 mins) – 78
This is an improvement of 10 from May's performance of 88.
June Performance (60 mins) – 6
This is a worsening of 1 from May's performance of 5.

Median Wait for Treatment - *Target <60*
Time from arrival to seeing a doctor or nurse practitioner.
June Performance – 92 minutes
This is an improvement of 3 minutes from May's performance of 95 minutes

Issues

- Continued NCL Sector pressures with regular LAS diverts and formal postcode redirections
- High number of out of borough conveyancing.
- Discharge bottlenecks into the community which impact on wider hospital flow.

Whittington position and impact

- Attendances higher (9127) when compared to June 2023 (9098)
- Increased acuity resulting in longer length of stay on the wards.
- Increase in ambulance arrivals to the site including out of area patients.
- Surge in Paediatric activity through the front door which impacted on Length of Stay (LOS) on the ward.

Actions and Mitigations

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 and UCC focus on consistently achieving greater than >92%

ED assessment and Management:

- Focussed work with START/Frailty on admission avoidance and utilising ambulatory care for this cohort of patients.
- RAT model embedded with senior registrar or consultant assessing patients at the front door
- GP tendering underway to provide increased GP provision in the UTC.
- Plan to relaunch ED-SDEC

Specialty review, discharge, flow and admission:

- Focus on UTC and Paediatrics performance to consistently deliver >92%.
- Exploring the establishment of a CDU to support non admitted flow
- Review of ED SDEC complete, amendments made and to be re relaunched in July
- Consultant led board rounds introduced once a day in Paediatrics.
- Improve specialty response times and escalations, started to meet with specialties to set expectations and agree timings.
- CAU SOP/criteria amended to support streaming from ED where appropriate
- 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.
- Long Length of Stay review meetings revamped with a focus on reducing number of patients who do not meet the criteria to reside to 40.
- Explore locations for a discharge lounge.

EQUITY

Activity

Indicator	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Activity
ED Attendances		8609	8042	8426	8772	8592	8911	8704	8364	9562	8958	9522	9125	
ED Admission Rate %		9.7%	10.0%	10.3%	10.2%	10.8%	11.4%	10.6%	10.2%	10.3%	9.6%	9.9%	9.7%	
Elective and Daycase		1912	2167	2160	2307	2407	1908	2179	2245	2217	2461	2571	2235	
Emergency Inpatients		1576	1589	1622	1638	1674	1777	1598	1557	1746	1556	1727	1566	
GP Referrals to an Acute Service		7129	7912	7830	8761	8361	6524	8614	9170	8354	9219	8759	7892	
% Of GP Referrals Completed via eRS		69.9%	71.0%	73.0%	73.0%	71.1%	67.8%	68.2%	73.1%	72.0%	65.7%	68.5%	67.2%	
% e-Referral Service (e-RS) Slot Issues	<4%	69.6%	65.8%	60.3%	61.2%	69.6%	71.9%	68.9%	69.4%	77.6%	82.7%	78.9%	83.1%	
Maternity Births	320	237	263	245	266	256	237	229	206	237	227	218	192	
Maternity Bookings	377	302	274	271	300	271	245	310	288	301	308	275	246	
Outpatient DNA Rate % - New	<10%	11.5%	11.2%	12.1%	12.9%	12.7%	11.5%	12.0%	13.0%	11.7%	11.5%	11.5%	11.7%	
Outpatient DNA Rate % - FUp	<10%	9.9%	10.3%	10.2%	10.9%	10.5%	10.9%	9.7%	10.9%	10.3%	10.2%	9.7%	10.4%	
Outpatient New Attendances		12868	13292	12279	13076	11751	9294	10676	10457	10217	11314	11119	9598	
Outpatient FUp Attendances		17044	18012	17318	17551	18760	15792	18931	17496	17227	18201	18746	17030	
Outpatient Procedures		6312	5979	6172	6344	6410	5533	6442	6034	6283	7336	7234	6039	

GP Referrals

June Performance – 7,892

This is a decrease of 867 compared to May's performance of 8,759.

It is a decrease of 192 compared to 8,084 in June 2023.

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

June Performance – 83.1%

This is a worsening of 4.2% from May's performance of 78.9%.

Robotic Process Automation for the management of triaging referrals has now begun, with a rollout plan for all services to be operational by the end of September. This will assist in reducing the ASI figures to achieve compliance by quarter 3 of 2024/25.

Activity - Highlights

Activity Highlights

Maternity Births June Performance – 192

This is a worsening of 26 from May's performance of 218, and a worsening of 36 from 228 in June 2023.

ED Attendances June Performance – 9,125 (Daily Average Attendance 304)

This is a decrease of 397 compared to May's performance of 9,552 (Daily average attendance 307), and it is an increase of 27 compared to 9,098 in June 2023.

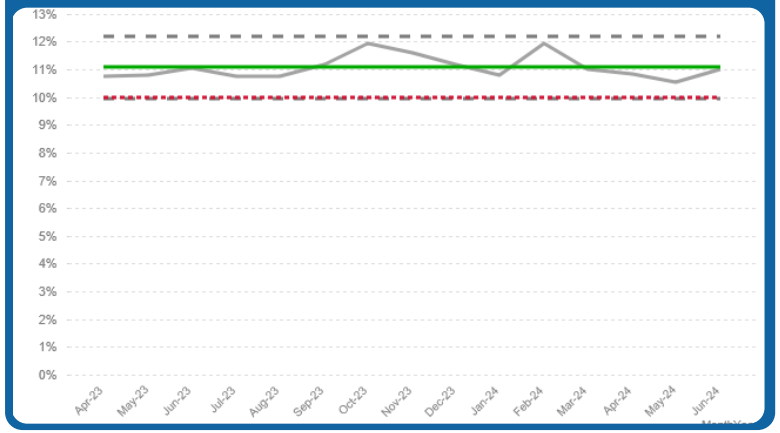
DNA Rates June 2024:

Acute DNA rate for June was 11%, this is a worsening of 0.4% from May's performance of 10.6%.

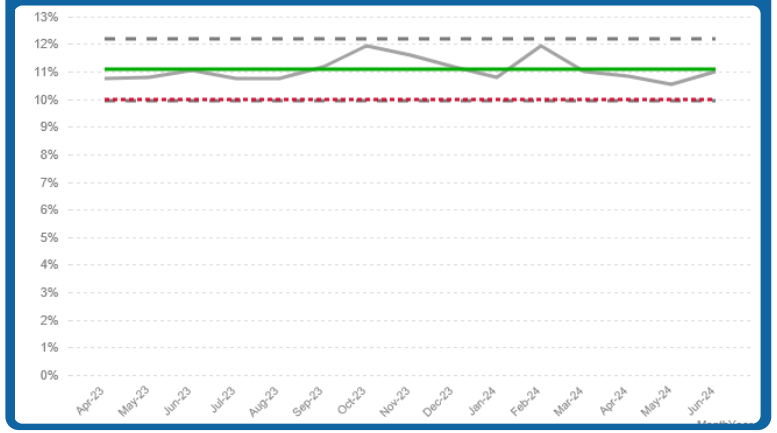
Outpatient DNA rate for new appointments was 11.7% for June, this is a worsening of 0.2% from May's performance of 11.5%.

Outpatient DNA rates for follow-up appointments was 10.4% for June, this is a worsening of 0.7% from May's performance of 9.7%.

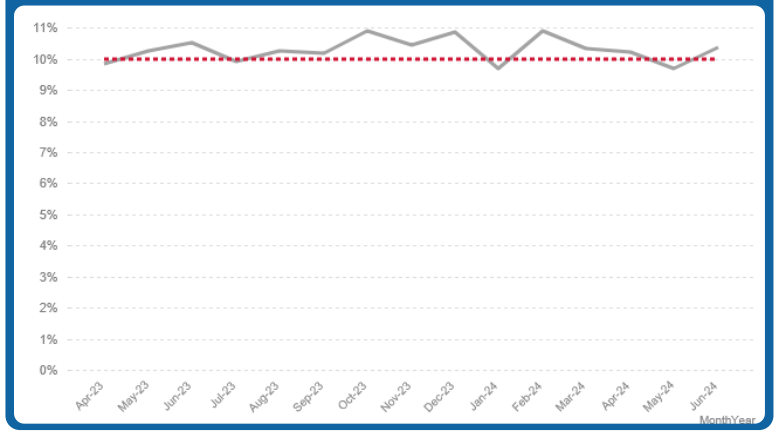
Acute DNA % Rate



Outpatient DNA % Rate - New



Outpatient DNA % Rate – Follow-Up



Activity – Activity and Forecasts

Activity Highlights

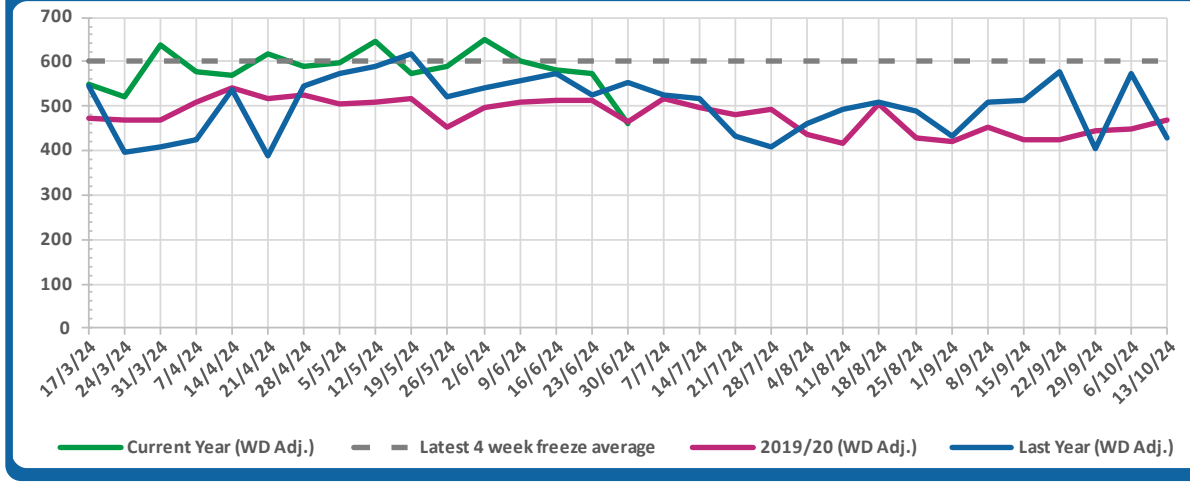
Outpatient First Appointments: There were 14,673 Firsts Appointments in the last 4 weeks of June 2024, this is 117% of 19/20 levels.

Outpatient Follow-up Appointments: There were 12,021 follow-up appointments in the last 4 weeks of June 2024, this is 92% of 19/20 levels.

