NHS
Whittington Health
NHS Trust

Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board held in public on **Friday, 27 September 2024** from **9.10am to 10.25am** held at rooms A1 and A2 Whittington Education Centre Highgate Hill London N19 5NF

Item	Time	Title	Presenter	Action
		Standing agenda items		
1.	*0910*	Welcome, apologies, declarations of interest	Trust Chair	Note
2.	*0911*	25 July 2024 public Board meeting minutes, action log, matters arising	Trust Chair	Approve
3.	*0915*	Chair's report	Trust Chair	Note
4.	*0920*	Acting Chief Executive's report	Acting Chief Executive	Note
		Quality and safety		
5.	*0930*	Quality Assurance Committee report	Committee Chair	Note
6.	*0940*	2023 Adult inpatient survey	Chief Nurse & Director of Allied Health Professionals	Note
		Governance and Strategy		
7.	*0945*	Whittington and UCLH Collaboration	Chief Strategy, Improvement and Digital	Note
8.	*0950*	Improvement, Performance and Digital Committee Chair's report	Committee Chair	Note
9.	*0955*	Medical Appraisal and Revalidation Annual Report	Acting Executive Medical Director	Note
10.	*1000*	Audit & Risk Committee Chair's verbal report	Committee Chair	Note
		People		
11.	*1005*	Workforce Assurance Committee report	Committee Chair	Note
		Finance and Performance		
12.	*1010*	Finance and capital expenditure report	Acting Deputy Chief Executive and Chief Finance Officer	Discuss

13.	*1015*	Integrated performance scorecard	Chief Strategy, Improvement and Digital	Note
14.	*1020*	Questions to the Board on agenda items	Trust Chair	Note
15.	*1025*	Any other urgent business	Trust Chair	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 25 July 2024

Present:	
Baroness Julia Neuberger	Non-Executive Director and Trust Chair
Dr Clare Dollery	Acting Chief Executive
Dr Junaid Bajwa	Non-Executive Director (from item 2)
Dr Charlotte Hopkins	Acting Medical Director
Naomi Fulop	Non-Executive Director
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
Liz O'Hara	Chief People Officer
Tina Jegede MBE	Joint Director of Inclusion & Nurse Lead, Islington Care Homes
Dr Elinor Sefi	Consultant Paediatric Oncologist (item 1)
Marcia Marrast-Lewis	Assistant Trust Secretary
Andrew Sharratt	Director of Communications and Engagement
Mirela Sidor	Patient Experience Manager (item 1)
Swarnjit Singh	Joint Director of Inclusion and Trust Company Secretary
Helen Taylor	Joint Clinical Director, Acute Patient Access, Clinical Support Services, Women's Health ICSU (item 12)
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.
1.2	Glenys Thornton advised that, following the General Election, there would be changes needed to the register of interests for her and that she would communicate these in due course. Junaid Bajwa reported that, from 1 September, he would step down from his position as Chief Medical Scientist at Microsoft Research, to take up a position as the Senior Partner Head of UK and Science Partner Pioneering Intelligence at Flagship Pioneering.

	The Board noted the changes to declared interests for Junaid Bajwa and noted that changes to Gleny's Thornton's interests would be communicated in due course.
2.	**Patient story**
2.1	Sarah Wilding introduced Mr X, who had attended the meeting to talk about his experience as a patient receiving treatment and shared care from Whittington Health and University College London Hospital (UCLH), and the Royal Free Hospital for leukaemia. Mr X said that he received exemplary care at Whittington Health over a period of three years and four months and highlighted the following points: • In 2018, he was diagnosed with acute lymphoblastic leukaemia when he was 16 years old, shortly before he was due to sit GCSE examinations. • Despite the shock of his diagnosis, Mr X continued to revise and prepare for his exams while he underwent treatment. He recalled that a significant amount of his revision took place at hospital, while he received chemotherapy. Mr X passed all of GCSEs with an A* grade and began his A-level studies. • During this time, he was still receiving treatment but was adamant that he would not allow his illness to derail his life. He was a keen sportsman and led a very active life. He played sports and made time to train and run a 5k charity race to raise money for cancer charity. • Mr X acknowledged that the standard of care he received as a patient from NHS organisations had been exemplary. He also felt that the care he received at Whittington Health was more personal. He stated that he developed good relationships with all the clinicians that dealt with him at Trust. In addition, he could easily reach his Consultant to talk through any issues or problems that were of concern to him, as she was always available to talk to him. • Mr X greatly appreciated the consideration shown by his Cancer Nurse Specialists, Sonal and Laura, who would bring his chemotherapy treatment to his school so that he would not miss out on lessons by attending hospital.
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 and that adding a personal touch could make all the difference to patient experience. • Glenys Thornton felt that Mr X's account of his experience at the Trust fully demonstrated the importance of a good local district general hospital in the community. • Clare Dollery informed the Board that the results of the national Cancer Survey Patient Experience mirrored Mr X's experience, in that the Trust had demonstrated a year-on-year marked improvement in the experience of patients receiving cancer care here. • Clare Dollery asked Mr X how he felt being treated for leukaemia during the pandemic, as many young people struggled with their mental health at that time. In response, Mr X said that, throughout the pandemic, he was in

	maintenance therapy, stable and abreast of his treatment schedule. He was, by this time, aged 18, his hair had grown back, and he could socialise with his friends. He felt it would have been very different if he had been newly diagnosed. Mr X explained that he did comply with the Government's recommendation to stay inside and was diligent when it came to hand washing and wearing a mask. The main challenge was uncertainty around the impact of the pandemic on life in general and the risk of contracting Covid-19. • Amanda Gibbon asked how his treatment was managed at the Trust once he started university. Mr X explained that, after his A-levels, he took a gap year and spent some time in Israel where he was able to continue his treatment. He reported that the handover of his care to the Schneider Children's Medical Centre in Israel was relatively smooth. Mr X also outlined that the links in London between the acute site and community services were seamless. He said that community nurses from the Royal Free Hospital would come to his school or home to take blood, and that this was very convenient and made a big difference to his life. He also welcomed the fact that Cancer Nurse Specialists were always contactable on their mobile phones during working hours. • Mr X found sport was extremely beneficial to his recovery. He had attained a good level of fitness before he became ill and, despite advice to the contrary, he continued to participate in sports and exercise, which had helped him to respond well to treatment and had a very positive impact on his mental wellbeing. • Mr X confirmed that he was keen to advocate for sports and exercise for similar patients. He was in the process of building a relationship with the Lead Physician at the Schneider Children's Medical Centre in Israel to promote the benefits of exercise and make it a standard of care, along with medical treatment. Mr X said that he had successfully convinced them to start a clinical trial of exercise with medication for patients. Dr Tracie Goldberg, Attending Physician, had written up the protocol which was approved under the World Medical Association Declaration of Helsinki. Steps had been taken to secure research funding. However, the current conflict in the Middle East had paused the project for the time being. • Chinyama Okunuga suggested that Mr X had the qualities needed to become a future leader in the NHS. In response, he informed Board members that, during his Mathematics with Management studies at University College London, he had considered medicine, but did not feel able to commit to a medical degree at that time. • Tina Jegede said that there were forums where his story would be well-received and he might consider sharing his experience with the North Central London Integrated Care Board (NCL ICB), who would be interested in hearing his account of his experience with three different organisations in the sector. **The Chair thanked Mr X for sharing his experiences with Board members and agreed that Mr X's patient experience be shared with the NCL ICB to demonstrate the benefits of partnership working for patients in this service.**

3.	**Minutes of the previous meeting**
3.1	The minutes of the meeting held on 24 May 2024 were approved subject to amendments in paragraph 2.1 where gastro would be replaced with gastric and in paragraph 5.3 where the National Institute for Clinical Excellence(NICE) should be amended to read as the National Institute for Health and Care Excellence. The updated action log was noted and there were no matters arising.
4.	**Chair's report**
4.1	The Chair thanked all staff and volunteers for their continued hard work in the delivery of safe services and a good experience for patients in the face of significant demand for services, and the additional pressures caused by ambulance diversions to Whittington Health.
4.2.	The Chair confirmed that her annual appraisal had been carried out by the Senior Independent Director using the updated Chair's Appraisal Framework issued nationally. The outcome was reported to NHS England (NHSE) by the deadline of 30 June. The Chair advised that appraisals of non-executive directors had been completed in accordance with the Leadership Competency Framework produced by NHSE.
4.3	The Chair thanked the Communications team for organising the successful staff awards event which took place on 4 July at the Royal College of Physicians. It was a thoroughly enjoyable night, made even more memorable with Michael Rosen as the master of ceremonies. **The Trust Board received and noted the Chair's report.**
5.	**Acting Chief Executive's report**
5.1	Clare Dollery presented the report and highlighted the following issues: • An agreement had been reached with speciality and associate specialist doctors who had accepted a pay offer. Discussions would continue to take place with junior doctors to negotiate a pay deal. She confirmed the British Medical Association's ballot for collective action had opened for GP partners in June and would close on 29 July. If the vote was to take collective action, this could happen from 1 August. It could impact the number of GP appointments made available to patients, as well as other activity outside of their core contract. She assured Board members that the Trust would work with the NCL ICB to prioritise patient safety during any period of collective action. • A fire safety week had been held during 22-26 July. All staff were actively encouraged to participate. Activities included daily reminders of fire risks and hazards and the steps that staff could take to protect themselves and patients, including familiarisation with evacuation routes. • There were significantly more patients attending the emergency department in June, as well as increased patient acuity. A working group had been set up to improve emergency care pathways and, following successful discussions with Haringey Social Services, it was agreed that two social workers would work on the hospital site for two days per week.

	• The recent global IT outage did not impact services across the Trust. • A new computer tomography scanner had been installed in the emergency department and would help to improve patient experience. • The Neonatal Intensive Care Unit had been officially accredited with Gold status in the Bliss Baby Charter Scheme. • She had attended the formal opening of the Highgate East Mental Health building. The facility was located on the site of the old Whittington Health Education Centre and provided beds for 78 inpatients. The event was attended by Alastair Campbell and Jeremy Corbyn MP. She said that the new service would provide an opportunity for Whittington Health to expand its clinical collaboration with colleagues at the North London Mental Health Partnership.
5.2	In discussion, Board members raised the following points: • Nailesh Rambhai sought clarification around the financial aspects of the land on which the Highgate East Mental Health building was built. In response, Clare Dollery confirmed that the land was previously owned by Whittington Health and was sold to Camden and Islington NHS Foundation Trust. • Nailesh Rambhai thanked executive director colleagues for the prompt response to the information technology outage and the speed at which efforts were made to communicate and assure non-executive directors that the Trust had had not been adversely affected. • Junaid Bajwa asked whether the Trust should consider if there was an opportunity for input into the review of the state of the NHS led by Lord Darzi. Clare Dollery stated that the Trust was an important source of information and every opportunity to comment on the review would be considered. **The Trust Board noted the Acting Chief Executive Officer's report.**
6.	**Quality Assurance Committee Chair's report**
6.1	Naomi Fulop took the report of the meeting of the Committee held on 10 July 2024 as read. She highlighted a presentation 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. Committee members were advised that the service focussed mainly on frail patients who had suffered a fall. Since the start of the project, an additional 60 to 70 patients had remained at home during the period between mid-November 2023 and April 2024. Committee members received assurance that the LAS would undertake further data analysis to determine whether the patients who remained at home were later taken to hospital.
6.2	The Committee escalated the following three items for the attention of the Board: • A higher number of community pressure ulcers, which was linked to the ongoing NRS equipment issues. The Committee received partial assurance on the pressure ulcer update, specifically around the ongoing

	issues with the timely delivery of pressure relieving equipment by NRS. She felt that more should be done to compel NRS to fulfil their contractual obligations, as the issues had been ongoing for more than one year. As a result, patients in the community had experienced longer waits for the delivery of equipment. Naomi Fulop acknowledged that the Trust could purchase equipment up to the value of £500 and suggested that the Trust should purchase more expensive items and invoice NRS for the cost. She also suggested that the issue should now be escalated to NHSE. • Risks associated with the transfer of the fragile Barnet 0-19 service. Although the Committee had received assurances that strong plans were in place to mitigate risks and improve the service, they were expected to take effect after an initial two-year period of recovery. • The management of ligature risks across the Trust. The Committee was informed that risk assessments were carried out which identified five high risk areas. An action plan of works had been shared and capital funding in the amount of £500k had been approved to commence the work, which was expected to take between 8 and 14 weeks to complete.
6.3	During discussion, Board members raised the following points: • Clare Dollery confirmed that the Trust had written to NRS on two occasions to inform them of the impact on patient care and experience. She confirmed that NRS's delays had also been raised at the North Central London Strategic Management Board and would be discussed by the Trust's Executive team. • Terry Whittle confirmed that the Trust had no powers to rescind or vary the terms of the contract, which was between NRS, the London Borough of Islington and the NCL ICB. He suggested that a letter could be sent to the London Borough of Islington to make some contractual deductions. The Chair suggest that contact should be made first with the leader of Islington Borough Council. • Nailesh Rambhai highlighted the Annual Population Health report considered at the meeting and queried how that data would be used. Naomi Fulop commented that the high quality data would inform the next steps to be taken with Population Health work. Jonathan Gardner explained that a redrafted action plan would better explain how priorities would be achieved and how the strategy was implemented. He confirmed that an updated report would be considered by the Quality Assurance Committee in quarter three. • Amanda Gibbon reported that she also was Chair of the Population Health Committee for the Royal Free Hospital and agreed that the data should be reviewed on an individual provider basis, as this could deliver more joined up working across the NCL sector. • Charlotte Hopkins drew Board members' attention to the Core20plus5 data which had been reported at NCL ICB level and looked at different outcomes across the five clinical areas of focus for adults and children. She suggested that the Trust should also look at what had been done in specific areas. **The Board noted the Chair's assurance report for the Quality Assurance Committee meeting held on 10 July 2024.**

7.	**Finance and capital report**
7.1	Terry Whittle reported that, at the end of May, the Trust had a deficit of £9.5m, which was £4.3m adverse to plan. He explained that there were several factors behind this: • Industrial action costs of £65k, and loss of income of £45k • Pay overspends for enhanced care services, general wards, domestics and unfunded pay pressures of £1.6m • Non-pay overspends of £1.8m • Underdelivery against cost improvement programme (CIP) targets. The monthly profiled target was £1.4m and £2.7m was achieved at the end of May; the annual CIP target remained at £16.6m • The Trust had spent £4.4m on agency staff in quarter one which was £600k above the agency cap. • The Trust had spent £1.4m on additional urgent and emergency care beds. Action had been taken to reduce the number of escalation beds from 43 to 25, but it was expected that winter monies would be fully utilised by the end of July. Discussions would continue with NCL ICB to access further funding for winter. • Income was £2m above plan. The Trust had underperformed as a result of the loss of cancelled outpatient and day case activity due to industrial action. • Focussed work was ongoing to improve the delivery of CIP schemes and to generate more recurrent savings. Currently, one-third of schemes in delivery were recurrent and two-thirds non-recurrent.
7.2	Terry Whittle confirmed that the five ICBs in London had a cumulative deficit of £288m; in NCL, the deficit was currently £43m. He reported on actions being taken across the NCL sector and in individual organisations to maintain financial sustainability.
7.3	Terry Whittle reported that capital expenditure at the end of June was £1.86m and that the Trust's capital allocation had increased to £12m. He advised that discussions would continue to take place for a capital allocation for fire remediation works and that additional funding would also be requested for urgent and emergency care and for the cost of industrial action.
7.4	In discussion Board Members raised the following points: • Rob Vincent observed that NHS was very focussed on the financial performance of the current year, but also needed to be looking ahead. He suggested that some time should be allocated to discuss financial plans beyond the current year. • In response, Terry Whittle confirmed that work had begun on financial plans for 2025/26 using the national funding regime and would be considered by the Finance and Business Development Committee. • Nailesh Rambhai reflected that good progress had been made with the delivery of CIPs compared to the same time in the previous year. He noted that the capital allocation for 2024/25 was less than half of the capital expenditure outturn in 2023/24.

	The Board noted the month three finance and capital expenditure report.
8.	**Integrated Performance Report**
8.1	Jonathan Gardner apprised the Board of the following headlines: • The launch of the graduated response for children with speech, language and communication needs in Haringey resulted in more children having their initial needs met by school interventions. Referrals had reduced and the numbers on the waiting lists were falling. Barnet was still challenged and speech and language referrals continued to exceed the available capacity each month. In the occupational therapy service, waiting times had decreased. • There was one hospital attributed case of MRSA in June 2024. This was a complex case and an after-action review found new learning that would have a good impact on future case management. • 63 patients were expected to have waited longer than 52 weeks for treatment at the end of September. 33 of these patients were in the lower urinary tract service where demand was high. • Cancer waiting times had seen improvement against the 28 and 62 day standards. Work would continue to improve cancer pathways, with a focus on gynaecology and breast in the next quarter. • Performance against the emergency department four hour waiting standard was 71.8%. There were more attendances in the emergency department in May and June compared with January and February. • Performance on response times to complaints had seen a gradual improvement. • Staff appraisals rates had seen an improvement of 0.9% from May's performance of 76.1% • Staff sickness rates had increased from 3.6% to 3.9% in May
8.2	Amanda Gibbon commented that the declining number of births was a cause for concern. She also observed that DNA rates for outpatient follow-up appointments were red-rated and was an area to be looked at over the longer term, as it was a population health measure. **The Board noted the Integrated Performance Report.**
9.	**Workforce Assurance Report**
9.1	Rob Vincent delivered a verbal report and apprised the Board of items discussed at the Workforce Assurance Committee meeting held on 22 July 2024. He highlighted the following issues: • The Risk Register report which recorded two new risks related to staffing: first, the workload of the children's safeguarding team; and secondly, the Barnet 0-19 service. • The Committee had welcomed an excellent Religion and Belief Guide, written by the Inclusion team to raise awareness amongst front line and other staff about religion, belief, culture and dietary and end of life preferences for our diverse patient community. • The Committee has also welcomed annual pay gap reports for gender, disability and race.

	• The findings of the People Pulse Survey. **The Trust Board noted the verbal report for the Workforce Assurance Committee held on 22 July 2024**
10.	**Audit & Risk Committee Chair's Assurance Report**
10.1	Amanda Gibbon presented the written report for the meeting held on 20 June 2024. She highlighted the following issues: • Capital expenditure in the previous financial year totalled £43.1m – the highest level ever achieved at Whittington Health. This was in stark contrast to the £10m capital allocation received for 2024/25. • A full evaluation of the estate had been carried out which resulted in a £28m impairment. This had been accepted by KPMG. • For the value for money assessment, KPMG concluded that a significant weakness had been identified associated with the Trust's financial sustainability. This related to the achievement of the CIP savings. It was hoped that this weakness would not be included in next year's audit. • The overall partial assurance rating with risk management arrangements within the Emergency and Integrated Medicine clinical division. • The overall partial assurance rating on the internal audit review of discharge management. • The appointment of a new counter-fraud team. **The Trust Board noted the Audit and Risk Committee Chairs Assurance report held on 20 June 2024.**
11.	**Information Performance & Digital Committee Chair's Assurance report**
11.1	Junaid Bajwa outlined the items from which Committee members were able to take good assurance: • A deep dive on the Urgent and Emergency Care pathway • An Improvement Programme update • A Cyber security update which included the Data Security and Protection Toolkit submission • The Board Assurance Framework • An update on information management & technical systems. The Committee discussed the 2024/25 capital plan which had allocated £400k for information technology. The Committee agreed that the level of capital was insufficient to manage the IT infrastructure on a year-on-year basis. **The Board noted the Committee Chair's report for the meeting held on 25 June 2024 and approved the revised Committee terms of reference.**
12	**Engagement Plan for the development of a Clinical Strategy**
12.1	Jonathan Gardner thanked Charlotte Hopkins and Helen Taylor for their work to develop a Clinical strategy. Helen Taylor outlined the methodology proposed to engage with stakeholders. She explained that the engagement plan described set out the Trust's approach, ways of working and the key pathways for its implementation.

12.2	Helen Taylor drew the Board's attention to appendix one of the proposal ,which outlined the other enabling strategies and appendix two, which showed Morecambe Bay's service level clinical strategy for their urgent and emergency care pathway, which could inform the way in which the Trust's strategy was developed.
12.3	In discussion, Trust Board members raised the following points: • Naomi Fulop queried how the strategy would inform clinical pathways. In reply, Charlotte Hopkins explained that a design meeting had taken place and the aim was for clinical teams to develop pathways which addressed population health priorities and reduced health inequalities. • Terry Whittle stated that the development of the clinical strategy was timely, as the current changes to EPIC and EPR clinical systems would make a difference to pathways. • Amanda Gibbon advised that the Royal Free Hospital had recently refreshed its clinical strategy which could provide some valuable insights for the Trust, particularly in relation to fragile services. She wanted to see a greater focus on collaboration work with UCLH, which should underpin the strategy. • Glenys Thornton also supported the inclusion of collaboration work with UCLH in the strategy. • Clare Dollery was pleased that this important work was under way and emphasised the need for good collaboration with system partners. • The Chair supported the need to include collaboration with UCLH, alongside alignment with the NCL ICB's strategy. She also advised engaging with Local Members of Parliament. **The Trust Board approved the engagement plan to develop the clinical strategy.**
13	**Any other business**
13.1	There were no items raised.

Trust Board, action log

July 25 meeting

Agenda item	Action	Lead(s)	Progress
Patient story	Share Mr X's patient story with the NCL ICB as a good example of partnership work between different NCL partners	Patient experience team	Completed
QAC Chair's assurance report	Contact the leader of Islington Borough Council to escalate issues with NRS equipment supplies	Clare Dollery	Completed

Action carried forward from January 2024 meeting

Agenda item	Action	Lead(s)	Progress
Patient story	Complete 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	This action has been included as Quality priority for 2024/25 and progress will be monitored by the Quality Assurance Committee

Meeting title	**Trust Board – public meeting**	**Date: 27 September 2024**
Report title	**Chair's report**	**Agenda item: 3**
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 25 July 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 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.

July private Board meeting

The Board of Whittington Health held a private meeting on 25 July and discussed two main items relating to Simmons House and a report from the authorised fire engineer.

Naomi Fulop

This is Naomi Fulop's final meeting as a non-executive director on the Board of Whittington Health. She joined us in October 2018 and has been a passionate advocate for patient safety and patient experience. On behalf of all Board members, I would like to thank her for her service and wish her well. She has been a wonderful member of the Board.

Annual General Meeting

The Trust is holding its annual general meeting in the Whittington Education Centre on 27 September and I look forward to seeing as many members of staff and the public as possible, as we look back on our achievements in 2023/24 and look forward to future priorities.

I have also participated in the following meetings and events:

- On 2 August, I met with Catherine West MP
- On 14 August I attended a meeting of the North Central London Integrated Care Board's Strategy and Development Committee
- On 9 September, I took part in corporate induction training and welcomed new starters to Whittington Health.
- I had an induction meeting with the new Chair of the North Central London Integrated Care Board on 12 September
- I have held meetings with colleagues in advance of local Overview and Scrutiny Committee meetings

Meeting title	**Trust Board – public meeting**	**Date: 27.09.2024**
Report title	**Chief Executive report**	**Agenda item 4**
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. Board members are also asked to approve the Trust's revised Communication strategy which establishes a framework for enhancing communication and engagement across the organisation and with local people. The strategy was developed through engagement with key stakeholders and has been agreed by the Trust's Management Group.	
Purpose	Approval	
Recommendation	Board members are invited to note the report and to approve the 2024/28 Communication Strategy shown in appendix 1.	
BAF	All Board Assurance Framework entries	
Appendices	1: 2024/28 Communication Strategy	

Acting Chief Executive report

Independent Investigation of the NHS in England

In July, Lord Darzi was commissioned to conduct an independent and rapid investigation of the NHS. His letter to the Rt. Hon Wes Streeting, Secretary of State for Health and Social Care, report and technical annex were published on 12 September and analyses current NHS performance across England and the challenges facing the healthcare system[1]. The review also identified the following major themes for inclusion in the forthcoming 10-year health plan, due for publication in Spring 2025:

- Re-engage staff and harness their talents to make positive change and empower patients to take as much control of their care as possible.
- Lock in the shift of care closer to home by hardwiring financial flows and expanding general practice, mental health and community services to adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population ages.
- Simplify and innovate care delivery for a neighbourhood NHS by embracing new multidisciplinary models of care that bring together primary, community and mental health services.
- Drive productivity in hospitals through better operational management of patient flows, capital investment in modern buildings and equipment, and empowering staff.
- Utilise the benefits of digital systems to help unlock productivity and the enormous potential in Artificial Intelligence to transform care and for life sciences breakthroughs to create new treatments.
- Contribute to the nation's prosperity and the capacity of the NHS to get more people off waiting lists and back into work.
- Clarify roles and accountabilities and ensure the right balance of management resources in different parts of the NHS structure and strengthen key processes such as capital approvals.

NHS leadership events

I took part in four leadership events in September. The first, held on 9 September, was follow-up workshop on the future of primary care in London held on 14 August and brought together clinical and managerial leaders to agree next steps in relation to integrated neighbourhood working and supporting the sustainability of primary care. Two other events took place on 3 September and 10 September and were organised by NHS England and its London regional team. The Secretary of State for Health and Social Care attended and discussed the mission of the new government to meet the challenge of a broken but not beaten NHS and keep it free at point of access so it is here when the population need it. He highlighted plans to move care from hospital into the community, to transform from analogue to digital and to shift emphasis from treatment to prevention. I have also attended a winter risk meeting considering Criteria to admit, Discharge and Flow and mental Health long waits.