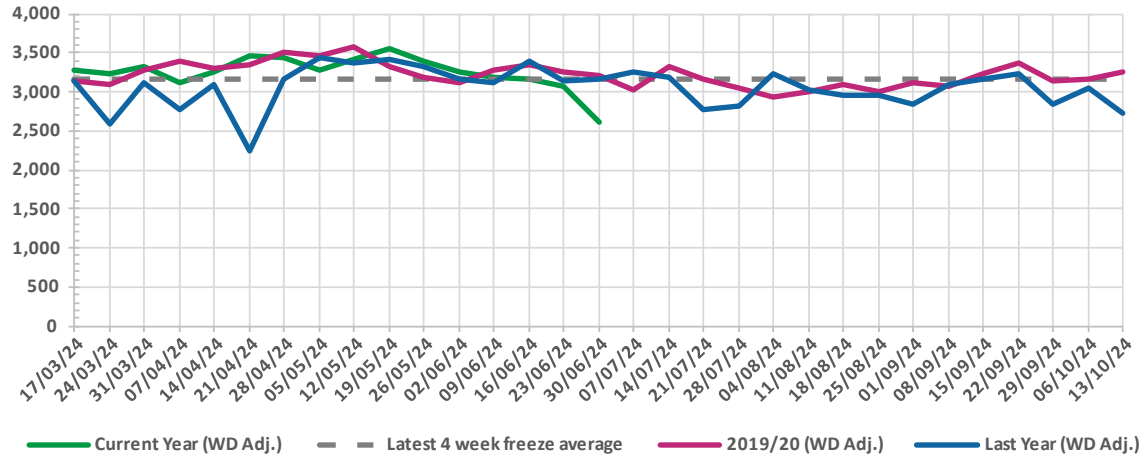
Follow-up activity is in line with productivity improvements.

Elective Activity: There were 2,212 cases in the last 4 weeks of June 2024, this is 111% of 19/20 levels. However, there is a variation in case mix where we have seen less inpatient activity and increased day cases.

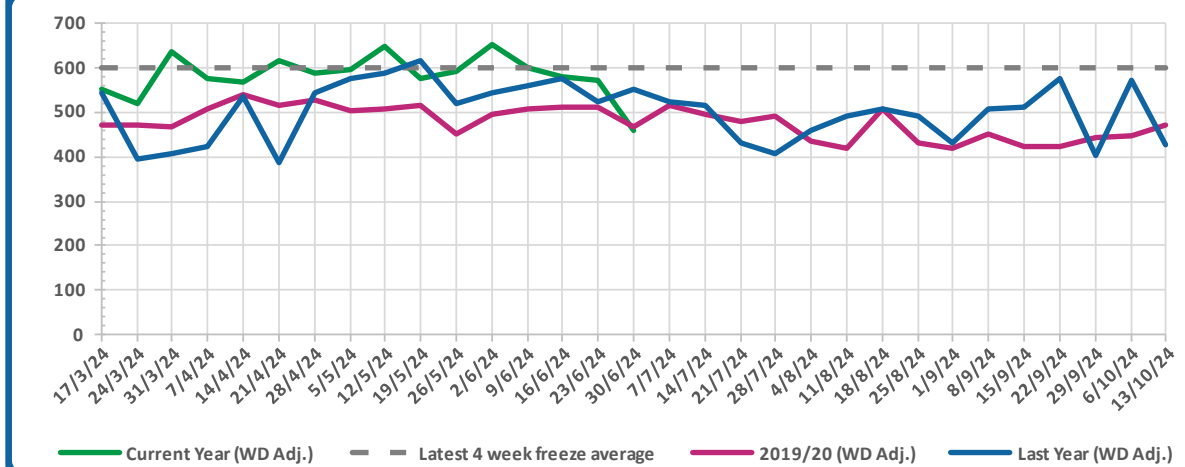
Weekly Outpatient First Attendances



Weekly Outpatient Follow-up Attendances

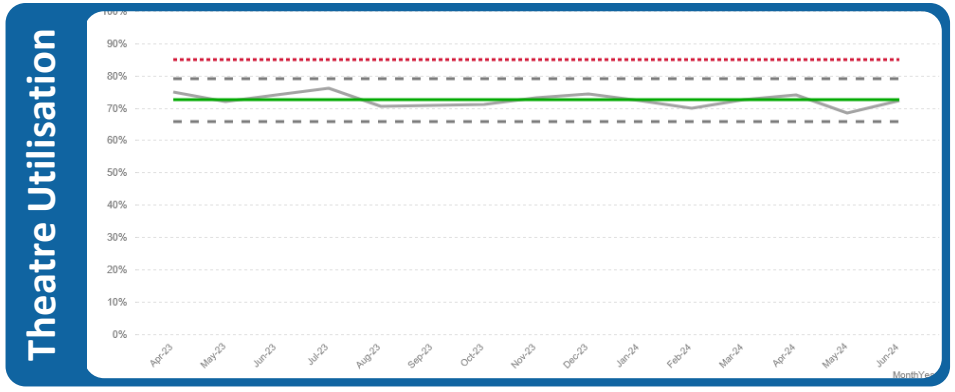


Weekly Elective Activity



Effective

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Cancelled Ops Not Rebooked <28 Days	0	May	1	6	7	L	F
Hospital Cancelled Operations	0	May	9	25	34	L	F
Theatre Utilisation	>85%	Jun	72.1%	68.5%	71.5%		F
Community DNA % Rate	<10%	Jun	7.0%	6.9%	7.1%		P
Acute DNA % Rate	<10%	Jun	11.0%	10.6%	10.8%		F
Outpatients New:Follow Up Ratio	2.3	Jun	1.77	1.69	1.69		
Non Elective Re-Admissions Within 30 Days	<5.5%	Jun	3.3%	4.3%	3.9%	L	P
Rapid Response - % Of Referrals With an Improvement in Care		Jun	63.1%	73.6%	71.7%		



Theatre Utilisation - Target 85%

Percentage of available Theatre time used for elective procedure.

June Performance – 72.1%

This is an improvement of 3.6% from May's performance of 68.5%.

Issues:

- The implementation of the new digital Pre-Operative Assessment (POA) process system has caused constraints with capacity for POA which has limited the booking of procedures.
- Delay in completion of booking rules to improve average case per list and theatre utilisation.
- There has been a higher than expected number of staff on leave in June 2024.

Actions:

- The introduction of a hybrid model for POA has provided a positive impact and booking have significantly improved.
- Additional POA capacity at weekend has been implemented.
- Additional resource to support specialities to complete and implement booking rules.
- Theatre user group to be restarted with the first meeting scheduled for Wed 24th July 2024 to promote clinical engagement.
- Rota coordinators to attend Theatre scheduling meetings to support cover for theatre lists.
- Ensure robust cover arrangements for surgeons leave to avoid decrease in activity

Hospital Cancelled Operations - Target 0

May Performance – 9

This is an improvement of 16 from April's performance of 25.

Actions:

- Recruitment for additional anaesthetic resource in progress.
- Formalised minuted handover meeting for next day equipment needs to be put in place.

Caring

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
ED - FFT % Positive	>90%	Jun	81.6%	78.0%	81.4%		F
ED - FFT Response Rate	>15%	Jun	8.0%	7.0%	8.1%		F
Inpatients - FFT % Positive	>90%	Jun	94.0%	92.4%	93.5%		P
Inpatients - FFT Response Rate	>25%	Jun	18.2%	19.3%	17.3%		F
Maternity - FFT % Positive	>90%	Jun	98.5%	96.3%	97.7%		P
Maternity - FFT Response Rate	>15%	Jun	17.8%	25.0%	24.6%	L	P
Outpatients - FFT % Positive	>90%	Jun	93.1%	91.9%	92.6%		P
Outpatients - FFT Response Rate	400	Jun	389	248	1019	L	
Community - FFT % Positive	>90%	Jun	94.5%	94.6%	94.2%		P
Community - FFT Response Rate	1500	Jun	913	1010	2537	L	
Complaints Responded to Within 25 or 40 Working Days	>80%	Jun	75.7%	72.7%	73.3%	H	F
Complaints (Including Complaints Against Corporate Division)		Jun	37	33	101		

Friends and Family Test (FFT)

June Performance

Trust wide FFT for positive response rates sits at 92%, this is 7% above the 85% NHS benchmark and a slight increase on May. All ICSU's remained above the NHS benchmark for the fifth consecutive month. Trust wide for negative response rates sits just below the NHS 5% benchmark at 4.76%.

Three areas of focus: Maternity 96% positive an increase on the previous month, Outpatients 93% and ED 81% an increase of 3% on May. Negative response rates for all areas has seen an improvement, with ED 11% a decrease of 4%, Outpatients 7% a decrease of 2% and Maternity 1% a decrease of 2%. An iPad has been provided to maternity to support the collection of FFT's and additional volunteer support including a ward befriender and FFT volunteer. FFT SMS for postnatal in place and posters provided to ED to increase feedback from patients.

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

June Performance – 75.7%

This is an improvement of 3% from May's performance of 72.7%.

There were 37 complaints received where a response was required in June 2024.

The 37 complaints due a response in June 2024 were allocated to E&IM 35% (13), S&C 31% (12), ACW 11% (4), ACS 8% (3), CYPS 6% (2), Corporate 6% (2) & E&F 3% (1)

Severity of complaints: 46% (17) were designated 'low' risk, 46% (17) were designated as 'moderate' risk, & 8% (3) were designated as 'high' risk.

Themes: A review of the complaints due a response in June 2024 shows that 'Communication' 43% (16), 'Medical Care' 16% (6), and 'Delay' 16% (6) were the main issues for complainants.

Of the 28 complaints that have closed, 4 (14%) were 'upheld', 15 (54%) were 'partially upheld', and 9 (32%) were 'not upheld', meaning that 68% of the closed complaints in June 2024 were upheld in one form or another.

Well Led

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Appraisals % Rate	>85%	Jun	77.0%	76.1%	77.2%		F
Mandatory Training % Rate	>85%	Jun	87.1%	86.9%	86.8%		P
Permanent Staffing WTEs Utilised	>90%	Jun	91.7%	91.9%	92.1%		P
National Quarterly Pulse Survey (NQPS)	800	April	324		324		
NQPS Staff % Recommended Work	>50%	April	54.8%		0.548		
Staff Sickness Abscence %	<3.5%	May	3.9%	3.6%	3.7%		F
Staff Turnover %	<13%	Jun	10.4%	11.6%	11.2%		P
Vacancy % Rate Against Establishment	<10%	Jun	8.3%	8.1%	7.9%		P
Average Time to Hire	<=63	Jun	58	56	58		P
Safe Staffing Alerts - Number of Red Shifts		Jun	2	0	2		
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		Jun	10.3	5.1	7.4		

Appraisals % Rate - *Target >85%*

June Performance – 77%

This is an improvement of 0.9% from May's performance of 76.1%

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: The Trust is actively working with services to support the completion of appraisals.