[1] Summary letter from Lord Darzi to the Secretary of State for Health and Social Care - GOV.UK (www.gov.uk)

Chief Nursing Officer for England
I am really pleased NHS England announced on 25 July that Duncan Burton had been appointed as Chief Nursing Officer for England, with immediate effect, following Dame Ruth May's departure after 40 years of dedication and service. Duncan brings a wealth of experience, including previous senior roles at University College Hospitals NHS Foundation Trust (ULCH), Kingston Hospital NHS Foundation Trust and at Frimley Health NHS foundation Trust.

Royal College of Nursing
I would like to congratulate Professor Nicola Ranger who was confirmed in July as the new General Secretary and Chief Executive of the Royal College of Nursing after a comprehensive and external recruitment process. It was my pleasure to welcome Nicola to our hospital site on 5 September where she met and spoke with staff.

Chris Streather, NHS London Chief Medical Officer
I was pleased to meet Chris Streather, NHS England London region's Chief Medical Officer during a visit hosted by our Interim Medical Director on 31 July. Dr Streather visited the Emergency Department and our Neonatal Intensive care unit where he was able to discuss the Start Well proposals with staff.

Industrial action
Members of the British Medical Association voted to accept the Government's offer of a 22% pay deal spread over two years. This brings to end the 18-month dispute which saw junior doctors take part in 11 separate strikes. At the same time, primary care doctors are continuing to take collective action as part of a formal dispute with NHS England over changes to the GP contract. I am grateful to Charlotte Hopkings, Acting Medical Director, who has been liaising with local GPs through the Clinical Interface Group to manage any adverse impact on Trust services and further the implementation of the interface agreement with primary care colleagues .

NHS pay award
On 29 July, the Government announced that it would accept in full the recommendations from the pay review body for a 2024/25 pay award of 5.5% for staff covered by Agenda for Change terms and conditions of service. This increase is expected to be reflected in October's payroll.

Riots and NHS and Trust response
As we know, the nation experienced significant violent and racially motivated unrest and rioting in August where some healthcare workers were targeted. This situation understandably created a climate of fear for our black and minority ethnic communities and staff. I want to re-iterate the messages sent out to staff at that time at the Trust, and nationally, by the NHS Chief Executive, Amanda Pritchard, setting out support for our staff, highlighting our values of respect and compassion, and making clear our abhorrence of the racism and islamophobia displayed against ethnic minority staff, whose dedication and commitment, the NHS relies on daily.

On 22 August, Isabelle Cornet, our Director of Midwifery, organised a listening event for maternity and neonatal staff to share their feelings and concerns about the riots. Our Chief Nurse was present to hear our staff. Staff who fed back said that they felt

safe and supported at Whittington Health itself, but that they, along with family and friends, felt less safe when travelling, especially in the evenings. Many noted that their children had been affected, not wanting to play on the street or to attend after-school activities. I am grateful to Kate Brinkworth, Chief Midwifery Officer for England, Nina Khazaezadeh, Regional Chief Midwife for London, and Baroness Glenys Thornton, one of our Non-Executive Directors, for attending this event and supporting our staff. I am also proud to join an event on 25 September, organised by our community services staff at Manor Gardens who will stand outside their building to say no to racism, islamophobia and any form of discrimination in our community.

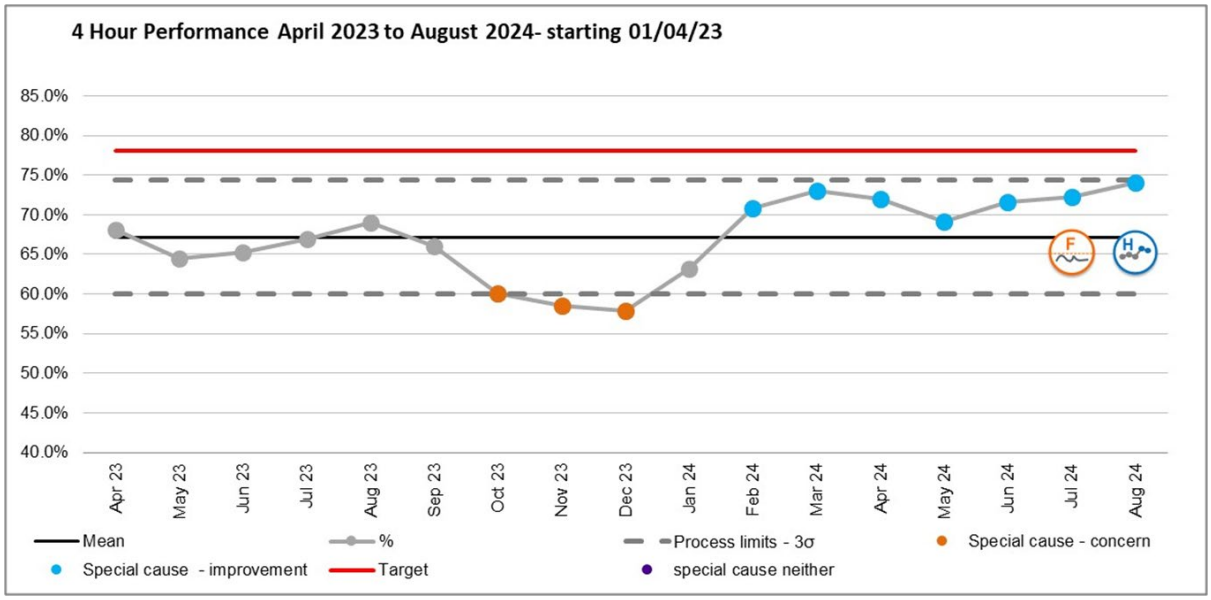
Death certification reform
On 9 September, changes came into force for the process of death certification in England and Wales which require an independent review to be carried out for all deaths, without exception. This will either be provided by independent scrutiny by a Medical Examiner or by investigation by a Coroner. The Whittington Health Medical Examiners' team are fully prepared for this rollout.

Haringey Borough Partnership
On 11 September, I attended a meeting of the Haringey Borough Partnership's Executive Board for Housing and Health where there was a good discussion about a better, joined-up approach between health, social care and service users, working together on housing and support pathways. A pilot exercise, funded by Whittington Health and the North London Mental Health Partnership is to be developed to support discharge pathways as a next step in this work.

National Adult Inpatient Survey Results
I am pleased that Whittington Health was one of the most improved NHS trusts in the outcomes from the 2023 national adult inpatient survey, published by the Care Quality Commission on 21 August. The survey outcomes are reported separately in an item on today's meeting agenda and I am grateful to the patient experience team and Sarah Wilding, Chief Nurse and Director of Allied Health Professionals, for their leadership in this area and for all the individual acts of caring by our staff which helped achieve this improvement in patient satisfaction.

2024 NHS staff Survey launch
On 23 September, the 2024 national staff survey launches and I encourage all of our staff to complete this important feedback to provide priority areas for action going forward.

Operational pressures and Emergency Department performance
The NCL sector faces ongoing pressures with frequent London Ambulance Service diversions and postcode redirections, leading to a high volume of out-of-borough arrivals. In August, emergency department attendances decreased to 8,258 from 9,125 in July, reducing the daily average from 302 to 266 patients. Patients waiting 12 hours to be admitted has reduced.



Communication and Engagement strategy
I would like to thank Andrew Sharratt, Director of Communication and Engagement, for the work his team have done to develop our 2024/28 Communication strategy. This has been produced through engagement with stakeholders and is brought to the Board for approval.

Fire safety
As part of a continued focus on fire safety, Whittington Health held a Fire Awareness Week during 22-26 July. One of the activities undertaken was a no notice fire evacuation exercise in the Jenner Building on 25 July, to test how effectively staff evacuate the building to a fire assembly point. There was valuable feedback shared, including the importance of staff familiarisation with fire egress routes and assembly points. I am grateful to Lee Smith, our Emergency Planning Officer, and to the Estates and Security team for making this a successful week.

CEO staff briefings
In August, staff attended briefings which covered items such as the unrest and rioting, the outcome of the 2023 national cancer patient experience survey; actions being taken as part of our financial sustainability programme; the launch of a new rota tool for clinical colleagues; an update on the North Central London review of performance in urgent and emergency care services; gene therapy treatment for thalassaemia patients; the annual awards for Allied Health Professionals; and work taking place on the refurbishment of mortuary services. The briefings held so far in September covered topics such as the review of our clinical strategy; a new electronic prescription system for community-based teams; Lord Darzi's review of the NHS; and the important learning from our Fire Safety Week.

Service visits
On 1 August, I had the pleasure to visit our District Nursing team at Hornsey Rise. I also saw the wonderful Multi-Agency Care and Coordination team along with the Mobility, Seating and Solutions team at Bounds Green and Edwards Drive on 6 August. I attended a meeting of our Pharmacy team on 19 August and visited the

acute paediatric service on Ifor ward on 20 August. On 16 September, I visited our Clinical Nurse Specialists in the children's outpatient department.

Northern Health Centre, Holloway Road
On 6 September, I visited the Northern Health Centre with Jeanette Barnes, our Associate Director of Nursing, in the Children and Young People clinical division, and met staff who work in our children's community nursing team.

Tynemouth Road Health Centre
On 12 September, I enjoyed a visit to meet members of the children in care and community paediatric teams.

Senior staff changes
I am pleased to announce two substantive appointments to Director of Operations roles. Ashley Nwanze will take up this role in our Surgery and Cancer clinical division and Jennifer Wilkins will have that responsibility for the Acute Patient Access, Clinical Support Services and Women's Health clinical division. I congratulate them both. In addition, I am also pleased to report that Iolanda Pedrosa has been appointed as our Chief Information Officer.

Queen's Nurse title
I am delighted that a number of colleagues have been awarded with the Queen's Nurse title. The Queen's Nurse title is awarded to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice. On behalf of the executive team, my congratulations go to:

- Maameya Adabie, Associate Director of Nursing, Adult Community Services
- Daryl Parker, Joint Head of Islington Community Child and Adolescent Mental Health Services
- Madeline Oliver, Team Leader and Health Visitor Specialist Community Public Health Nurse
- Grace Adjei-Clinton, Senior Haemoglobinopathy Nurse, Genetic Lead Counsellor and a Paediatric Community Sickle cell and Thalassaemia nurse

NHS Parliamentary Awards

The NHS Parliamentary Awards were created in 2018 to celebrate and recognise the outstanding contribution of staff, volunteers and others working in the health and care sector. I am delighted to announce that Huda Mohamed MBE has been shortlisted for the 2024 Parliamentary Award's Nursing and Midwifery Award. She will join other shortlisted health and care staff at a celebratory award event on Monday, 14 October. Huda has been the Female Genital Mutilation Specialist Lead Midwife at Whittington Health N since 2016, and in 2024 was awarded an MBE for services to midwifery.

Black and Minority Ethnic Health & Care Awards
I congratulate Professor Monica Lakhanpaul who works in paediatric service for being shortlisted for the Groundbreaking Researcher category at these annual awards in recognition for the work and research she has carried out, and its potential to improve health outcomes of patients and communities In addition to her nomination, recently Monica was awarded an honorary doctorate of science from DeMontfort University and was also appointed the Strategic Lead for Children at National Institute for Health Research.

Extra Mile Awards
Congratulations and many thanks to our Extra Mile winners in July 2024, Sarah Batehup and Ruth Wetherall, for going above and beyond in providing care and support to patients and colleagues. Sarah Batehup is the Allied Health Professionals Clinical Lead in our Haringey Multi Agency Care & Coordination Team. Sarah gave extraordinary support to a Physiotherapy student with a registered disability on a placement here and who was in London for the first time. Sarah reminded me of the important historical role the Whittingotn has played in training visually impaired people to be physiotherapists.

Ruth Wetherall is our Acute Liaison Learning Disability Clinical Nurse Specialist, responsible for providing support to patients. Her nomination was for giving support to two patients making personal visits alongside providing care bags and turning a dreaded experience into a positive one.

August's winners of the Extra Mile Award saw acknowledgements for Sebastian Kwok, our Postgraduate Medical Education Manager, who was nominated for supporting postgraduate staff members and delivering high quality teaching and the intranet and web team who have continued to innovate while also addressing downtime due to external issues

For September, the winners of Extra Mile Awards are Taf Musendo and Cristina Aguiar. Taf Musendo is a matron working in the community as part of the Virtual

Ward. His nomination related to his care and compassion for vulnerable patient who needed to navigate several services and Trusts and he was nominated by a GP.

Cristina Aguiar, our Endoscopy Unit Manager, was nominated for being an excellent and supportive manager under whose leadership the unit has expanded and staff are being trained to become nurse endoscopists thus enabling Whittington Health to be a training centre with NHS England's Workforce, Training and Education Directorate (formerly Health Education England).

NHS
Whittington Health
NHS Trust

Communications Strategy

Contents

Executive Summary

The Whittington Health Communications Strategy 2024-28 establishes a framework for enhancing communication and engagement across the organisation. It flows from our organisational vision – to help local people live longer, healthier lives – and the strategy objectives that support the vision.

This strategy underscores the critical role of effective communication in achieving our Trust's goals, maintaining the trust that our patients and community have in us, ensuring that our colleagues have the information they need to perform their roles effectively, and maintaining positive sentiment amongst our stakeholders for the work that we do.

We have delivered a great deal since our last communications strategy, and we continue to provide high quality business-as-usual communications support to the organisation. This strategy sets out how we will refine this, as well as setting out some large, long-term strategic projects that we hope to complete over the next four years. These projects aim to enhance Whittington Health's communications architecture and provide step-change improvements in the communications function's performance.

The following activities will support the organisation to achieve each of our corporate objectives:

Deliver outstanding safe and compassionate care in partnership with patients:

- Conduct stakeholder and community perception surveys to inform improvements
- Develop and implement a comprehensive engagement toolkit for staff
- Modernise hospital wayfinding and signage for better patient navigation

Empower, support and develop engaged staff:

- Overhaul the intranet to provide a more user-friendly and efficient platform
- Create a centralised brand toolkit to ensure consistency and professionalism in communications and allow our colleagues to quickly 'self-service' when they have simple communications product needs
- Roll-out the Whit-Team briefing system organisation-wide
- Refresh and unify the wellbeing brand to better support staff

Integrate care with partners and promote health and wellbeing:

- Redesign the website to improve user experience and accessibility
- Increase participation in external awards to showcase excellence and innovation
- Work alongside partners, including UCLH and NCL ICS, to promote the benefits of partnership and integrated working to our colleagues, stakeholders, patients, service users and community

Transform and develop sustainable and innovative services:

- Develop a cohesive brand for the improvement program to unify various initiatives
- Provide resources and tools to support new, efficient ways of working

The Whittington Health Communications Strategy 2024-28 is designed to foster a culture of effective communication, ensuring alignment with organisational goals and stakeholder needs, to support the Trust to deliver on its vision. Our communications vision is to "Ensure that the people who use our services, colleagues and community see us explain, promote and defend the work of Whittington Health and are involved in the decisions about what we do and how to we do it. So we maintain and enhance the trust required to enable us to deliver on our vision to help local people to live longer healthier lives."

Strong, well-planned, thoughtful and engaging communications underpin how our colleagues feel about working with us, how easily our patients and service users can navigate their care journey, and how our community and stakeholders perceive us.

Through these strategic initiatives, the communications function aims to enhance patient care, support staff, promote integrated care, and drive innovation, ultimately contributing to improved health outcomes for the community.

The Context

This strategy sets out why good communications matter, the environment we are working in, what our communications priorities and major projects will be, and how we will work for the next four years.

The purpose of this document is to set the strategic direction for communications and engagement, and to explain clearly what the people who use our services, our colleagues, our community and our partner organisations and stakeholders can expect from us.

Since our last strategy, the team have delivered much of what we set out to do. The biggest success has been in the completion of a project to implement a new email distribution system. This has enabled us to track how impactful our email communications are and to tailor our messages down to individual staff groups. We have been able to use the data we get to improve the communications we produce and make them more personalised, relevant and user friendly. For example, we have recently changed the format of our all staff NoticeBoard weekly email based on the insights we got from sending out different versions to different colleagues (known as 'A and B testing').

We have also opened up the system to other teams and colleagues to use under our oversight and with our support and training. This means that not only do their regular staff or patient and service user communications now look and feel more professional, they are quicker to produce and they also benefit from stronger data protection safeguards and insights about how well each message performs and what type of content is of most interest to their audiences. We can also now offer a quick and easy way for people visiting our website to sign up to hear from us, and in the past year nearly 1,000 people have done so.

We also undertook a project to refine the structure of our ageing intranet to make it simpler to navigate and find the information our colleagues need, as well as updating content on our most-visited pages.

We created a new role dedicated to engaging with people to ensure that their voice is at the centre of how we plan and deliver major projects such as the new Community Diagnostic Hub in Wood Green, our plans for an integrated health hub in Haringey, and our plans to transform our maternity estate. A number of these engagement exercises and consultations have been praised by those who scrutinise our work for their thoroughness and how we made space for everyone to have their voice heard.

Externally, the team have continued to create more opportunities to allow the media to tell interesting and engaging stories about what we do well, why and how we do it. Internally, we are in the middle of a pilot of a tool which we hope eventually will support all of our managers, at every level, to cascade the information their teams need to them in a consistent but quick and easy way that does not rely solely on staff reading emails.

One major change we have seen since the publication of our last communications strategy is the formation and formal establishment of Integrated Care Systems (ICS) and Integrated Care Boards (ICB). Whittington Health sits within the North Central London Integrated Care System.

The formal establishment of these organisations has allowed us to build on the already very strong working relationships that exist within North Central London (NCL). We are very lucky to enjoy excellent and supportive working relationships with our local partners and these relationships undoubtedly help to improve patient care for everyone who uses health and care services in NCL.

We are incredibly fortunate that as an integrated system we have built a thriving, supportive, and well-developed communications network, which adds real value to the work that we do here at Whittington Health. Going forward, these well-established relationships will allow us to become more efficient as a system, ensuring that where possible we do things once and do not duplicate effort, allowing us to leverage our scale. For example, through joint procurements (some of which have already delivered value) and by allowing the sharing of skills, experience, and ideas.

We are indebted to our colleagues and partners across NCL for their support and their mature attitudes to partnership working.

Like all relationships, this one and those we have with our other partners will continue to evolve and change over the course of this strategy as we find new ways to support and serve our communities.

What does not change is Whittington Health's vision – to help local people live longer, healthier lives – and neither does our team's commitment to playing our part in delivering on making that vision a reality.

However, we live in a dynamic world, and the old adage that "the only constant in life is change" has never been more true. Priorities shift, expectations rise, needs change and our communications must adapt to that change. That is what this document is about; it is here to set out what we will continue to do, what we want to start, and potentially consider not doing in the next four years.

But why bother?

At its most basic, the communications discipline performs three roles on behalf of the organisation, regardless of the audience (the examples are illustrative and not exhaustive):

Explain

- Tell people what you are doing, when, why and how it will affect them
- Let people know what actions they need to take
- Give people the information they need to successfully interact with the organisation as staff, patients and partners
- Allow people to understand why you have made decisions or implemented the policies, rules or procedures you intend to implement
- Show people how the organisation is structured and who is responsible for the decisions the organisation makes
- Provide people with the information they need to make informed decisions

Promote

- Celebrate achievement
- Encourage others to learn from success and repeat it elsewhere
- Show why people should want to interact with the organisation
- Show how the organisation is adding value
- Encourage people to behave in a certain way or take specific actions
- Normalise good behaviours and choices and target bad behaviours and choices

Defend

- Correct misinformation and inaccurate narratives
- Provide a counterview to an assertion or accusation
- Demonstrate why a decision was made and/or why any alternatives were rejected
- Protect the organisation from making choices that would damage its reputation where better options exist or where mitigations can be built in
- Advocate for those whose voices have not been included or properly considered to ensure that the organisation makes the best decision based on all the facts, views and evidence
- Explain why unpopular decisions were unavoidable and how the organisation sought to mitigate their impact
- Minimise the reputational damage from things that go wrong

Strong, well-planned, thoughtful and engaging communications underpin how our colleagues feel about working with us, how easily our patients and service users can navigate their care journey, and how our community and stakeholders perceive us. It supports and enables our organisational plans and our culture, though culture is impacted by everyone's actions.

At Whittington Health, we help our patients and service users to have an excellent experience of their care and cement our reputation amongst our community and stakeholders as a caring organisation that delivers high-quality, person-centred and safe care.

On the flip side, poor communications result in unmet needs and messaging that does not meet the needs of the audience, impacting staff morale, causing a loss of public confidence and trust, and damaging our organisational reputation.

As a health and care provider, confidence and trust are vital. Our patients and service users entrust their health and wellbeing, and in some cases their lives, to us, as well as a significant proportion of the taxes they pay to NHS organisations like Whittington Health.

It is essential that we can show and tell people how their trust and taxes are in safe hands.

Communications, as well as people's lived experiences of their interactions with us, are core to ensuring this.

Who are our Partners?

We work with a range of organisations, these include:

- Our Patients and Service Users, and the wider community we serve
- Our Integrated Care Board
- Our Commissioners
- Our Trades Union colleagues
- Local Authorities in the places where we provide services
- Other local NHS organisations, including UCLH with whom we have a formal partnership
- Our colleagues working in Primary Care
- The local voluntary and charity sector and advocacy groups
- Healthwatch organisations in the places where we provide services
- North Central London Recruitment Shared Services
- Our Bank Staff providers
- UCL Medical School and local Higher Education Providers
- The Whittington Health Charity

We also enjoy the support of numerous businesses and organisations who support us, including Arsenal and Tottenham Football clubs who have provided support to us in numerous ways for many years and who continue to do so.

Communications Vision

To ensure that the people who use our services, colleagues and community see us explain, promote and defend the work of Whittington Health and are involved in the decisions about what we do and how to we do it.

So we maintain and enhance the trust required to enable us to deliver on our vision to help local people to live longer healthier lives.

Where we start:

Our Corporate Objectives

How does what we do fit with the bigger Whittington Health picture?

The frame in which we will be developing this strategy is that everything we do must help the organisation to deliver on our vision *to help local people live longer healthier lives*. Later in this document when we set out our main strategic work programme we will define how each project will contribute to our four objectives that sit under that vision.

How we will go about this will be driven by our values, which shape and guide how we behave as individuals, as a communications team, and as an organisation.

Our Vision Motivates us:

Helping Local People Live Longer, Healthier Lives.

Our Values Guide How we act:

Innovation
Compassion
Accountability
Respect
Excellence

All underpinned by Equity

Our Objectives tell us how we will achieve the vision in partnership with our patients and service users

Deliver outstanding, safe, compassionate care

Empower, support and develop engaged staff

Integrate care with partners and promote health and wellbeing

Transform and deliver innovative, financially sustainable services

Whittington Health is on an improvement journey. Teams from across the organisation have come together to establish the key areas we need to see improvements in, in order to drive up the performance of the organisation as a whole.

Communications has a key role supporting these areas of work, and this is likely to take up a significant amount of our time and resource during the early period covered by this strategy.

We will also support our colleagues working in our community services – which have led the organisation's improvement trajectory for a number of years – to continue to sustain, embed and expand on their success to date. In particular we will look to identify what has worked in our community service's improvement journey's and share and promote them where those leading these changes in our acute services can learn from or implement them.

We have also recently implemented the new Patient Safety Incident Response Framework. This is a long-term project requiring a shift in both how safety incidents are carried out but also the culture around our approach to safety and sharing learning. We will continue to support this ongoing change.

Similarly, a new set of priorities around patient experience are being developed. We will wholeheartedly support our colleagues in delivering their priorities for improving the experiences of our patients.

NHS
University College London Hospitals
NHS Foundation Trust

Working with UCLH

While remaining separate organisations, University College London Hospitals NHS Foundation Trust (UCLH) and Whittington Health have agreed there is a case for closer collaboration between our two organisations. This approach has been signed off by both organisation's boards.

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

We enjoy excellent relations with our colleagues in the UCLH communications team and we are actively working together to strengthen those links further and add more value to both organisations.

We will also work to promote the benefits of the partnership throughout this period, helping to demonstrate how it is benefitting our communities.

What does the data tell us?

We carried out a self-selecting, organisation-wide survey inviting people to provide feedback on their experiences of our team's work, and what is important to them.

Overall, respondents rated us 6.5 out of 10 when asked how likely they were to agree that Whittington Health does a good job of ensuring they have the information they need to do their job at the moment.

It should be noted that this was deliberately phrased at an organisational level. We know that communications and how individuals experience them go well beyond the corporate communications we support.

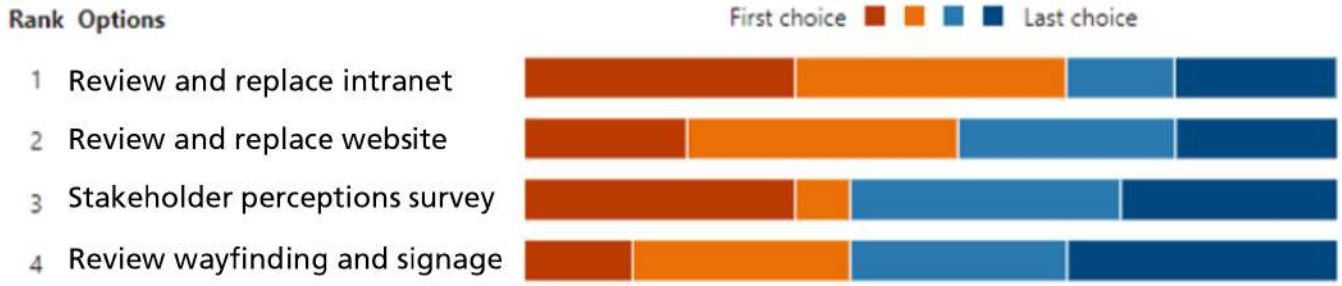
When we those who had worked with the communications team previously about the support our team provides, respondents rated the us at 9 out of 10, with 54% saying they received more support than anticipated from us.

When we asked people to tell us about the things they felt we currently did well, we received a range of replies. The openness, content, and style of the CEO briefing being was most frequently mentioned. The weekly NoticeBoard was also singled out for praise.