National Quarterly Pulse Survey (NQPS)

April Performance - Responses Received - 324

Staff % Recommended Work 54.8%

Issue: Response rate dropped

Actions: Increase staff communications about NQPS survey, created calendar invites and all-staff emails from Chief People Officer with actions taken as a result of the previous survey. % of recommending staff as a place to work is above target and on-going work on the staff survey action plan is aimed at increasing staff engagement and advocacy.

Staff Sickness Absence % - *Target <3.5%*

May Performance – 3.9%

This is a worsening of 0.3% from May's performance of 3.6%.

Issues: The Trust is beginning to see a slow increase in the overall sickness absence rate, which is now sitting 0.4% above the Trust target.

Action: The HR Business Partnering team will assess the data available to understand any specific peaks in reasons for absence and/or areas of concern. Direct support will be provided to those areas where an increase has been identified.

Meeting title	**Trust Board – public meeting**	**Date: 25 July 2024**
Report title	**Audit & Risk Committee Chair's Assurance report**	**Agenda item: 10**
Committee Chair	Amanda Gibbon, Non-Executive Director	
Executive lead	Terry Whittle, Chief Finance Officer	
Report authors	Marcia Marrast-Lewis Assistant Trust Secretary, and Swarnjit Singh, Trust Company Secretary	
Executive summary	This report details areas of assurance from the items considered at the Audit and Risk Committee meeting held on 20 June 2024. **Areas of significant assurance:** • 2023/24 Whittington Health Annual Report • 2023/24 Whittington Health Annual Accounts • ISA 260 • External Audit annual report • Draft Audit opinion • Internal Audit progress report and Head of Internal Audit Opinion • Board Assurance Framework • Counter-fraud update. • Counter-fraud annual report. **Areas of moderate assurance:** • Trust risk register • Internal audit reviews – discharge management, risk and workforce information In addition, the Committee also noted the following reports: • Quality Assurance Committee Chair's assurance report for the meeting held on 24 May 2024 • Tender waiver and breaches report • Special payments, losses and write offs • Debtors' report Key issues to report to the Board are: • Internal audit annual report • Opinion on the year end statement • Value for money statement. .	
Purpose	Noting	

Recommendations	Board members are invited to: i. note the Chair's assurance report for the Audit and Risk Committee meeting held on 20 June 2024; and ii. note the successful conclusion to the 2023/24 annual accounts.
BAF reference	All entries
Report history	Board meetings following each Committee meeting
Appendices	1: Q1 Board Assurance Framework

Committee Chair's Assurance report

Committee name	Audit and Risk Committee
Date of meetings	20 June 2024

Summary of assurance:

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

2023/24 Annual Report

Committee members received the draft annual report and the Committee Chair thanked Swarnjit Singh for his work on the Annual Report and the assessment against NHS England's provider code of governance for NHS trusts. Committee members were informed that there would be a further iteration of the annual report sent to the Committee Chair, which would include reference to this assessment and highlight any non-compliance on a comply or explain basis.

The Committee approved the draft 2023/24 Annual Report, subject to final drafting amendments in accordance with the delegated authority given by the Trust Board and noted that the further iteration would be sent to the Committee Chair to review and agree.

2023/24 Whittington Health Annual Accounts

Committee members were able to take good assurance from the report accompanying the annual accounts which set out the key judgements made as part of preparation of the financial statements. The Assistant Director of Financial Services explained that the Trust was reporting a deficit position of £8.711m which was adjusted to a financial surplus of £606k, once impairments were added back. The cumulative breakeven assessment was satisfactory. The closed cash balance position was £68.5m which represented a £4.4m reduction. The Committee was informed that capital expenditure in the previous year totalled £43.1m – the highest level achieved for a number of years. The Committee was also told that the private finance initiative provision remained in place for the private finance initiative building at a reduced level. A full evaluation of the estate had been carried out which resulted in a £28m impairment. It was agreed that the Committee would be provided with the change log which would detail all changes made to the draft accounts between the current version and the final version to be submitted.

The Committee approved the 2023/24 Annual Accounts, subject to minor amendments, in accordance with the delegated authority given by the Trust Board.

Draft ISA 260

Committee members welcomed the draft ISA 260 report on the Trust's financial statements, in which KPMG stated their independence. KPMG thanked Martin Linton and the Finance team for their support during the audit process. Committee members were apprised of the changes that took place.

Issues highlighted in the ISA 260 by KPMG were, as follows:

- Four significant audit risks were identified. Two of these were standard risks related to the management override of controls and expenditure recognition. There were no issues or errors that were identified during the audit to bring to Committee members' attention on these risk areas.
- Of the other two risks, the first related to the valuation of the land and buildings in which the valuation had significantly reduced. KPMG had involved their valuation specialists to assess the assumptions underpinning the valuation and to critically assess the objectivity and expertise of the valuation of Trust properties. KPMG were comfortable with the valuation which was consistent with the ranges given for the hospital and other North London sites where these assets were located. Additionally, the Trust's valuers had reconsidered the classification of several assets outside of the main hospital and treated them as specialised assets. The previous valuer had considered them to be non-specialised which meant that they were valued differently. This had resulted in a downward movement in valuations. KPMG confirmed that they were comfortable with the classification but requested that the change in valuations was disclosed.
- The final risk related to the legal claim provision valuation which was felt to be at the prudent end of an acceptable range with the provision not allowing for contingency and optimism bias, as the Trust expected to recover the cost of rectification works. KPMG were comfortable with the approach which was reasonable given the inherent uncertainty.
- For the value for money assessment, KPMG concluded that a significant weakness had been identified associated with the Trust's financial sustainability, which specifically referred to the level of recurrent savings identified. KMPG drew the Committee's attention to some benchmarking carried out of the Trust against similar-sized NHS providers. KPMG said that the significant weakness comment would be removed from next year's audit, depending on the level of recurrent savings achieved in 2024/25.
- KPMG also highlighted their work in reviewing a potential investigation for which a provision had been made. They confirmed that they had reviewed the legal advice for risks related to legal and coronial procedures. KPMG confirmed that this was an area of the audit that would need to be certified, at a later date, and before the 30 September publication deadline for annual accounts.

The Committee noted the outcome from the ISA 260 and that some work was being completed to finalise the document. The Committee agreed to convene a separate meeting in July to agree the wording around certification.

Representation letter

Committee members considered the draft letter of representation, which was the standard letter from the Trust to KPMG in connection with the financial statements covering comprehensive income, financial position, changes in taxpayers' equity and cash flows. KPMG drew the attention of the Committee to paragraphs 15a and 15b. Committee members were content to positively confirm compliance with the content of paragraphs 15a and 15b.

The Audit and Risk Committee approved the draft letter of representation.

Going Concern report
Committee members reviewed an assessment of the Trust's ability to continue as a going concern for at least 12 months, in line with accounting standards. They concurred with the conclusion that there were no operating or other issues that would prevent the 2023/24 Annual Accounts being prepared on a going concern basis.

Internal Audit progress report and Head of Internal Audit Opinion
RSM confirmed that they had issued the final Head of Internal Audit Opinion for 2023/24, based on the work performed during the year. Their assessment was that the Trust had an adequate and effective framework for risk management, governance and internal control and that their work had identified further enhancements to this framework to ensure that it remained adequate and effective. RSM highlighted the assurance ratings given to key reviews during the year which informed their opinion. This included a substantial assurance rating for the review of key financial controls and reasonable assurance ratings for reviews of incidents (controlled drugs), Covid-19 preparations for the Covid-19 public inquiry, payroll systems, workforce information and for central risk management arrangements covering the board assurance framework and risk register.

The Committee noted the progress with delivering the 2023/24 internal audit plan and the Head of internal Audit's Opinion.

Internal audit review – risk management
The Committee considered the final audit review for risk management which assigned a split opinion to reflect the varying levels of maturity with risk management arrangements within the Emergency and Integrated Medicine (EIM) ICSU which received an overall partial assurance rating. The review had given a higher assurance rating level for the elements of the review which looked at the board assurance framework and risk register.

The Committee discussed the governance processes around the reporting of risk management within the EIM ICSU and agreed that it was important to ensure that risks were regularly reviewed and reported through ICSU boards and the EIM Quality Committee, at regular intervals. The Chief Nurse agreed to take this forward with ICSU leads with the view of strengthening risk management processes within the EIM ICSU and training. A report on the progress achieved would be brought back to the Committee in due course.

The Committee was assured that work would continue to improve on risk management practice across the Trust and that the risk register and board assurance framework would be presented to the Trust Board on a regular basis.

	Internal audit review – workforce information The Committee considered the audit review on workforce information which found the Trust to have appropriate governance processes in place to support the management and oversight of workforce information. Overall, the review achieved a rating of reasonable assurance. The Committee was apprised of the four medium and one low priority management actions. It was agreed that the report would be taken to the Workforce assurance committee for further consideration. **The Committee noted the report.** **Board Assurance Framework** The Committee discussed the quarter one 2023/24 Board Assurance Framework detailing risks to the delivery of the Trust's strategic objectives which had been reviewed by other Board Committees and the Trust Management Group. Committee members were informed that the Improvement, Performance and Digital Committee did discuss the likelihood score for the Sustainable 3 entry and agreed that the score should not be increased at this time but be kept under review. **The Committee approved the board assurance framework and took assurance that it had been discussed by relevant board committees and the trust management group in quarter one.** **Local Counter-fraud progress report** Committee members received an update on counter fraud activity undertaken since the previous meeting. They noted that a review of procurement and contract management had commenced, in line with guidance from the NHS Counter Fraud Authority and would be completed by 30 September 2024. RSM had also started a Trust-wide fraud and bribery risk assessment to inform future counter fraud activity. An update would be submitted to the Committee upon completion of the assessment. The Committee was informed that six new referrals had been made to the Counter-Fraud Service since 1 April 2024 which was indicative of a good reporting culture. **The Committee noted the counter fraud progress report.** **2023/24 Counter Fraud Annual Report and Functional Standard Return** Committee members received and noted the annual report and functional standard return for 2023/24 .
2.	**The Committee is able to report moderate assurance from the following items:** **Trust risk register** The Committee reviewed the risk register entries scored at 15 or higher and took moderate assurance that effective mitigations were in place. The report contained 35 risk entries and there were also six risk entries awaiting approval for inclusion on the risk register. The Committee was informed that the risks related to ligature risk reduction work, the delivery of the Barnet 0-19 service

	and the obsolete main intake panel in C Block which increased the risk of a catastrophic power failure and were all scored at 20. Committee members were advised that the risk relating to the main intake panel in Block C had been included in the capital plan and that the ligature risk reduction works had commenced. The Committee discussed the risk related to a cyber attack and agreed that the Improvement, Performance and Digital Committee should review the total risk score for the Sustainable 3 entry on the board assurance framework, particularly in the light of the recent cyber attack on a provider of pathology services in south east London. The Committee considered an additional report on lower scored risk entries, of which there were 228 on the risk register. The majority of these entries were scored between 8 to 12. **The Committee noted the report and agreed that the Improvement, Performance and Digital Committee would review the risk scoring for the sustainable 3 entry in relation to a cyber attack.** **Internal audit review – discharge management** The Committee noted the internal audit review report and its assessment of a partial overall risk assurance rating, with five medium priority actions. The review had looked at discharge processes, with a specific focus on data quality, reporting, governance and oversight. The review highlighted how data was used and that delays around discharge were monitored and managed. The Committee was apprised of the five medium priority actions contained in the report. The Committee was informed that additional measures would be implemented to reduce the number of patients who did not meet the criteria to reside and appropriate escalations were in place to link in with external partners. There was also a recognition that the review did not reflect on operational pressures that impacted on discharge across the Trust. **The Committee noted the report and agreed to include the data around patients who did not meet the criteria to reside to the integrated performance report for onward reporting to the Quality Assurance Committee together with the internal audit report on discharge management.**
3.	**20 June 2024 meeting attendance:** **Present:** Amanda Gibbon, Non-Executive Director (Committee Chair) Rob Vincent, Non-Executive Director Glenys Thornton, Non-Executive Director **In attendance:** Clare Dollery, Acting Chief Executive Terry Whittle, Deputy Chief Executive and Chief Finance Officer

	Mike Cooshnea, Deputy Chief Operating Officer Clive Makombera, RSM Daniella Cohen, RSM Jerry Francine, Operational Director of Finance Martin Linton, Assistant Director of Financial Services Dean Gibbs, KPMG LLP Phil Montgomery, Procurement Business Partner Anne O'Connor, Head of Quality Governance Mohini Katoch, KPMG LLP Kirsty Clarke, Counter Fraud Specialist, RSM Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary Sarah Wilding, Chief Nurse and Director of Allied Health Professionals Vivien Bucke, Business Support Manager Marcia Marrast-Lewis, Assistant Trust Secretary **Apologies:** Jonathan Gardner, Chief Strategy, Digital and Improvement Officer

Appendix 1: Q1, 2024/25 Board Assurance Framework

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
Quality 1 – quality and safety of services	Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients and families, due to errors, or lack of care or lack of resources and a lack of a quality improvement focus, results in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation	4	5	20	4	Chief Nurse / Medical Director
Quality 2 – capacity and activity delivery	Due to a lack of capacity, clinical attention and continuing pressures (e.g. industrial action), 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 to appropriate beds • patients not receiving the timely elective care they need across acute 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	4	5	20	4	Chief Operating Officer / Chief Nurse / Medical Director

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
People 1 - staff recruitment and retention	Lack of sufficient substantive staff, due to increased staff departures and absence, and difficulties in recruiting and retaining sufficient staff, results in further pressure on existing people, a reduction in the quality of care, insufficient capacity to deal with demand, and increased temporary staffing costs	4	5	20	9	Director of Workforce
People 2 – staff wellbeing, engagement and equity, diversity and inclusion	Failure to improve staff health, wellbeing, equity, diversity and inclusion, empowerment, and morale, due to the continuing post-pandemic pressures, and the restart of services, poor management practices, and an inability to tackle bullying and harassment and behaviours unaligned with the Trust's values result in: • a deterioration in organisational culture, morale and the psychological wellbeing and resilience • adverse impacts on staff engagement, absence rates and the recruitment and retention of staff • poor performance in annual equality standard outcomes and submissions • a failure to secure staff support, buy-in and delivery of NCL system workforce changes and an increased potential for unrest	4	4	16	4	Director of Workforce
Integration 1 – ICB/S and Alliance changes	Lack of system clarity, or specific changes brought about by national policy, a still maturing ICB, and an emerging provider alliance, (such as corporate	4	3	12	8	Chief Executive / Director of

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

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
	projects, and improvements in patient care and savings not being achieved					
Sustainable 2 – estate modernisation	The failure of critical estate infrastructure, or continued lack of high-quality estate capacity, due to insufficient modernisation of the estate or insufficient mitigation, results in patient harm, poorer patient experience, or reduced capacity in the hospital	4	5	20	8	Chief Finance Officer
Sustainable 3 – digital transformation and interoperability	Risk that if we do not invest effectively in our digital strategy and in keeping technology hardware updated, cyber security solutions current and configured correctly, enable interoperability and testing of continual improvement of software (e.g. electronic patient record), ensure contracts are managed and supported and maintain the ability to report and enable clinicians to have access in a timely manner, with enough sufficient skilled workforce, then there is a possibility of catastrophic downtime. This could lead to inaccessibility of information, inefficiency of operational processes, hampering operational flow, transformation with efficiencies and cost improvement programme delivery and reduced levels of integration with system partners.	5	3	15	6	Chief Strategy, Digital & Improvement Officer & SIRO

Quarter 1, 2024/25 Board Assurance Framework

Quality entries

Strategic objective		**Deliver outstanding safe, compassionate care in partnership with patients**
Executive leads		Chief Nurse and Director of Allied Health Professionals; Medical Director; Chief Operating Officer
Oversight committees		Quality Governance Committee, Trust Management Group, Quality Assurance Committee
Principal risks	**Quality 1**	Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients and families, due to errors, or lack of care or lack of resources and a lack of a quality improvement focus, 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, clinical attention and continuing pressures (e.g. industrial action), 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 to appropriate beds • patients not receiving the timely elective care they need across acute 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

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

Risk	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**			**Target**
	C	**L**	**S**	**C**	**L**	**S**	**C**	**L**	**S**	**C**	**L**	**S**	
Quality 1	4	5	20										4
Quality 2	4	5	20										4

Controls and assurances

Key controls	Assurances	Tier
Maintain expanded rapid response services across adult community and children and young people's services and re-start other community services in a safe way, prioritising the vulnerable and maintain as much business as usual as possible to prevent escalation of other illnesses	• The weekly executive team meeting is alerted to any areas of concern	• 1st
	• Trust Management Group monitors the delivery of targets for elective, emergency department, outpatient, and community services each month.	• 1st
	• Quality Governance Committee reviews the risk register at each meeting	• 1st
	• The Quality Assurance Committee reviews the risk register at each meeting	• 2nd
Work with partners in the system to manage flow and demand to ensure patients are in the right place to receive care	• The monthly Trust Management Group (TMG) meeting reviews the elective recovery dashboard key performance indicators for Whittington Health and North Central London (NCL) partners	• 1st
	• Weekly NCL Operational Implementation Group	• 2nd
Partner with service users to deliver our quality, safety, and patient experience priorities, with a focus on protecting people from infection and implement actions from the CQC inspection report	• The bi-monthly 'Learn, innovate and improve steering group reviews progress with delivery of the Trust's Care Quality Commission (CQC) actions.	• 1st
	• The Quarterly Quality Assurance report is reviewed by the Quality Assurance Committee	• 2nd
	• Clinical and national audit findings, (compliance with Getting it Right First Time and National Institute of Clinical Excellence guidance) are reported to Quality Assurance Committee on a quarterly basis, along with any identified actions within the quarterly quality report	• 2nd
	• Quality Account priorities (monitoring of priorities is included within the quarterly quality report presented to Quality Assurance Committee	• 2nd
	• CQC Relationship Assurance meetings	• 3rd
	• Peer review visits	• 3rd

Key controls	Assurances	Tier
	• Delivery of Patient Experience Strategy annual implementation plan presented to Patient Experience Group (PEG)	• 1st

Gaps in controls and assurances

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

People

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

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

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

Controls and assurances

Key controls	Assurances	
Psychological/wellbeing support to staff	• Trust Board, TMG, People Committee (PC), Partnership Group, and Workforce Assurance Committee (WAC) receive updates on activities • The importance of staff rest and recuperation emphasised and the ability to take annual leave was agreed by the executive team and Trust Management Group members and remains important • Implementing health and wellbeing discussions with all staff as part of annual appraisal reports • Ensuring Health and Wellbeing intranet hub is kept up-to-date and accessible • Appointment of Trust's first Health & Wellbeing lead for staff with regular reports to WAC	• 1st • 1st • 1st • 1st/2nd
Corporate and local staff survey action plans are being developed following the 2023 Staff Survey outcomes	• ICSU Boards and Directorates consider quarterly pulse surveys, annual staff survey results and create local action plans • Quarterly People Pulse report to TMG, Partnership Group (PG) and PC; 2nd tier assurance at WAC • Templates provided for ICSU/Directorate level and for team level to maximise empowerment through participation in making improvements • NHS staff survey outcomes and action plans report to the Trust Board, Workforce Assurance Committee, Trust Management Group, People Committee and Partnership Group • Listening events held on career progression and staff wellbeing reported to TMG and WAC	• 1st • 1st • 1st • 2nd • 2nd
Implemented activities under the #Caringforthosewhocare initiative	• The range of interventions provided for staff under the #Caring for those who care activities are reported to each meeting of the Workforce Assurance Committee, TMG, PG and PC	• 2nd
Implemented updated action plan for	• Workforce report to quarterly meeting of the Workforce Assurance Committee and People Committee and from well led indicators on the Trust Board's monthly integrated performance report	• 2nd

Key controls	Assurances	
recruitment and retention strategy		
Develop and implement a WRES improvement plan	• Annual workforce disability and race equality standard submissions paper to Workforce Assurance Committee, Trust Management Group and Trust Board • Workforce Assurance Committee reviews progress with the equality and inclusion action plan	• 2nd • 2nd
Inclusion strategy and action plan in place	• People Committee and Workforce Assurance Committee	• 2nd
Trust-wide Talent management and succession planning arrangements	• Further development and rollout of cohorts for the Bands 2 -7 development programme for black, Asian and minority ethnic staff	• 1st
People strategy	• Trust People strategy agreed at December 2023 Board meeting	• 2nd

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
Talent management programme for staff at Band 8A and above	This is being developed by the Organisational Development team	Q2 2024/25

Integration

Strategic objective		**Integrate care with partners and promote health and wellbeing**
Executive leads		Chief Executive; Director of Strategy and Corporate Affairs
Oversight committees		Trust Management Group, Finance and Business Development Committee (Integration 1 entry); Quality Assurance Committee (Integration 2 entry); Trust Board
	Integration 1	Lack of system clarity, or specific changes brought about by national policy, a still maturing ICB, and an emerging provider alliance, (such as corporate services' rationalisations, Fuller report, community services review, "Start Well" review, and pathway reconfiguration), may result in unclear governance decisions and difficulty in strategic planning which impact adversely on patient services, particularly fragile ones, and the strategic viability of the Trust
Principal risk	**Integration 2**	Local population health and wellbeing deteriorates, because of a lack of available investment in, or focus on ongoing care and prevention work, and due to unsuccessful collaboration with local sector health and social care partners, resulting in continued high demand for services which is insufficiently met