We also asked people if there is anything the communications team might do better or improve. Responses mainly centred around the intranet and website, with frequent complaints that content was out of date or difficult to find. One person noted that "Teams need to be chased up to review their webpages and amend them. It's sometimes impossible to find the correct information about a person or a department."

Someone who works at a community site said, "It is difficult to feel connected to it. I've noticed there isn't much mention of teams outside the hospital."

We also shared potential projects we are planning to deliver as part of this strategy (which would involve a cost to deliver), and asked respondents to rank them in the order of importance to them:

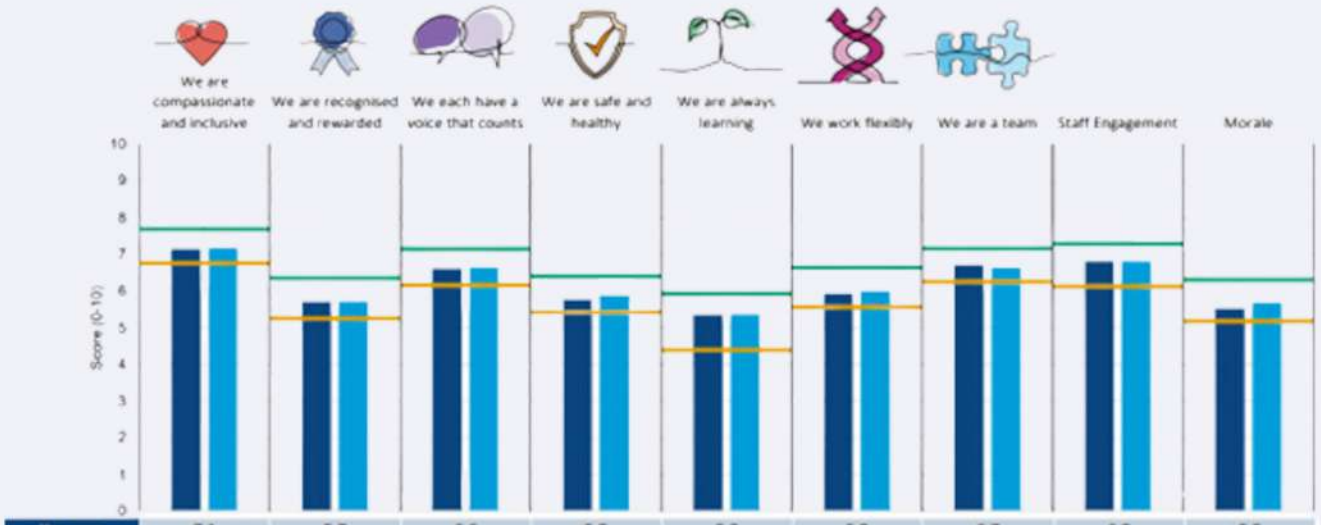


The theme of our intranet not supporting staff to be effective in their jobs was again the overwhelming response. However, another comment suggested that Operational information is not shared consistently across and down into teams.

Further feedback confirmed the theme that we need to do better at communicating with all our community staff, who don't always read their emails and who we struggle to make feel part of the Trust.

What do our staff say about Whittington Health, overall?

58.9% of our staff would recommend Whittington Health as a place to work.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.1	5.7	6.6	5.8	5.3	5.9	6.7	6.8	5.5
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2

What do our Patients say about Whittington Health?

Celebrating Success and Achievement - Business as Usual

A key plank of promoting the work of the Trust is ensuring that our colleagues, who are our best ambassadors, are kept up to date with good news, positive stories and achievements from elsewhere in the trust. That is why we will continue to deliver opportunities for sharing positivity, through:

- Weekly compliment's column in all staff NoticeBoard emails
- Annual staff awards events
- Annual long service celebrations
- Supporting teams to be recognised via external awards nominations
- Monthly Extra Mile awards
- Promoting achievements across our social media feeds.

What do our community and stakeholders say about us?

In writing this strategy, we have identified that we do not have any insights or data about what our stakeholders and our wider community think and say about us. This is a significant gap in our understanding. It will be these views that form the basis of our organisation's external reputation and influence our future.

Whilst we know what the people who do use our services say about their experience, we do not know how we are perceived by those who have not, or perhaps more importantly, choose not to use our services.

This data will be helpful in allowing us to understand where we need to target our communications efforts in order to improve our reputation and/or rectify incorrect perceptions about us.

For example: our colleagues ranked the replacement of the intranet and website as the most important potential strategic communications projects, with a review of wayfinding and signage coming last. This may be because most staff already know their way around the site. If we put the same question to patients, visitors and service users, their priorities might be markedly different.

Our Strengths

- We have systems in place to ensure that our communications are timely, consistent, and of high quality
- We are a well-respected team throughout the organisation
- We're seen as accessible, capable, responsive, and 'can do'
- We have extremely high open rates for our email communications
- We have built strong relationships with our local MPs, councillors, and stakeholder groups
- We are open to innovation and trying new things – for example, changes to NoticeBoard based on data and insights about how people were using it
- We are well respected across the NCL ICS
- We have good relationships with our local media
- When we work proactively with regional or national media, these opportunities are consistently well managed and lead to positive reporting
- Despite the pandemic and industrial relations issues (over which the Trust does not have direct control), employee engagement has remained broadly stable
- Our following on social media continues to grow. We recently set up a LinkedIn and now have almost 8,000 followers

Our Weaknesses

- A lack of a fully implemented channel strategy can lead to a scattergun approach to messages
- We don't have a robust and effective route to cascade information down through our line management structures to ensure that messages consistently reach those colleagues who do not use email on a day-to-day basis (though a pilot of a 'Whit-Team brief' is in progress)
- We don't adequately support managers to communicate with their teams as effectively as possible
- We don't support colleagues across the organisation to understand the importance of incorporating patient voice into their day-to-day work and the value it can add
- Our intranet is sprawling, often out of date. Colleagues tell us they struggle to find information
- Our website is outdated, and there are risks regarding how compliant the site is with the latest accessibility standards and rules. We cannot assure that information is accurate and up-to-date
- The recruitment section of our website does not create the best first impression for potential staff and needs a thorough update to support us in attracting and retaining the best talent
- Staff increasingly want to use their own devices at work. Our intranet currently does not allow non-WH devices to log in
- Sometimes we do not receive notice of the need to support projects in advance, which creates resource challenges and can cause our communication channels to become crowded
- Our community staff often express feeling 'at arm's length' from the Trust and not fully part of the team because messages are too hospital-centric
- Awareness of our wellbeing and employee benefits is low, and our offerings are not sufficiently understood; therefore, there has been limited uptake and fewer colleagues benefit
- Patients often report finding it difficult to navigate our hospital estate. They tell us that wayfinding and signage are insufficient or do not meet their needs. There is little support for those with specific needs such as visual impairments. This issue is often compounded by departments or units moving, and the signage and site map on the website have not been completely updated to reflect this. Furthermore, the locations named on patient appointment letters do not always match how these locations are described on our physical signage

Our Opportunities

- We are already piloting the 'Whit-Team briefing' cascade system and manager's guide and support pack within our Children and Young People's ICSU. This is progressing well and can be extended to other parts of the organisation with the aim of rolling it out everywhere
- We have recently recruited a new Wellbeing Lead for the Trust. They are currently working to refine and enhance our wellbeing offerings
- Whittington Health achieves many great things and there are opportunities to share these stories in more places and more publicly. The evolution of media allows us to tailor stories to outlets and audiences better than before, such as through the growth in podcasts
- Our closer partnership with UCLH may enable us to benefit from information, knowledge, and resource sharing, given that their communications team is larger with more specialist roles
- The redevelopment of our maternity estate (subject to the outcome of the Start Well review) will require updates to wayfinding, presenting an opportunity to review this across the entire site
- Currently, we do not enter many awards, considering our trust's size. Increasing the number of entries should improve our chances of receiving external validation, which is helpful in securing media coverage for our achievements
- We have capacity within our engagement function to develop better support packages for managers to integrate listening to patient and public voices into their everyday work
- Several long-term improvement projects are underway across the Trust. These include issues such as ensuring our administration and business support are as effective as possible, improving patient flow, reducing waiting times, fulfilling previous CQC recommendations, and preparing our staff for CQC assessments. There is an opportunity to consolidate this work into a cohesive whole under one banner for staff to demonstrate the scale of our improvement efforts and their successes
- We could adopt a more video-first approach, especially externally
- Evolution of social media – we could integrate into new spaces such as Nextdoor and WhatsApp channels

Our Threats

- The media and social media landscape is changing and will continue to evolve rapidly. This may result in channels that are currently effective becoming less effective, necessitating innovation and the development of new communication routes. This may require us to change our focus and how we allocate resources
- Our audiences are busy, and we have to compete for their attention, a trend likely to persist
- Audiences are increasingly moving away from public and broadcast channels such as Twitter, Facebook, towards more closed spaces like Telegram, WhatsApp, Snapchat, and TikTok
- The fragmentation of the media landscape, with people spending more time on social media, YouTube, and podcasts at the expense of TV, radio, and press, complicates communications efforts to reach the public
- Many of the long-term improvements we want to make will require funding, some classified as capital spending. Budgets across the organisation will remain limited and must be prioritised, especially our capital budget, which may constrain our ability to deliver communications improvement projects
- The organisation is large and complex, with many diverse priorities and projects in progress at any one time. Our communications resources are fixed, which may strain them too thinly
- We're a small team. While this ensures resource efficiency, it also limits capacity and makes us vulnerable to being hindered from delivering long-term changes and improvements due to the need to focus on day-to-day essentials
- As we aim to share our stories more publicly in more places, it brings risks associated with increased scrutiny

What do our audiences want?

	Who they are	What they need	What they want
Staff	**The people who work for us. The people who make Whittington Health happen** **They are already have a relationship with us**	They need the information they need to do their jobs safely and effectively. They need to be able to find policies, procedures quickly and easily, if, as or when they need them. They need to be aware of the benefit and support available to them as a WH employee. They need to feel included and valued for their unique contribution. They need to know what is expected of them as a Whittington Health colleague, what our values and standards look like in practice. They need to be prepared to welcome the CQC and other external agencies and to be able to represent their service or team confidently.	They want to receive information and communications that are relevant to them, and the role they play. They want to be told about new developments, changes to processes and procedures that affect them, but not about those which do not. They want to know that the organisation respects them as an individual and the unique contribution they make. They want to feel that regardless of who they are, they are included. They want simple ways to self service digitally. They want the information they need at their fingertips when they need it. They don't want to be overloaded with information that isn't relevant. They want the organisation to understand how they work and to find ways to communicate with them that fit in with this. They want to feel they belong and are appreciated

	Who they are	What they need	What they want
Patients	**People who we provide care to** **Some will choose to be cared for by us (for example maternity service users), whilst others will not (emergency admissions)**	They need to be confident that Whittington Health will provide high quality, safe and effective care and that they (or their loved ones) are safe in our hands. They need to have the information they need to access care, find their way to appointments and be clear about what care will be provided, where, and when. They need information that is accessible to them regardless of any protected characteristics. They need information to help them to stay well and be active participants in their care.	They want information that is easily accessible and easy to read and understand. They want to see themselves represented in our imagery and to be confident that whoever they are, we have considered their specific needs. They want us to be curious about their experience of care from us and for us to want to hear their feedback. They want to know what we have or will do as a result to make services even better and more patient centred. They want communications from us to be professional and to look and feel consistent but also to be warm and caring and to enhance their confidence in our ability to provide safe, effective care. They want to hear about our successes to build confidence in the excellence of our services. They want to know that we will be there for them if they need us. They don't want to be forced to try and navigate around our organisational structures in order to find the information they need.

	Who they are	What they need	What they want
Elected officials	**Members of Parliament, elected councillors representing the communities we serve** **Members of overview and scrutiny committees covering the boroughs we provide services within**	They need clear and concise information about how well we are performing. They ned to understand our strategy. They need to know about our challenges and what we are doing to address them. They need support to resolve constituent cases. They need to hear about positive developments and news from across their local NHS organisations.	They want headlines not huge volumes of detail. They want information that is tailored to their constituency or ward. They want the full truth, not a sanitised version of it. They want us to respond quickly. They want to be warned as soon as possible when things have gone wrong. They don't want surprises.
Wider stakeholders	**Our ICS and ICB** **Other NHS organisations in NCL and beyond** **Local GPs** **Charity, Community and voluntary groups** **Local Healthwatch organisations** **And similar – this is not an exhaustive list**	They need to know information at a summary level. They need to hear about developments and improvements we are making and how they have translated into better care. They need to know about changes to services we are making and how it will affect their organisations and the people they represent. They need to know that we have strategies and plans in place to be better at everything we do. They need to know how they can support and engage with our work.	They want high level information, delivered briefly. They want to know how to contact us if they want more information or to ask questions. They don't need to hear from us too frequently.

	Who they are	What they need	What they want
Our Community	**The many and various people and diverse communities who live and work in the places we serve** **They may not have used or services recently but we would be their local provider, should they need care**	They need to know that if they need us, that we can be trusted to provide safe, effective and compassionate care to them or their families. They need to be aware of major developments and successes and what we are doing to improve if things go wrong. They need to be informed about changes we are thinking about making to services and have the opportunity to tell us what their views are. They need information to help them to help themselves to stay well and avoid the need to use our services where possible.	They want to have the option to hear from us regularly, should they choose to. They want information easily available when they need us, but most of the time they don't want to hear from us proactively. They want us to keep them informed about any major changes and have the chance to have their say. They want advice to help themselves stay fit and healthy. They want to be confident that we are spending their taxes wisely and efficiently. They want to help us to shape services. They want us to respect that they have busy lives and if we want their attention we need to show them why the issue should matter to them. They don't want to be hectored or nannied.

Supporting our Charity

Whittington Health Charity and Whittington Health NHS Trust work side-by-side to bring huge benefits to both patients and staff, and to make a difference to hundreds of thousands of people each year.

Our charity is separate to the Trust and has its own brand, tone of voice and priorities which are owned by the Charity. However, we will continue to support them with communications resources and access to our channels to allow them to promote their achievements and seek support for their work.

Whittington Health Charity

What we will do

How we will play our part in helping Whittington Health to deliver its four key corporate objectives.

Deliver outstanding, safe, compassionate care

- Stakeholder and community perceptions survey followed by action planning
- Listening and engagement toolkit (delivered by the patient experience team) and training for staff (delivered by the communications team in partnership with the patient experience team)
- Hospital site wayfinding review
- Wayfinding and signage replacement / updating

Empower, support and develop engaged staff

- Intranet content review and scoping with a view to replacing the current intranet
- Intranet content review for the most used pages, identification of subject matter experts/page owners for these
- Development of a brand toolkit / resource centre / photo library to help staff self service and improve consistency and quality of non comms produced content
- Organisation wide roll out of Whit-Team brief
- Refresh and relaunch a new unified wellbeing brand to replace caring for those who care
- Refresh our recruitment offer online

Integrate care with partners and promote health and wellbeing

- Website content review and scoping with a view to replacing the current website
- Increase the number and quality of external award entries
- Work alongside partners including UCLH and NCL ICS to promote the benefits of partnership and integrated working to our colleagues, stakeholders, patients, service users and community

Transform and deliver innovative, financially sustainable services

- Implement work in development to create a "Whittington Voices engagement group and Engagement network for staff who are trained to champion and carry out patient engagement
- Develop a new brand to unify the various strands of our improvement programme and our work to ensure that all of our colleagues are ready to welcome the CQC if they attend for an inspection
- Develop a suite of resources and tools to support teams to develop new ways of working that deliver improved patient and efficiency

Our Values

How we will live them

INNOVATION

We will welcome ideas, be willing to change and to make new partnerships.

We will continue to seek out new channels and tools to speak to people 'where they are' and not expect them to 'come to us'.

We will be brave and give ourselves permission to try new things, to embed the ones that work and to fail fast, learn and try again when things don't.

COMPASSION

We will value our relationships, treat people with kindness, look after each other and create an environment that fosters privacy and dignity.

We will be clear with people about what they can expect from us and what they cannot.

We will always deal with people with kindness, use positive and enabling language.

ACCOUNTABILITY

We will take ownership for what we do, use the public's money well, learn from our mistakes, hold others to account and be open and honest.

We will listen to feedback from our colleagues, patients and service users, our community and stakeholders then reflect and act on it. We will be honest about the things we cannot change.

RESPECT

We will treat people fairly, recognise individuality and deal with inappropriate behaviour.

We will always try to design and deliver communications that meet the needs of the audience.

We will acknowledge that our audiences time and attention is precious.

EXCELLENCE

We will keep people safe, deliver high-quality services, keep on improving and learn from mistakes.

We will continue to try to ensure that all of our colleagues have the information they need to provide safe, effective compassionate care.

When we make mistakes we will learn from them.

EQUITY

We will deliver services to patients and provide opportunities to staff that achieve outcomes which are fair and in line with our I.CARE values.

We will do better at ensuring that our communications are accessible to everyone with specific needs.

We will ensure that everyone who works for us or receives our care can see themselves in the imagery we use.

We will use inclusive and enabling language.

We will support our colleagues to ensure they understand why this matters and how to do it and we will veto communications created elsewhere that do not.

We will continue to support colleagues to undertake bespoke placements and secondments within our team so that they learn what we do and how to communicate better and so we get a better understanding of their roles and how they use the communications we produce.

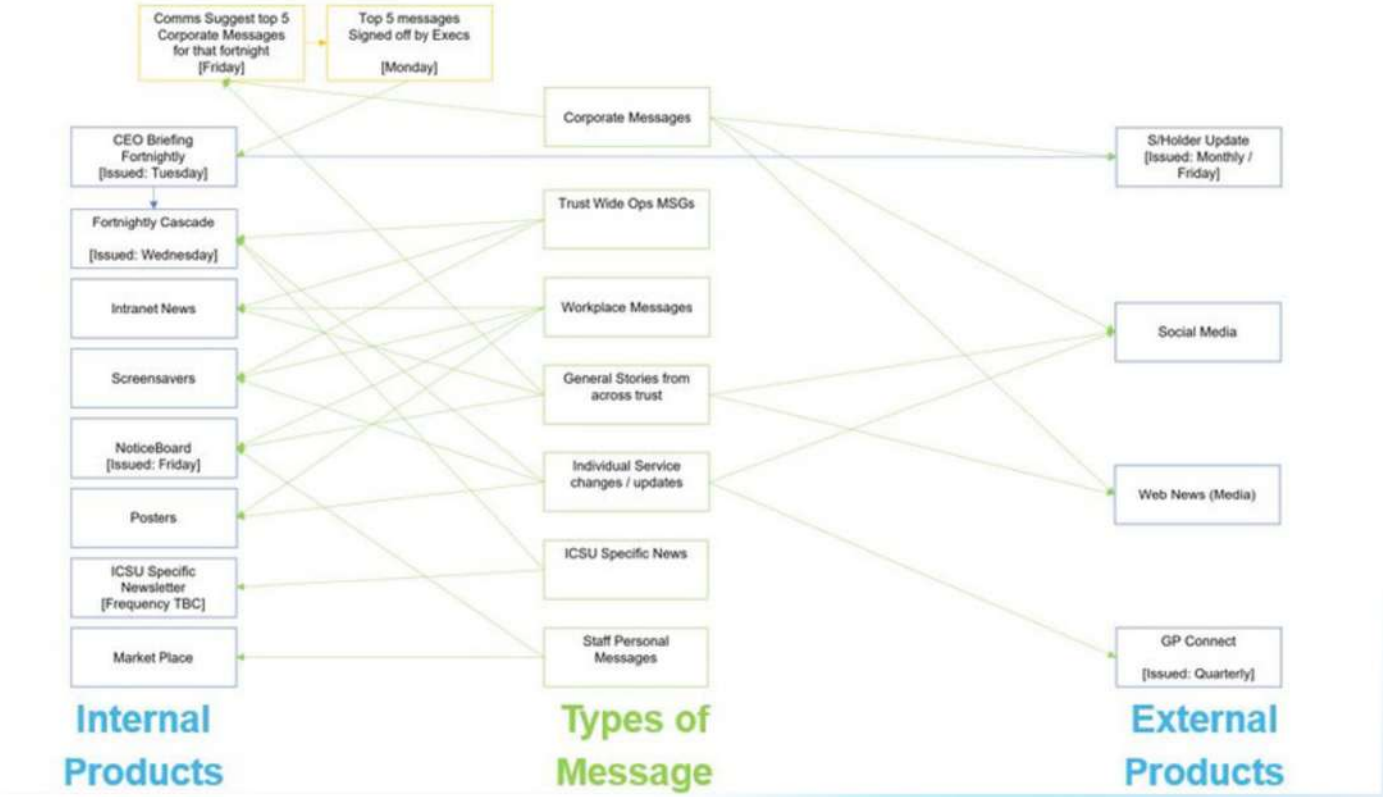
Our Channel Strategy

We are in the process of implementing a new channel strategy.

This is underpinned by the roll out of a new internal communications channel. We have, to date, relied on managers to cascade important information to their teams but we do not support or equip them to do so. We also leave it to individual managers to determine which of our many messages issued via a range of channels are the most important ones for their team to hear.

To overcome this challenge, we have been trialling a new channel to support managers to rapidly but consistently brief their teams, verbally, on the most important news from across the Trust. The aim is to make it easier for managers to support their teams and to help all colleagues feel better informed and included in what is happening across the trust and locally to them. The trial in our Children and Young People's ICSU has been successful and we are not ready to roll this out across the whole organisation, an ICSU or corporate area at a time.

Once this has been fully rolled out, it will allow us to refine where we place our news:



Patients and our community at the heart of our work

Working alongside Patient Experience

Engagement with patients and our communities can be said to be "the other side of the same coin" as our efforts to improve patient experience. They enjoy a symbiotic relationship.

We will continue to work alongside the Patient Experience team in their work to implement their dedicated strategy, which aims to:

- Work closely with patients and carers to improve patient experience.
- Support and empower our staff to improve patient experience.
- Work closely alongside our local partners to improve patient experience.

At Whittington Health we want to be sure that everyone in our local community has absolute confidence in our services and the care and treatment they receive.

Placing our patients at the heart of all our planning and service developments will allow us to better influence our services based on our patients' needs.

We do currently listen to our patients and community both at a service and corporate level. But there is an opportunity to do this better, to do this more regularly, and to formalise how we do it.

Staff and patients who partake in engagement often do so on a project basis, participants, activity, and outcomes aren't currently stored or shared which limits the opportunity for continued engagement or shared learning. The development of a patient engagement group and engagement champion staff network will provide an infrastructure to enable listening and engagement across the trust.

This plan focuses on the introduction of a listening and engagement infrastructure to uniform, streamline and centralise engagement activity within the trust. This project will be delivered within 3 phases, this plan has been created based around these phases:

1.To engage and recruit staff and patients in listening and engagement initiatives

- To ensure staff and patients are aware of the engagement group and engagement champion staff network, and the routes to getting involved.
- To streamline and centralise the engagement work happening across the trust.

2. To generate awareness and acquire members of the engagement group.

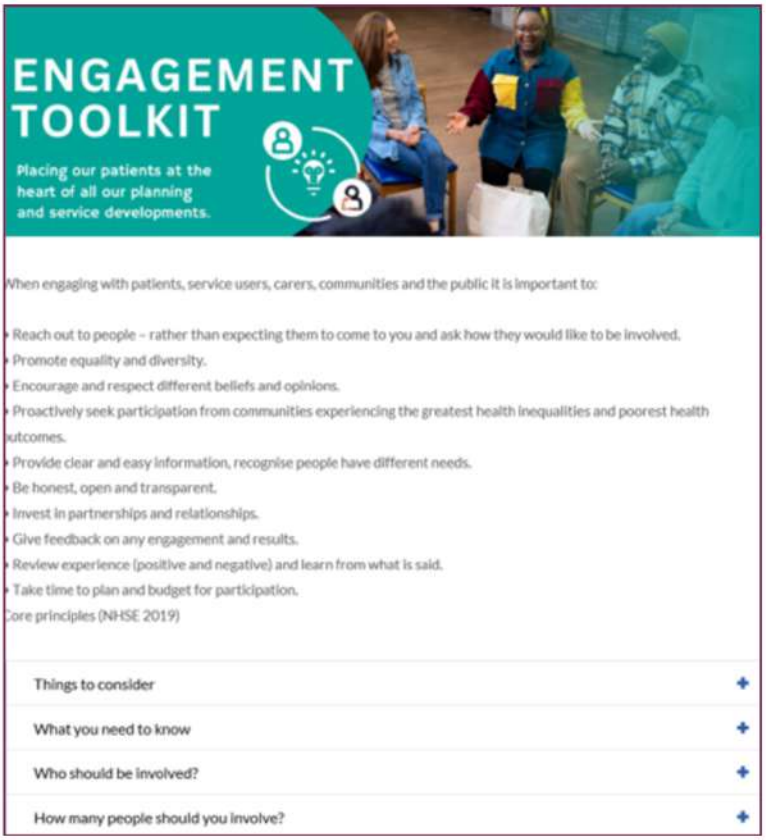
- To grow the number of staff and patients who are part of the engagement group and engagement champion staff network.
- To ensure representation of services from all divisions within the engagement champion network.
- To embed the engagement infrastructure within existing channels and systems across the trust.

3. Implement staff training on the engagement toolkit.

- To equip our colleagues who are responsible for the design, development and delivery of services with the tools to effectively listen to, engage and involve patients and service users in service design, development, and changes both large and more every day via the engagement champion staff network.
- To help us to become an even more patient centred organisation.

We have already run an exercise to name our new patient engagement group, the most popular name was Whittington Voices. This name dovetails in nicely with our existing, well established and productive Whittington Health Maternity and Neonatal Voices Partnership group, which will continue unchanged and is a beacon for the rest of the organisation demonstrating the power and value of embedded and long term patient and service user involvement.