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

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

Controls and assurances

Key controls	**Assurances**	**Tier**
Participation in NCL forums by executives.	• Regular communication with executive counterparts in other NCL bodies and good liaison through NEDs to other Trusts. Strong engagement by all Directors in NCL forums e.g. Senior Management Board • The Director of Strategy is on the Elective Strategy Group	• 1st • 1st

Key controls	Assurances	Tier
	• Shared Chair with UCLH • Chair and CEO sit on the NCL provider alliance Board • Quarterly meetings of the Joint Partnership Development Committee-in-Common between UCLH and WH • Director of Inclusion is a member of the NCL Population Health and Health Inequalities Committee	• 1st • 1st • 1st
Participation in NCL pathway boards	• Community Diagnostic Hub Board (Director of Strategy present) • Diagnostic Board – (Director of Strategy present)	• 2nd • 2nd
Oncology services strategy – collaboration with UCLH	• Conversations have been held with UCLH regarding a proposed model and they are also helping with staffing capacity through a locum appointment. We have also just recruited to several other posts • Cancer Board – meeting roughly quarterly • Clear clinical cancer lead in place • Regular project group for cancer set up now meeting at least monthly UCLH / Whittington Clinical Collaboration board meets every two months	• 1st • 1st • 1st • 2nd
Orthopaedic hub – collaboration with UCLH	• Monthly report to Transformation Programme Board • UCLH and WH Clinical Collaboration Board	• 1st • 2nd
Implement locality leadership working plans through close liaison with Islington and Haringey councils	• Three Islington Leadership teams in place, and a single leadership team in Haringey in place and meeting monthly • Monthly Borough Partnership Boards attended by CEO and Dir Strategy • Monthly Haringey, Start Well, Live Well, Age Well and Place Boards Place board chaired by the Director of Strategy and service leads attend other boards • Islington and Haringey Overview & Scrutiny Committees meet ad hoc to consider any issues	• 1st • 3rd • 3rd • 3rd
Community services review – anticipatory care / urgent response / streams of work, we are leading on the virtual ward	Project progress as per plan reported to Integrated Forum on monthly basis.	
Progress Anchor Institution work and population health work	• National anchor institution learning network • Haringey and Islington borough partnership *monthly*	• 1st • 1st

Key controls	Assurances	Tier
– Director of Strategy leading on an action plan around the key areas of employment, procurement, buildings, environment, partnerships. Participation in various groups in Haringey and Islington – to progress local employment, engage in regeneration schemes, support the green agenda and to promote the London Living wage	• Haringey neighbourhoods and inequalities board *monthly* • Islington Health and Social care academy *quarterly* • Islington London Living Wage working group *two weekly* • Annual report to the Trust Board on population health	• 2nd • 2nd • 2nd • 2nd • 2nd
Our population health report and anchor institution work reports to the Quality Assurance Committee every six months and Board every year.	• Trust Management Group • Quality Assurance Committee •	• 1st • 2nd • 2nd
We have created an inequalities dashboard and now report on waiting times by ethnicity in our annual report.	• Yearly report to Board	• 2nd •

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
None identified		

Sustainable entries

Strategic objective		**Transform and deliver innovative, financially sustainable services**
Executive leads		Chief Finance Officer; Chief Operating Officer
Oversight committees		Financial Efficiency Programme; Trust Management Group; Finance and Business Development Committee; Improvement, Performance and Digital Committee
Principal risks	**Sustainable 1**	Adverse funding arrangements regionally or nationally; or failure to a) manage costs, b) reduce the run rate, c) properly fund cost pressures, due to poor internal control systems, or inability to transform services and deliver the cost improvement programme savings, or due to insufficient flexibility under a block contract along NCL system and provider alliance changes, result in an inability deliver the annual control total, a deterioration in the underlying deficit for the Trust, increased reputational risk and pressure on future investment programmes, or cancellation of key Whittington Health investment projects, and improvements in patient care and savings not being achieved.
	Sustainable 2	The failure of critical estate infrastructure, or continued lack of high-quality estate capacity, due to insufficient modernisation of the estate or insufficient mitigation, results in patient harm, poorer patient experience, or reduced capacity in the hospital.
	Sustainable 3	Risk that if we do not invest effectively in our digital strategy and in keeping technology hardware updated, cyber security solutions current and configured correctly, enable interoperability and testing of continual improvement of software (e.g. electronic patient record), ensure contracts are managed and supported and maintain the ability to report and enable clinicians to have access in a timely manner, with enough sufficient skilled workforce, then there is a possibility of catastrophic downtime. This could lead to inaccessibility of information, inefficiency of operational processes, hampering operational flow, transformation with efficiencies and cost improvement programme delivery and reduced levels of integration with system partners.

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

Risk	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Target
	I	L	S	I	L	S	I	L	S	I	L	S	
Sustainable 1	4	5	20										8
Sustainable 2	4	5	20										8
Sustainable 3	5	3	15										6

Controls and assurances

Key controls	Assurances	
Create replicable better more efficient and effective pathways for the long-term including 'virtual by default' where possible and promoting self-management	• ICSU monthly Board meetings • Community Estates Programme Group –fortnightly meetings • Monitoring of monthly updates at TMG • ICSU quarterly performance reviews • Monthly integrated performance report to Trust Board • Monthly elective recovery dashboard reviewed by TMG and elective recovery targets included in the revised integrated performance report	• 1st • 1st • 1st • 1st • 2nd • 1st
Maintain financial governance controls. Manage our expenditure to lower than last year's run-rate to enable investment in other services	• Monthly Investment Group • Monthly Transformation Programme Board • Monthly Finance report to Trust Management Group • ICSU deep dives at Finance & Business Development Committee • Monthly Finance report to Trust Board	• 1st • 1st • 1st • 2nd • 2nd
Monthly Cost Improvement Programme (CIP) delivery board	• Financial efficiency work programme established to show progress against the 2024/25 CIP target • Finance & Business Development Committee reviews progress at its bi-monthly meetings	• 1st • 2nd
Accountability Framework	• Monthly performance reviews continued and targeted support provided to ICSUs where this is identified	• 1st
Development of an estate plan Strong monitoring of fire safety procedures and compliance	• Estate Strategic Outline Case agreed by Trust Board • Monthly Private Finance Initiative monitoring group • Monthly Fire safety group	• 2nd • 1st • 1st

Key controls	Assurances	
Capital programme addresses all red risks	• and fire warden training with a comprehensive fire safety dashboard reported monthly to TMG • Monthly Health and Safety Committee • Capital Monitoring Group	• 1st • 1st • 1st
Estate Strategy is approved Strategic Outline Case for maternity and neonatal services phase 1 business case is approved	• Maternity Transformation Board monthly • Transformation Programme Board monthly • Finance & Business Development Committee next review in the Summer for phase 2 business case	• 1st • 1st • 2nd
Pathology services	• Updates on contract performance to executive team every 6-8 weeks • Transformation Programme Board monthly • Finance & Business Development Committee and Trust Board	• 1st • 1st • 2nd
Community estate transformation programme Tynemouth Road is complete Consultation for Wood Green community hub is complete and approved	• Integrated Forum monthly review • Monthly summary report to Transformation Programme Board • Community Estates Programme Group every two weeks • Trust Board agreed empty sites as surplus to requirements • Overview & Scrutiny Committee and consultation (completed)	• 1st • 1st • 1st • 2nd • 3rd
Facilitate Trust's Agile working policy	• Monthly report to Transformation Programme Board	• 1st
Deliver maternity and neonatal transformation programme five workstreams meeting weekly – Ockenden, Culture, IT, Estates, Continuity of Carer	• Monthly Maternity Transformation Programme Board • Monthly Transformation Programme Board	• 1st • 1st
2023/26 Sustainability (Green) Plan	• Agreed by Trust Board	• 2nd
Digital strategy has been written and tracking processes are in place. E.g. patient systems,	• Digital strategy agreed by the Trust Board during 2021/22 with progress on implementation overseen by the Innovation and Digital Assurance Committee • Innovation and Digital Transformation Group meetings	• 2nd • 1st • 2nd

Key controls	Assurances	
information and technical services each have a tracker that is presented at IDTG and IDAC. Regular cyber security audits and an annual discussion and training at board on cyber security	• Improvement, Performance and Digital Committee meetings • NCL Digital Board – updates provided quarterly • Annual national submissions • Cyber security audits • Updates and assurance on our resilience against cyber-attacks are reported to the Improvement, Performance and Digital Committee	• 3rd • 3rd • 3rd • 2nd

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
None currently identified		

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

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

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

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

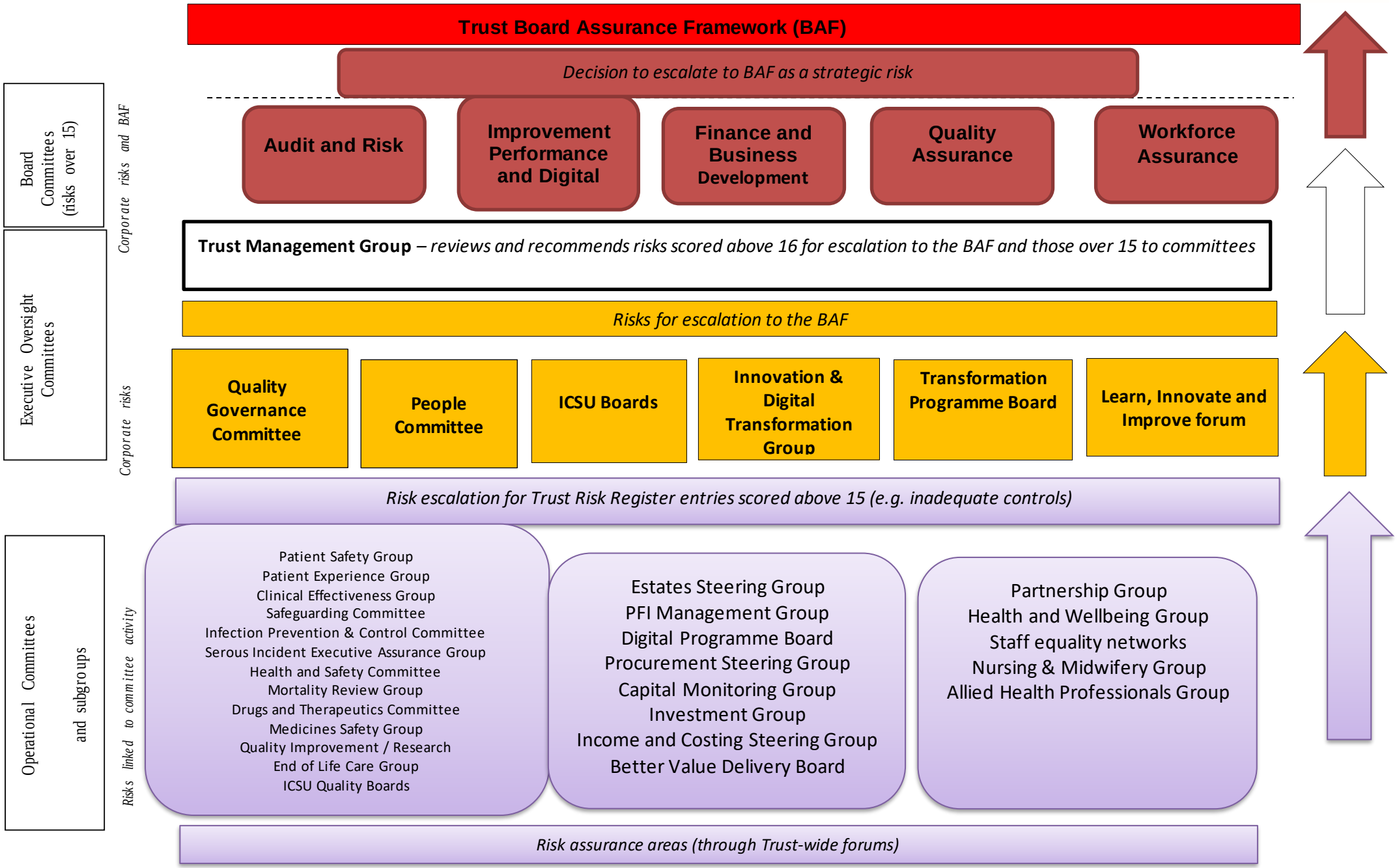
	Likelihood				
	1	2	3	4	5
Consequence	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