The need for communications will not end in regard to listening and engagement across Whittington Health, a long term BAU communications plan will be developed once the engagement infrastructure has been successfully embedded across the trust.



Helping us to Help you

Communications Champions

We will recruit and train a group of "communications champions" from across our organisation who can assist their respective areas in designing high-quality communications products in line with our corporate brand guidelines. We will also equip them with the necessary tools to do so.

This initiative will create additional capacity within the organisation and provide valuable experience and expertise, supporting individuals' development in a corporate department where gaining experience and insight can be challenging.

We strive to consistently deliver our best work. Therefore, we ask all our colleagues to support us in serving you, our patients, and community by considering the following factors:

First on the Grid:

The communications grid outlines weekly releases across all our channels, including intranet news stories, CEO briefings, external news stories/press releases, social media, etc.

Space on the grid is limited across all channels to avoid overwhelming our audiences.

This is particularly crucial for channels like our intranet homepage, where more than four stories per week can result in stories rotating off the homepage (where they are most visible) in less than one week. This is especially relevant in our organisation where colleagues do not adhere to traditional Monday-Friday shift patterns. It is also important for NoticeBoard, where including too many stories can lead to incomplete reads, potentially causing important messages to be missed.

Whilst items will not be added to the grid on a strict "first come, first served" basis, if a particular channel is full in a given week, we are unlikely to displace an item unless the requesting team could have notified us of the communication need earlier.

Great communications don't happen by accident

They require careful planning and craftsmanship.

Please give us as much notice as possible when you anticipate needing a communications package to support a project, initiative, or issue you are working on. We understand that circumstances can change rapidly, and we are flexible. However, our resources are finite, so we must always prioritise projects that will impact the most people or have the greatest effect on the Trust's reputation.

Involving us early in the life of a project or issue allows us to manage competing demands effectively and provide the best possible service to everyone.

Bring us your objectives, not solutions: We excel at creating impactful, successful, and bespoke communications that help achieve your desired outcomes. Share your goals with us, and we will advise you on the communication strategies and tools that will deliver them. Please trust our professional advice rather than simply requesting a press release, poster, or screensaver because you believe that's what you need.

Managing the Media: If your service is the subject of a media enquiry, we will contact you to gather information about the story the media intends to publish. Please assist us in explaining, promoting, and defending your service and the Trust by providing all relevant facts, even if they are challenging. We are here to support you and will collaborate to devise the best possible response.

Because the media operate on strict and often tight deadlines, we may need your prompt responses to our requests. We understand your busy schedule, but timely responses are crucial to ensure accurate representation in the media. Delayed responses could lead to misrepresentation of the situation to our patients, stakeholders, or community.

If contacted directly by the media, please inform us immediately to seek our assistance. Refrain from answering media inquiries without consulting us first. Additionally, never initiate contact with the media in a professional capacity without prior discussion with us.

Appendix A

Our strategic projects in more detail

TItle	**Stakeholder and community perception survey**
Aligns to objective:	Deliver outstanding safe and compassionate care in partnership with patients
Teams involved:	Patient Experience
Aims	Understand our reputation amongst our key stakeholders and our community at large. To help us to identify what we do well and should continue To help us understand where there is a perception that we do not perform well in order to deliver improvements To help the organisation to understand where it should focus its improvement resources To aid prioritisation of actions Support us to ensure we are doing the things that matter most to the communities we care for
Rationale	Our corporate objective is to deliver improvements in partnership with patients but we currently lack any robust insights into what matters to them. We have some quantitative data from the friends and family test and individual services should be engaging with their patients and service users to get some level of quantitative data (but there is no record held centrally around whether this happens consistently across all services or the feedback). However, there is no robust data for the Trust as a whole to inform us around what really matters to our community. Any current data is also drawn from existing patients and service users and therefore does not include insights from those who choose not to use our services. This is important because we have a blind spot in our data which may lead to poor decision making and prioritisation as we are not hearing from those who are so dissatisfied with us or their perceptions of us are so poor that they actively disengage from our services. We also have no insights at all from our key stakeholders around how they perceive us and how well we perform as a partner. In a system working environment this is increasingly important. A survey of this type would give us rich, robust, independent quantitative and qualitative that will allow us to develop an action plan to deliver changes and improvements (and to ensure we protect what we do well). It will also aid our decision making when it comes to important prioritisation decisions allowing us to focus on what matters to our community.
Risks of proceeding	Risk of criticism for spending money on a "PR exercise" Risk of criticism that we prioritise reputation over quality (in reality for the reasons set out above, the latter informs the former). Would require effort to ensure that our stakeholders engage with "another survey".
Risks of postponing	We make decisions that are not based on data We make decisions and do things that are not important to the community we serve We make decisions based on our own "world view" or assumptions, which may not accurately reflect the diversity of the communities we serve We make decisions only based on the feedback we get from "those who shout loudest" We fail to address issues that matter to people and our reputation as an organisation providing high quality, effective, safe and person centred care declines without us knowing about it resulting in greater numbers of our community disengaging and choosing care elsewhere. We miss out on opportunities to celebrate what we do well.
Cost estimate	Based on similar surveys carried out by other NHS organisations, we estimate the costs of carrying out this activity would be in the region of £15,000-£20,000.

TItle	**Listening and engagement toolkit and training for staff**
Aligns to objective:	Deliver outstanding safe and compassionate care in partnership with patients
Teams involved:	Patient Experience, Learning and Development
Aims	To ensure that all of our colleagues who are responsible for the design, development and delivery of services understand the importance of engagement To ensure that they understand the benefits of patient engagement To equip them with the tools to effectively listen to, engage and involve patients and service users in service design, development, changes both large and more everyday To help us to become an even more patient centred organisation.
Rationale	To equip colleagues from across the organisation to incorporate listening, engagement and feedback into their day to day work and to help support them to ensure that patient voice is always at the heart of everything we do. The toolkit (produced by the Patient Experience team) is designed to show the benefits of listening and engagement and the training (delivered by Communications and Engagement) will help to bring it to life. It is about helping busy colleagues to understand that engagement is not an add on to their role but something they can easily be done as part of their usual work. Together they will support the organisation to move more towards coproduction of change, developments and improvements alongside patients, service users and our community.
Risks of proceeding	There is lots of statutory and mandatory training, this is another "ask" of our staff Busy colleagues do not see the value of engaging with the toolkit and training and therefore are not equipped to benefit from the advantages of high quality patient engagement.
Risks of postponing	We fail to equip colleagues to engage effectively and that we make poorer decisions as a result. We don't provide the support our people need in order to succeed in their roles. Reputational risks stemming from decisions which do not have patient voice at the heart of the decision making process.
Cost estimate	The toolkit and training will be created and delivered by exiting Patient Experience and Communications and Engagement team colleagues at no additional cost. There may be a need for minor external design or systems work (for example should we want to add the training to Elev8) but we anticipate this would only be in the region of £1,000, if required.

TItle	**Hospital site wayfinding review**
Aligns to objective:	Deliver outstanding safe and compassionate care in partnership with patients
Teams involved:	Patient Experience, Estates and Facilities, Patient Reps, EDI Team, PALS team *Consultation with: individual services and teams* *Links to: Website / Intranet / Patient Comms and letters project given all naming conventions must be the same.*
Aims	To ensure that all of our patients, including those with specific needs, can find their way quickly and easily to where they need to where they need to go. Consistency between letters/patient communication and what is stated on signage To make using our services easy and stress-free To reduce missed / late appointments caused by patients and service users getting lost. To enhance patient safety by ensuring that in an emergency our staff and patients can get to where they need to be quickly.
Rationale	It has been over 10 years since any substantial changes were made to our signage and wayfinding across our whole hospital site. In that time there have been many changes including the development of new services, services moving locations, services changing names etc. Our signage has not kept pace with this. There has been some ad-hoc signage development but across the estate we lack a clear, thought out, user friendly signage and wayfinding system. In particular mismatches have developed between how services are named on patient letters and our website and the physical signs in our hospital. This leads to confusion and unnecessary stress for our patients and service users. We also lack any meaningful consideration in our signage and wayfinding for those who are blind or partially sighted or who have other additional or specific needs. Our current signage (in particular our main external signboards) are scruffy and do not present a professional image of our organisation consistently. Our external maps and those on our website are also very out of date (not showing the new location of the WEC or Highgate West, for example).
Risks of proceeding	It is a large scale, complicated project that will require the input of all of our hospital based services. There are physical building works planned across the site which this project would need to be mindful of. But we will never get to a point where our building is fixed and unchanging. Will require significant financial investment into something that many people will wrongly assume is quick, easy and intuitive to solve.
Risks of postponing	Our signage becomes increasingly out of date Our patients, service users, visitors increasingly perceive us as difficult and complicated to deal with Our buildings become an increasing patchwork of differing signage styles which looks messy, unprofessional and not user friendly. Increased patient complains More appointments missed or delayed because people cannot find their way Safety risks associated with staff required urgently cannot find their way to the emergency.
Cost estimate	To bring in the external expertise with an understanding of both the art and science or wayfinding and to develop a plan for what signage should go where across the entire site we estimate allowing in the region of £100,000. This is based on insights from other similar projects undertaken at other NHS Trusts. For example Buckinghamshire Healthcare NHS Trust are investing around £500,000 to undertake a project like this across their (much larger than ours) Stoke Manderville Hospital site.

TItle	**Wayfinding and signage replacement / updating**
Aligns to objective:	Deliver outstanding safe and compassionate care in partnership with patients
Teams involved:	Patient Experience, Estates and Facilities
Aims	To implement the wayfinding and signage review and final plan through the replacement of existing signage across our hospital. To ensure that all of our patients, including those with specific needs, can find their way quickly and easily to where they need to where they need to go. To make using our services easy and stress-free To reduce missed / late appointments caused by patients and service users getting lost. To enhance patient safety by ensuring that in an emergency our staff and patients can get to where they need to be quickly.
Rationale	It has been over 10 years since any substantial changes were made to our signage and wayfinding across our whole hospital site. In that time there have been many changes including the development of new services, services moving locations, services changing names etc. Our signage has not kept pace with this. Our current signage (in particular our main external signboards) are scruffy and do not present a professional image of our organisation consistently. Our external maps and those on our website are also very out of date (not showing the new location of the WEC or Highgate West, for example).
Risks of proceeding	This will require significant investment
Risks of postponing	The work to produce the wayfinding and signage plan will become increasingly out of date, reducing the ROI from this work if not implemented quickly. Our signage becomes increasingly out of date Our patients, service users, visitors and staff increasingly perceive us as difficult and complicated to deal with Our buildings become an increasing patchwork of differing signage styles which looks messy, unprofessional and not user friendly. Increased patient complains More appointments missed or delayed because people cannot find their way Safety risks associated with staff required urgently cannot find their way to the ward / department / service.
Cost estimate	It is difficult to predict the costs having not completed the review above and have a plan in place for what signage needs to be replaced etc. However, based on similar projects at other NHS trusts I would suggest an investment of at least £20,000 would be required to procure new signage, remove existing and put up new signs across the whole hospital estate.

TItle	**Intranet content review and scoping with a view to replacing the current intranet**
Aligns to objective:	Empower support and develop engaged staff
Teams involved:	IM&T *We would also want to establish 2 steering groups, one for staff/users (including those with disabilities and additional needs) and one representing "the organisation" made up of managers and leads from across the Trust.*
Aims	To create an online space where colleagues from across the organisation can get the information they need to do their jobs quickly and easily To ensure that all information on our intranet is up-to-date and accurate To improve our colleague's ability to work remotely and "on the move" by giving access to the intranet on personal devices or trust mobile devices not connected to the network To ensure that the platform complies with all current best practice around accessibility To create more opportunities for digital self-servicing to make processes quicker and more efficient. To create a process for and policy around individual services keeping their own information up-to-date and accurate and allow them to self-service updates.
Rationale	The Trust's intranet is currently very large. It has over 2,500 individual pages. At the moment we cannot be sure that all of the information is still relevant, up-to-date or accurate. The Communications and Engagement team do our best to update and correct information that is incorrect where we identify it but we do not have the capacity to audit every page. We are also required to be involved in updating individual pages where page owners request this but there is no process in place to identify a page owner for every page or for page owners to be proactively requested to check and update the content of their pages (with the exception of policies and SOPs). As a result the site has become sprawling and it is not structured in the most relevant way for users. We often receive feedback that colleagues struggle to find the information they need. We are also not applying best practices with regard to accessibility in all cases. For example we still make widespread use of PDF, word and other attachments which may not be accessible for screen readers and other assistive technologies when current best practice is an HTML first approach. Since the development of the site technology has also changed at remarkable pace and there may be opportunities for us to use new and emerging technologies such as AI, machine learning and generative chat tools. We propose to replace the current platform in 3 stages (which may overlap): 1. Carry out a full review of the current site in order to ensure that all current pages are relevant, accurate and up-to-date. Assigning a responsible person or team to every page. Remove pages which are irrelevant. 2. Design a specification for what a new intranet platform may look like and procure against that specification. 3. Design and deliver a new platform with thorough testing then swap over the old for the new intranet. – this process will be made easier having cleaned up the current site. We anticipate this whole process will take 2-3 years and is likely to require some element of business change as we identify policies online which are out of date and which require through rewriting by the relevant owners.