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

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

NHS
Whittington Health
NHS Trust

Trust-wide review and escalation of strategic risks



Meeting title	**Trust Board – public meeting**	**Date: 25 July 2024**
Report title	**Improvement Performance & Digital Committee Chair's report**	**Agenda item: 11**
Committee Chair	Junaid Bajwa, Non-Executive Director	
Executive lead	Jonathan Gardner, Chief Strategy Digital and Improvement Officer	
Report author	Marcia Marrast-Lewis, Assistant Trust Secretary	
Executive summary	The Improvement Performance & Digital Committee met on 25 June 2023 and took significant assurance from the following items considered: • A deep dive on the Urgent and Emergency Care Pathway • Improvement programme update • Cyber security update including Data Security and Protection Toolkit • Board Assurance Framework • Information management & technical systems update There are no items for which the Committee is reporting limited assurance to the Board.	
Purpose	Approve	
Recommendations	Board members are asked to note the Chair's assurance report for the meeting held on 25 June 2024 and to agree the updated terms of reference.	
Board Assurance Framework	Sustainable 3 – Digital strategy and interoperability strategic objective entry	
Appendices	1: Revised Committee Terms of Reference	

Committee Chair's Assurance report

Committee name	Improvement Performance & Digital Committee
Date of meeting	25 June 2024
Summary of assurance:	
1.	**The Committee confirms to the Trust Board that it took good assurance in the following areas:**
	Deep dive into the urgent and emergency care pathway. The Committee received a detailed presentation on performance in the emergency department. The Committee took good assurance that performance against the four hour access standard had improved since January 2024. The Trust achieved 71% performance in June 2024, despite ongoing challenges arising from postcode diversions and ambulance diversions from North Middlesex University Hospital (NMUH). The Committee was informed of a correlation between 12 hour trolley breaches and ambulance waiting times. Flow was impacted by discharge and patients who did not meet the criteria to reside (NCTR) and these patients occupied approximately 25% of the bed base. Work would continue to reduce NCTR by 10%. The Committee welcomed the development of an ED improvement plan which would improve the four-hour standard and treatment times and bring a focus on: • The delivery of an urgent treatment centre and paediatric performance target of 92% • Improve streaming to same day emergency care (SDEC), primary care services and alternative pathways. • The work with the Screening Tool to Alert to Right Treatment and frailty. • Conversion of 25 out of 43 winter beds to a nursing/allied health professional led model. • Improving specialty response times and shared accountability for ED flow. • A relaunch of the ED/SDEC model in July • Locate a suitable area for a clinical decision unit where off-the-clock patients would receive treatment while waiting for other investigations. • Early system escalation of system pressures. • The promotion of a cultural change in ED. • Learning from high performing trusts • The maximisation of information technology solutions to monitor ED performance and track patients in SDEC. • The development of dashboards through business intelligence software which would enable quick decision making and interventions. The Committee discussed flow through emergency care pathways which was key to managing ED pressures and issues around the lack of space, highlighted during periods of overcrowding. The Committee was assured that a plan to reconfigure the ED was in development with the Estates and Facilities team and would include the rationalisation of available space to improve patient flow and safety.

	The Committee was informed that the use of artificial intelligence in the ED had been trialled which found AI-assisted x-ray fracture detection to be suitable for use in the ED. This would be explored further **The Committee noted that work would continue to improve on the four-hour standard, reduce waiting times and improve safety in the emergency department.**
	Cyber-security The Committee received a presentation on cyber-security which outlined the approach to be taken to protect the Trust against a cyber-attack, including: • Managing security risks through the Data Security and Protection Toolkit (DSPT) and penetration testing which provided assurance that the organisation was practising good data security and that personal informational was handled correctly. The Trust was required to submit a DSPT annual self-assessment by 30 June 2024. The annual penetration test was carried out to validate security measures in place and identify vulnerable areas in the systems. The latest results demonstrated the improvements made over the past year. • Continuous investment in the replacement of end-of-life hardware. Due to capital constraints, changes had been made to the schedule of new equipment required. This would not increase the level of vulnerability of devices at the moment, but further investment would be required in future years. • Increase the use of multi factor authentication to improve security, particularly for remote access. • Regular patching and automatic changes to local passwords. Unused accounts were also disabled after 60 days and network links were segmented for medical devices. • Detecting cyber security events through the continuous monitoring of the infrastructure was in place. The Trust had also subscribed to the NHS Digital CareCERT system which would alert the Trust to emerging threats. • Minimising the impact of cyber security incidents – the Trust's business continuity plan would be enacted in the event of an incident. Recovery plans were regularly reviewed and a training scenario was in development around end plan network downtime in partnership with the Emergency Planning Officer. Regular back-ups were carried out and testing of recovery procedures of critical systems and data. • Awareness and training – a collaborative approach with information governance colleagues was taken to develop a communication plan around phishing, as well as additional work with the national team to complete a cycle of phishing exercises. An exercise was undertaken in December 2023 which found that 3.5% of trust staff had entered their details in response to a fake phishing email. • Regular meetings were in place with the NHS England Cyber Security team to share learning and explore opportunities. The Trust was also a member of a working group that managed a cyber security risk reduction fund.

	The Committee discussed resilience around cyber-security and business continuity preparedness and acknowledged that work would continue with the Trust's Emergency Planning Officer to refine and improve plans. The Committee was informed that a cyber-security exercise had been carried out which had simulated a complete failure of information technology and patient systems to test the resilience of business continuity plans. The Committee discussed the Trust's cyber-resilience dealing with suppliers in the supply chain, contractors, sub-contractors, in light of recent events with Synn ovis. The Committee was assured that swift action was taken to ensure that information technology infrastructure was not compromised and to decide on next steps. The Committee was also informed that cyber-security due diligence would form part of pre-contractual arrangements with contractors and suppliers. **The Committee noted the report and agreed that a deep dive in cyber security should be reported to the Committee on a bi-annual basis and that cyber-security training should be included in the Board seminar programme.**
	Improvement programme update. The Committee was updated on the progress made on the delivery of the Trust's improvement priorities, as follows: • **Elective improvement programme** – there was limited success with an increase of pre-operative assessments which resulted in a lack of demand for theatre lists going forward. A hybrid approach had been implemented which had made a positive impact. Other measures implemented included the sign-off of booking rules on a service-by-service basis. Recruitment into gaps in nursing and additional administrative staff for pre-operative assessments had been recruited. New anaesthetists had also been recruited to operationalise the new theatre schedules. A limit of six inpatients per day was still in force, due to pressures in the bed base. Jonathan Gardner confirmed that more process flow mapping work would be undertaken to help and train the bookings team to make progress on waiting lists. • **Outpatients' improvement programme** – good improvements had been made in relation to surgery and cancer procedures and the Trust was on course to achieve activity levels seen in 2019/20. Jonathan Gardner informed the Committee that a significant amount of work was ongoing in relation to training and strengthening outpatient teams. He explained that a robust governance framework was in place with oversight of cancer programmes and collaboration meetings between the access team and the ICSUs. More work had been undertaken to improve links between the patient, primary care and the cancer services through the partial booking system, as well as E-outcoming and procedure coding. Robotic process automation (RPA) had gone live in rheumatology and gynae. The Committee was advised that the rollout of RPA and e-outcoming would be completed by the end of August • **Flow improvement** - Jonathan Gardner advised that an escalation chat had been developed by the improvement team and had been in place for 22 weeks with 1,100 escalations raised. Discharge escalation meetings were in place to work with individual clinicians.

	The Committee noted the update on improvement activities and agreed that future reporting would contain more detail around the reduction of NCTR patients.
	Board Assurance Framework (BAF) The Committee considered the quarter one Board Assurance Framework, specifically the likelihood score for the Sustainable 3 entry. The risk had been considered at the Audit and Risk Committee on 20 June 2024 which had asked that this forum reconsidered the score which had a likelihood score of 3. The Committee had an extensive discussion of the issues around cyber-security and the impact to the Trust, given the recent cyber-attack on Synnovis. The Committee and agreed that the likelihood score be increased from 3 to 4 and that the impact score remain at 5. **The Committee agreed to increase the total Sustainable 3 risk score to 20 to reflect the increase of the likelihood of a cyber-attack.** **Information Management and Technical patient systems infrastructure and business intelligence update** The Committee discussed the 2024/25 capital plan which had allocated £400k for information technology. Committee members fed back that this level was insufficient to manage the information technology infrastructure on a year-on-year basis. The Committee recognised that it was important to ensure that the funding was available for information technology infrastructure, cyber-security and for the switches that would take place in the following year. It was agreed that £400k spread across the organisation for information technology was too small so next year it would need to be increased. It was agreed that this would be highlighted to the Trust Board. **The Committee noted the updates.**
2.	**Review of committee effective and terms of reference**. The Committee reviewed the terms of reference and agreed that no revisions were required with the exception that apart from greater clarity around membership, in line with the approach adopted by other Board Committees. Committee members discussed the review of committee effectiveness and raised the following points: • The Chair found deep dives to be helpful and found that the right level of discussion and interrogation had been achieved. He suggested that the Committee could gain a greater understand on the progress of projects. • Naomi Fulop stated that improvements had been made with cover sheets to the main reports which provided a good overview of the detail contained within. **The Committee approved:** • **the terms of reference, subject to amendments to the membership of the committee.** • **the self-assessment of the committee's effectiveness.**

2.	**Present:** Junaid Bajwa, Non-Executive Director (Committee Chair) Naomi Fulop, Non-Executive Director Nailesh Rambhai, Non-Executive Director **In attendance:** Clare Dollery, Acting Chief Executiv Mike Cooshnea, Director of Operations EIM/Deputy Chief Operating Officer Iolanda Pedrosa, Interim Chief Information Officer/Chief Nursing Midwifery & AHP Information officer Jonathan Gardner, Director of Strategy and Corporate Affairs Sam Barclay, Chief Clinical Information Officer Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary Marcia Marrast-Lewis, Assistant Trust Secretary **Apologies** Chinyama Okunuga, Chief Operating Officer Mark Livingstone, Cheif Allied Health Professional Charlotte Hopkins, Acting Medical Director. Paul Attwal, Head of Performance

Appendix 1: IPDC terms of reference

Improvement, Performance and Digital Committee (IPDC) terms of reference	
1. 1.1 1.2	**Authority** The Board of Directors hereby resolves to establish a Committee to be known as the Improvement, Performance and Digital Committee (IPDC) (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 • seek any information it requires for any employee, and all employees are directed to co-operate with any request made by the Committee • obtain outside legal or other professional advice, if it considers this necessary, via the Company Secretary
2. 2.1	**Role** The role of the Committee is to provide assurance to the Trust Board that: • the Trust's operational performance (e.g. efficiency and waiting times) and actions and trajectories are in place to address any areas of performance concerns • there is a successful development of our green (sustainability) strategy and the implementation of its action plan • there is an effective structure, process and system of control for the governance of innovation and transformation matters and the management of risks related to them • there is a Trust Innovation / Transformation Strategy and it is sucessfully implemented • the Trust complies with its obligations with regard to commercial opportunities • appropriate processes and systems are in place for data, information management and governance to allow Whittington Health to meet its stated objectives, legislative responsibilities and any relevant requirements and standards determined for NHS providers • there is continuous improvement in relation to information governance and information security within the Trust and that risks arising from this are being managed appropriately • the procurement of major and critical IT systems or equipment is carried out so that it is fit for purpose and secures value for money
3. 3.1	**Membership** The membership of the Committee shall comprise: • At least two Non-Executive Directors (one of whom shall Chair this Committee); • Chief Strategy, Digital & Improvement Officer (lead executive director for the committee);

	• Chief Finance Officer • Chief Operating Officer • Medical Director
4. 4.1	**Quorum and attendance** The Committee shall be deemed to be quorate if attended by one 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: • Chief Information Officer • Chief Clinical Information Officer • Chief Nursing Midwifery & AHP Information Officer • Chief Allied Health Professional • Director of Improvement • Deputy Chief Operating Officer • Head of Performance • Director of Estates & Facilities • Trust Company Secretary
4.4	The Secretary of the Committee will keep a register of attendance for inclusion in the Trust's Annual Report.
5. 5.1	**Frequency of meetings** The Committee must consider the frequency and timing of meetings needed to allow it to discharge all its responsibilities. The Committee shall meet at least four times a year but aim to meet every 2 months. The Committee Chair can call special meetings, if required.
6. 6.1	**Agenda and papers** 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.
7. 7.1	**Duties** The Committee will carry out the following duties for the Trust Board: i. Monitor operational performance areas, in particular efficiency and waiting times; ii. Review the Sustainability (Green) Strategy and monotor the

	implementation of its plan, receiving regular progress reports to scruinise delivery and the meeting of key milestones and receive an annual report on perfomance against our net zero route map; iii. Keep under review the development and delivery of the Trust's Innovation, Digital and Transformation Strategies in reponse to national guidance and emerging opportunities; iv. Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning innovation, business intelligence, digital and business intelligence investments; v. Ensure that decisions taken at a Board level, have sufficiently considered and taken account of impacts and benefits of digital and innovative approaches; vi. Receive details of innovation and digital priorities that arise from annual business planning processes and to receive exception reports on any significant risks or issues; vii. Ensure that effective digital enablers are put in place to drive innovation and the digital agenda; viii. Advise the Board on key strategic risks relating to innovation, digital, transformation, business intelligence and our green sustainability plan and review their effective mitigation; ix. Receive and review regular reports from the Information Group, Investment Group, Transformation Programme Board and Innovation and Digital Transformation Group as well as reports on the quarterly performance reviews for Integrated Clincial Service Units; and x. Review and report progress on the mitigation of relevant entries on the Board Assurance Framework and Corporate Risk reguster covered by its remit.
8.	**Reporting**
8.1	Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.
8.2	A Committee Chair's assurance will be prepared for the next meeting of the Trust Board. The Chair of the Committee shall draw to the attention of the Board key risks and concerns 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: • Trust Management Group • Information Group • Transformation Programme Board • Innovation and Digital Transformation Group • Investment Group • Integrated Clinical Service Units' quarterly performance reviews

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 July 2024 and will be reviewed, at least annually.

Meeting title	**Trust Board – public meeting**	**Date: 25 July 2024**
Report title	**Engagement Plan for Developing a clinical Strategy**	**Agenda item: 12**
Executive director lead	Charlotte Hopkins Medical Director and Jonathan Gardner Director of Strategy	
Report author	Helen Taylor Clinical Director and Deputy Director of Strategy	
Executive summary	We have a clear organisational strategy, but we have not articulated a clinical strategy to give a framework to the Whittington way of working clinically and how that can be applied to individual service lines and patient pathways. This paper outlines a proposed way forward to engage with the organisation in developing the new strategy. It builds on the previous engagement work and proposes: **Objective:** To develop a comprehensive clinical strategy that describes our approach and ways of working and the key pathways for enabling its implementation. The strategy should tell us how we will deliver our mission, corporate objectives, whilst remaining true to our values. **Approach**: a. PHASE 1: We will start with engaging on high-level ways of working and what our key patient pathways are. We will aim to bring this to the September board for further discussion and then agree it at the October board b. PHASE 2:Then with key "ways of working" and "pathways" agreed, we will then ask the agreed key pathway clinicians to co-develop implementation plans by December/January. **Scope:** Involves hospital services, community health services, and integration of care pathways.	
Purpose:	The paper is asking for Board approval of the proposed engagement plan to develop the clinical strategy. The board are asked to comment on: - Is the two phased approach sensible? - Are there other stakeholders we should consider?	

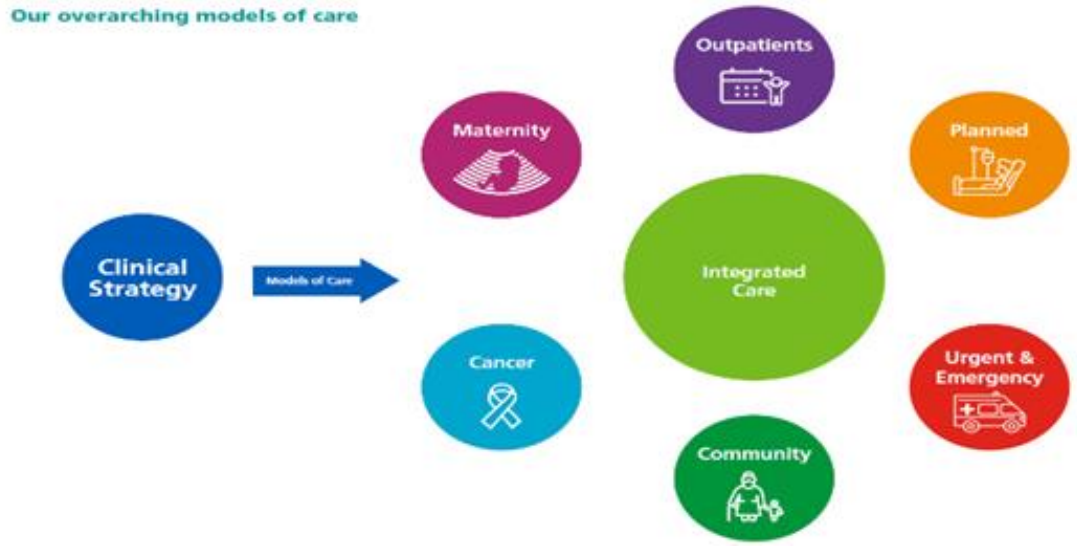
	- Are the questions for phase one and two appropriate? - Is the board happy to spend some time in September looking at the questions themselves to lead the framing of the strategy?
Recommendation(s)	Board approve the engagement plan to develop the clinical strategy
Risk Register or Board Assurance Framework	N/A
Report history	Presented at ETM on the 8th July
Appendices	Proposed Engagement plan

Engagement Plan for Developing a Clinical Strategy

1. Define Objectives and Scope of the project

- **Objective:** To develop a comprehensive clinical strategy that describes our approach and ways of working and the key pathways for enabling its implementation. The strategy should tell us how we will deliver our mission, corporate objectives, whilst remaining true to our values.
- **Approach**:
  - PHASE 1: We will start with engaging on high-level ways of working and what our key patient pathways are. We will aim to bring this to the September board for further discussion and then agree it at the October board
  - PHASE 2:Then with key "ways of working" and "pathways" agreed, we will then ask the agreed key pathway clinicians to co-develop implementation plan by December/January**. Do we agree with this proposal?**
- **Scope:** Involves hospital services, community health services, and integration of care pathways.

Example of a potential outcome of the clinical strategy work as in Morecambe Bay.



Way of working

2 Ways of approaching this process.

3. Identify Key Stakeholders

- **Internal Stakeholders:**
  - Hospital and community healthcare staff (doctors, nurses, allied health professionals)
  - Administrative and support staff
  - Clinical leaders and department heads
  - Patients and patient advocacy groups
  - Triumvirate of each service
- **External Stakeholders:**
  - Local community
  - Primary care providers
  - Local authorities and public health officials
  - Regulatory bodies (e.g., NHS England)
  - Charities and non-profit organizations
  - ICB and local NHS providers
  - UCLH
  - Voluntary Sector
- **Are there any other key stakeholders we have forgotten?**

4. Engagement Activities So Far

Summary of activity so far

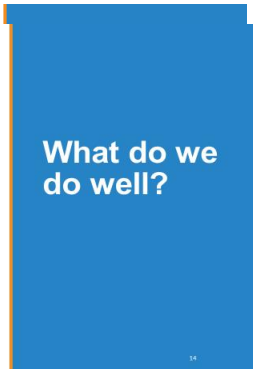
Throughout August and September 2023 , we reached out to Networks, ICSUs, and Staff Groups to establish an understanding of what is important to our workforce, what Whittington means to them, and what we can do better to achieve this.

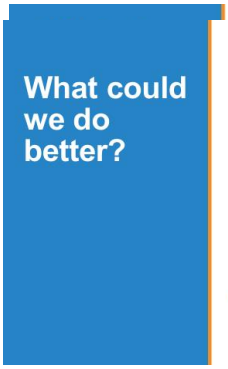
This has been explored by asking the four questions:

1. What do you want from Whittington Health?
2. What do we want to be known for?
3. What do we do well?
4. What could we do better?

This provided us with understanding what our workforce values and what should serve as the foundation of our strategy.

Summary of feedback





Key themes from engagement

Care	Our Staff	Culture	Integration	Enabler
Excellent Patient-focussed Care	Development Opportunities	Respectful	Excellent Integrated Care	Integrated and Improved Digital Services
Centre for Excellence	Teamwork	Ambitious and Innovative	Collaborative Care across Clinical Areas	Positive Working Environments
Equitable Care	Recognition	Community and Family Spirit	UCLH Partnership Working	Voice for Clinical Staff
Compassionate	Wellbeing and Support Services	Open, Transparent, and accountable	Support across all areas of the workforce	Efficient Processes

Suggestions for Improvement

Following this initial work two workshop events were held and within that key clinical themes that emerged were centred around **Compassionate Care** and **Integration**

- Compassionate care, address health inequalities, community working, patient centred, data driven insights to address needs of the diverse community and their experience, patient centred clear communication.
- Integration, enter equal partnerships, engage with patients, expand integration, take pride in integration.

6. PHASE 1 Collaborative Development

Objective: Co-create the framework for our clinical strategy and the models of care around which the clinical strategies will be created. To explain the purpose and scope. To ask the questions below to start framing our strategy.

Method:

- To ask questions of teams about the key things that are unique ways of working or things they are proud of to help frame the principles.
- With existing meetings, but also where possible multidisciplinary workshops to prioritise strategic initiatives.

List of groups:

Meeting	Date
TMG	16 July 24
MD/CD	6 Aug 24
Operational Incubator	18 July 24/1 Aug/8 Aug/15 Aug
ACW Additional Board	6 Aug 24
ACW Board	18 July 24/15 Aug 24
Trust Board	25 July 24
Staff Race, Equity, and Nationality Network	25 July 24
LGBTQ+ Staff Network	17 July/ No Aug date yet
WhitAbility Staff Network	TBC
Women's Staff Network	September date TBC
Senior Nursing and Midwifery	TBC
ADoNs meetings	TBC
AHP ICSU Leads	20 Aug 24
AHP Leadership Group	8 Aug 24

Workshop Questions:

- How do we want to work in the future?
- What are your priorities for care?
- What do your patients want?
- What are the key patient pathways around which we should organise our clinical strategy?

Surveys and Questionnaires: To gather feedback and expectations from a broad audience.

For External stakeholders they will be asked:

- What would you like us to consider in our clinical strategy formulation?

Are these the right questions?

These will be fed into a discussion at the September board for Board discussion and then agreement in October Board.

7. PHASE 2 Pathway specific clinical strategy Engagement

Throughout October to December we will engage with Divisional Clinical leadership groups and MDTs to help them create clinical strategies based around the framework that has been decided around September / October.

- Working Groups: With the Divisional Clinical leadership form groups focused on specific areas
- Scenario Planning: Discuss potential future scenarios and develop strategies to address them. Agree the parameters with the executives to frame the strategies.

Questions that can be asked are:

- How will your service specifically deliver care for patients with the priorities outlined in the strategic framework?
- What are the health inequalities you would like to improve?
- Which pathways do you want improved integration?
- What populations do you want to focus on?
- What do your patients want?
- What do your teams want to deliver?

8. Communication Plan and Key milestones

Communication plan

- **Channels:**
  - Email updates, newsletters.
  - Internal portals and community websites
  - Social media for broader community engagement
- **Key Messages:**
  - Importance of stakeholder input
  - Updates on progress and next steps
  - Key findings and decisions
- **Frequency:**
  - Regular updates (e.g., bi-weekly or monthly)
  - Immediate communication after major milestones or meetings
  - **Draft Strategy Review:** Share initial drafts with stakeholders for feedback.
  - **Feedback Sessions:** Hold meetings or workshops to discuss feedback and make necessary revisions.
  - **Public Consultations:** Host open meetings or online forums to gather wider community input.

Key Milestones

- **Week 8th July :** Project kick-off and planning complete.
- **Week 15th July :** Stakeholder list finalised and initial communication plan in place
- **Week 29th July :** Stakeholder engagement report completed.
- **Week 19th August:** Data analysis report completed.
- **Week 28th September:** Board discussion of the 'ways of working' framework
- **Week 28th October :** Board sign off of the 'ways of working' framework.
- **Week 11th November :** Clinical pathway strategies developed.

- **Week 13th January :** Final strategy implementation plan presentation delivered.

Appendix 1

The other enabling strategies

Trust Objectives	Patient experience	People	Digital	Estates
Deliver outstanding safe compassionate care	We will improve the information we provide to patients and carers to enhance two-way communication	Workforce planning and design Rewarding and recognising staff	Continuously improving models of care delivery	Improve the estate to be patient/client centred with ease access to care both physical access and transportation acc Ensure that the Trust's estate has the capacity to meet demand for healthcare in the right places, while also factoring in efficiencies and technological advances that reduce space requirements Continue to manage estate risks and meet all necessary standards
Empower, support and develop staff		Education, training and learning Becoming an employer of choice	Right information right technology to enhance staff experience and encourage innovation	Improve the quality of the estate to meet patient and staf expectations, engender pride in the organisation, and supp staff wellbeing

The other enabling strategies

Integrate partners and promote health and wellbeing.	We will improve our patients' journey ensuring we provide integrated holistic care, from the first contact and throughout their care	Employee engagement and wellbeing	Placing connected services, people and culture at the centre	supporting the co-location of services to enable integratec care through the development of networks/hubs. Maximise the opportunity of partnerships and engagement with our local community and ensure Trust plans align witl wider health economy plans. Also to work with the Greate London Authority (GLA) and local authorities to get the be value from our estate for the wider public sector priorities such as housing
Transform and deliver innovative, financially sustainable services.	We will work in partnership with patients, families and carers to build a foundation for co-design and service improvement	Performance management, maximising productivity and ensuring quality	Operating Efficiency and Effectiveness encouraging innovation and agility	Maximise the effective use of the estate to support clinica service delivery. Ensure that we have flexible and modern space in all our buildings, that it has the correct digital infrastructure, anc future proofed for innovation and technologies in care provision. Ensure that the delivery of the Estate Strategy supports th future sustainability of the organisation in terms of quality finance (reduced expenditure and contributing to a reduct in debt), effective working and environmental sustainabili We want to create a low carbon campus

Appendix 2

Morecambe Bay Service Level Clinical Strategy

Urgent and Emergency

Urgent & Emergency

Our successful model of care means:

We are committed to improving experience and outcome through greater coordination, support and planning for those who are at most risk of needing urgent & emergency care. We will work with our Place Based Partnerships to prevent escalation of care for these populations. We will have effective information, signposting and advice that support people and their families to self-care or care for their dependents.

We will provide responsive, effective and personalised age-appropriate care delivered in or as close as possible to our patient's homes, for those with non-life threatening but urgent physical or mental health needs.

Where assessment within an acute hospital setting is required our urgent & emergency care services will be fully integrated & operational 24 hours a day every day.

For those with more serious or life-threatening emergency needs, we will work in partnership with our provider colleagues across Lancashire & South Cumbria to provide timely access to expert clinical assessment and treatment with an aim to maximise the chances of survival and a good recovery.

Where admission to hospital is clinically justified, we will ensure, early decision making with senior decision maker(s), putting patient needs, not service at the centre and where necessary involving multi-specialty inputs early.

There will be a focus on maintaining independence to prevent deconditioning ensuring that all patients return to their home wherever possible.

To support delivery we will:

- Utilise our population health data to deliver prevention & population health management to improve demand management
- Optimise current and create new out of hospital pathways to prevent attendance to hospital
- Optimise streaming and single point of access arrangements for ambulatory care
- Change our approach to care provision such that each patient episode is approached as one suited to ambulatory, assessment-unit or same-day care, unless by exception
- Where an inpatient bed is clinically necessary, this exception decision will be based upon assessment of that patient by a senior, experienced clinician
- Our ambulatory care areas will be expanded and managed operationally, in collaboration with community care colleagues, such that they are able to function seven days per week
- Support the use of anticipatory care planning
- Prevent deconditioning by promoting independence and self care
- Align the 10 point plan for improving mental health responsiveness and compliance with quality standards in UEC settings
- Embrace a user perspective, seeking feedback and working with patients, families and colleagues to co-design processes to support development of high-quality services for our community
- We will develop our workforce with new skills and roles to support a sustainable workforce both now and in the future

Measures of success:

- Improved patient experience
- Improving colleague engagement scores from the NSS and pulse surveys
- Increase in use of ambulatory / same day emergency care
- Consistently be in the upper quartile for delivery against the emergency care 4 hour standard
- Ambulance handovers within 15 mins of arrival
- Reduction in harms (falls /PU)
- Reduce the number of times a patient moves for a non-clinical reason
- Reduced average length of stay for any acute admission staying >24 hrs across all specialties
- Reduce the number of patients who have been assessed as no reason to reside in an acute hospital bed.
- Reduced inequalities in access, experience and outcomes

ICARE EQUITY

NHS Whittington Health NHS Trust

UCLH Strategy

Providing High quality patient care

- We will reduce waiting times for appointments, tests and teatments to deliver national performance targets for planned and emergency care by 2024/25
- We will deliver fair access to our clinical services and work in North Central London and beyond to improve population health. This will be achieved in partnership with our residents, and neighbouring and national health and care providers, using data to target and improve health inequalities
- We will maximise the use and value of our existing hospitals and facilities and, by the end 2023/4, agree our approach to investing in our older buildings including the National Hospital for Neurology and Neurosurgery and University College Hospital at Westmoreland Street
- We will make better use of digital technology to support patients using healthcare services, including managing their appointments, accessing their healthcare records and streamlining care, by sharing records with all partners in their care pathway

Other strategies in development

- Cancer strategy which will establish how we increase radiotherapy capacity within the next five years; further develop the paediatric radiotherapy service; and the continued development of cancer partnerships, including with Whittington Health and Mount Vernon Cancer Centre. The strategy will also build on the cancer research undertaken with UCL and in partnerships across NCL, including with Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH)
- Queen Square strategy which details the vision to be the number one centre of excellence for neuroscience in the world and a national centre of excellence for NHS integrated medicine.
- Mental health strategy which sets out how we will improve the delivery of mental health care to our patients through the support and development of our staff.

Leeds Approach using Improvement methodology

Key features of our response