Risks of proceeding	This is a large project which will take considerable management time from across both the communications and IM&T teams as well as input from across the Trust to deliver Whilst far from ideal, the current platform has relatively low ongoing hosting and management costs, it is entirely possible that a new solution could have higher ongoing costs. We would hope that these would be offset through making it quicker and simpler for colleagues to find the information they need and by automating and digitising some colleague services which are currently manual The intranet is a vital piece of business critical infrastructure on which most of the organisation relies Any changes must be carefully managed and risks mitigated to avoid impacting our operations There is a risk that this could be perceived as a vanity project from outside the organisation as there isn't an immediate intuitive link between a high quality intranet and patient care In creating a route for users to access the intranet from a non-trust device you are creating a new route into our network for hackers etc. The security aspects of the creation of a new intranet need to be very carefully planned, managed and scrutinised in order to mitigate such risks
Risks of postponing	The site continues to grow and increasingly this will cause the user experience to slow down, causing it to take longer for our colleagues to use it for the many tasks for which it is vital The current platform ceases to be protected by the latest cybersecurity features creating a network vulnerability, or requires large additional financial investment just to maintain the sub-optimal status quo Staff see the difficulties they have and will increasingly have using the site as an example of the organisation not valuing them and this will affect employee engagement and staff retention Staff act on out of date or inaccurate information with negative consequences Because of the local nature of the current platform, we are at risk of failure of the system without a pool of knowledgeable resource who are familiar enough with it to fix it
Cost estimate	We do not have the resource within the communications or IM&T teams to dedicate to this large project. We therefore would require external resource dedicated to this project to complete steps 1 and to prepare the business case to deliver the procurement stage of step 2 for approval to proceed. We anticipate this would require in the region of £110,000 over 2 years (2 year, B6 equivalent, FTC employed on a contract basis). Further costs to proceed to step 3 would then be presented for further approval at the end of step 2.

TItle	**Development of a brand toolkit / resource centre online**
Aligns to objective:	Empower support and develop engaged staff
Teams involved:	N/A
Aims	To create a "one stop shop" where colleagues can access communications materials, collateral, pictures, advice and guidance in one place To provide the organisation with the resources they need to communicate on behalf of the trust professionally, consistently and confidently To improve the quality and professionalism of locally created products and communications To allow more colleagues to self-service and reduce demand on the communications corporate team Make communications more equitable
Rationale	For an example of the type of resource we want to provide, visit: https://brand.humber.nhs.uk. We often get asked to produce communications materials and resources which could more quickly and easily be produced locally (by the people with the actual subject matter knowledge) if they had the skills, resources, collateral, guidance and confidence to do so We also often see sub-standard products being created by colleagues locally that do not meet the organisations brand standards because the person creating them did not have the parameters, guidance and tools they needed to meet them. By creating a resource like the example above for Whittington Health we can reduce demands on the central communications team to focus on the tasks which truly require our specialist skills, experience and knowledge.
Risks of proceeding	People take the resources but apply them incorrectly. This will require monitoring, but this already happens so it is not a significant new risk.
Risks of postponing	The communications team continue to have to service requests that could be handled more quickly and easily locally, diverting us away from other more relevant projects. Teams continue to produce products which do not align with our brand standards which can undermine our patient and service users trust in our communications. Staff are frustrated at turn around times for products we have to produce on their behalf when they could self-service.
Cost estimate	We anticipate that the vast majority of this work can be delivered in-house by the communications and engagement team. We may require some external design and production skill (for example to produce locally editable products) but the costs of this are likely to be less than £1,500.

TItle	**Organisation wide roll out of Whit-Team brief**
Aligns to objective:	Empower support and develop engaged staff
Teams involved:	All ICSUs and Corporate Teams, sequentially, over the next 18 months.
Aims	To ensure that all our staff, especially those who do not routinely access emails and our digital channels have the information they need to do their jobs and the updates they need from the trust to be kept up-to-date with important news To support managers to cascade information to their teams To support the expectation that managers cascade information through the organisation To equip line managers with the skills to feel confident in briefing their teams effectively To provide a feedback loop on key corporate announcements
Rationale	We know that the more patient facing a colleague is and the more junior they are the less likely they are to interact with email and our digital channels such as intranet news stories etc. For this reason we have developed a team brief cascade tool which we have been trialling in the CYP ICSU since late 2023. We have learned a huge amount from the pilot and we would now like to roll the tool out to all ICSUs and corporate teams. One of the key learning points from the trial was that there is no set concept of "a team" within each area of our organisation. Therefore, rather than launching the tool onto the organisation as a whole, we would plan to do a phased roll out, working closely with an ICSU and corporate area at a time in order to support them and tailor the roll out so it is implemented successfully and mainstreamed in all areas.
Risks of proceeding	N/A
Risks of postponing	We continue to expect manager to cascade information without supporting and equipping them to do so. Therefore we risk continuing a patchy cascade and colleagues reporting that they don't feel they know what is happening across the organisation.
Cost estimate	This work can be delivered in-house by the communications and engagement team at no additional cost. The additional resource put into creating this will come from fewer stories going out as intranet news stories as Whit-Team briefing allows us to tailor messages to relevant audiences more easily.

TItle	**Refresh and relaunch a new unified wellbeing brand to replace caring for those who care**
Aligns to objective:	Empower support and develop engaged staff
Teams involved:	Workforce / OD, Employee Wellbeing Lead
Aims	To highlight to colleagues across the organisation the breadth of support there is for their wellbeing To create a unified whole that holds together and amplifies the disparate sum of its parts To help colleagues to recognise the varied ways we promote and support wellbeing
Rationale	From employee discounts and clubs, to counselling, OD interventions, giveaways and mental health first aid, the trust funds a huge amount of projects, programmes and initiatives which are all designed to enhance and support colleagues wellbeing. However, there is nothing that holds this work together to help colleagues to recognise how the various strands all sit together to form an overall comprehensive package of support. We therefore want to relaunch the Caring for those who Care brand, originally developed during the COVID-19 pandemic to badge all of this activity together.
Risks of proceeding	No package could ever be 100% complete or totally comprehensive, bringing the activity together could highlight gaps in the provision
Risks of postponing	Staff do not recognise the breadth of our offer and therefore feel less valued and engaged Higher staff turnover More challenging recruitment
Cost estimate	This work can be delivered by existing Communications and Engagement and Employee Wellbeing colleagues at no additional cost.

TItle	**Refresh our recruitment offer online.**
Aligns to objective:	Empower support and develop engaged staff
Teams involved:	Workforce, Recruitment Shared Service, Nurse Recruitment Team, AHP recruitment team
Aims	To improve potential candidates first impressions of Whittington Health as an employer To create a more powerful and compelling rational and emotional pull to apply to work at Whittington Health To give potential and current recruits the information they need to reduce the number of individual questions and enquiries we receive To increase applications and contribute to a higher vacancy fill rate
Rationale	We operate in a competitive market where candidates can often take their pick of potential NHS employers locally and nationally. Our recruitment pages should be refreshed and updated to ensure we can continue to attract the very best talent. This would build on the good practice and learning from dedicated recruitment campaigns we have run for the ACS and CYP ISCUs in recent years.
Risks of proceeding	N/A
Risks of postponing	Potential talent is put off by recruitment pages (our "shop window") which are not professional, appealing and up to the same standards as those with whom we compete for talent
Cost estimate	The majority of the content and site changes can be made by existing communications and recruitment colleagues, however we would, in addition, seek to procure new: • Photography: c£4,000 • Corporate recruitment films x2: c £15,000 (higher than usual to allow us to film across multiple sites in order to show the breadth of our work).

TItle	**Website content review and scoping with a view to replacing the current website**
Aligns to objective:	Actively collaborate to deliver integrated, joined up care for our communities
Teams involved:	IM&T *We would also want to establish 2 steering groups, one for patients/service users/users (including those with disabilities and additional needs) and one representing "the organisation" made up of managers and leads from across the Trust.*
Aims	To create an online space where people can get the information they need about us and their care / job search etc quickly and easily To ensure that all information on our website is up-to-date and accurate To facilitate easy access to digital tools such as Zesty and LifeBox To ensure that the platform complies with all current best practice around accessibility To create more opportunities for digital self-servicing To create a process for and policy around individual services keeping their own information up-to-date and accurate and allow them to self-service updates To present the organisation as professional, competent and one in which quality matters
Rationale	The current website design and structure is very out of date in terms of design and structure. It has not received anything in the way of substantial change in the last 5 – 10 years despite massive changes to technology, how people use the internet and trends in website design during that time. It is now appropriate to look to replace the current site which is built on a bespoke CMS in order to ensure that the content is up-to-date, relevant and accurate and that it meets best practice standards for UX and accessibility. For example we still make widespread use of PDF, word and other attachments which may be old and not accessible for screen readers and other assistive technologies when current best practice is an HTML first approach. The process of moving content from a PDF download to HTML first approach is necessary but in itself a huge task. Since the development of the site, technology has also changed at remarkable pace and there may be opportunities for us to use new and emerging technologies such as AI, machine learning and generative chat tools. We propose to replace the current platform in 3 stages (which may overlap): 1. Carry out a full review of the current site in order to ensure that all current pages are relevant, accurate and up-to-date. Assigning a responsible person or team to every page. Remove pages which are irrelevant. 2. Design a specification for what a new website platform may look like and procure against that specification. 3. Design and deliver a new platform with thorough testing then swap over the old for the new intranet. – this process will be made easier having cleaned up the current site.
Risks of proceeding	This is a large project which will take considerable management time from across both the communications and IM&T teams as well as input from across the Trust to deliver Whilst far from ideal, the current platform has relatively low ongoing hosting and management costs, it is entirely possible that a new solution could have higher ongoing costs. There is a risk that this could be perceived as a vanity project
Risks of postponing	Potential talent is put off by recruitment pages (our "shop window") which are not professional, appealing and up to the same standards as those with whom we compete for talent

Risks of postponing	The longer we delay this project the increased risks that as an organisation we undermine our image as a provider of high-quality care as the website (which is effectively our 'shop window to the world') will increasing look old fashioned and not high quality. Potential job applicants may also be put off if they believe that the old-fashioned website is synonymous with low quality IT provision in the Trust The current platform ceases to be protected by the latest cybersecurity features creating a network vulnerability, or requires large additional financial investment just to maintain the sub-optimal status quo Patients act on out of date or inaccurate information on the site because at present there is no page or content ownership within services. This could lead to increased complaints. Because of the local nature of the current platform, we are at risk of failure of the system without a pool of knowledgeable resource who are familiar enough with it to fix it
Cost estimate	We do not have the resource within the communications or IM&T teams to dedicate to this large project. We would recommend undertaking this project following the proposed review of the intranet (a much larger task) above. We would look to procure a platform for the new intranet which could also host any new website. We therefore would require external resource dedicated to this project to complete steps 1 and to prepare the business case to deliver the procurement stage of step 2 for approval to proceed. We anticipate this would require in the region of £85,000 over 18 months years (2 year, B6 equivalent, FTC employed on a contract basis). Further costs to proceed to step 3 would then be presented for further approval at the end of step 2.

TItle	**Increase the number and quality of external award entries**
Aligns to objective:	Actively collaborate to deliver integrated, joined up care for our communities
Teams involved:	All teams with potentially suitable work to showcase in an award nomination
Aims	To highlight best practice from across the Trust To showcase our innovation, quality and values To provide external validation for our colleague's hard work To increase pride in our achievements within our workforce
Rationale	We know that there is a huge amount of excellent, high quality innovation happening across the Trust, we want to support the organisation to enter, and hopefully win more external recognition for our good work. We would seek to work with teams to create compelling entries, coaching them on what good looks like, identifying gaps in submissions and suggesting ways to make them as compelling as possible.
Risks of proceeding	Time wasted on creating entries which are not shortlisted The more entries we submit, hopefully the greater number of teams who will be shortlisted with the team invited to finals events. These are often at a not unsubstantial cost.
Risks of postponing	Fewer examples of best practice acknowledged and shared Opportunities to boost morale missed Fewer external validations of teams' hard work which we can promote externally Other trusts see their reputations enhanced by winning awards when we have superior initiatives
Cost estimate	This can be delivered within the existing communications and engagement team's resources, in support of teams who are involved in work which is potentially award winning. Some awards' charge for entries whilst others also/instead charge for places at finals events. These costs would need to be met from within the relevant team's budget.

TItle	**Develop a new brand to unify the various strands of our improvement programme and our work to ensure that all of our colleagues are ready to welcome the CQC if they attend for an inspection.**
Aligns to objective:	Transform and develop sustainable and innovative services
Teams involved:	Quality Governance, Improvement Unit with engagement with other interested parties
Aims	To bring together a range of disparate activity under a unified umbrella to demonstrate to our colleagues and our patients, service users and community the breadth of our work to develop even higher quality, safer and more efficient services. To equip our colleagues to feel confident to tell about how the work they are doing contributes to overall organisational improvement work. To create a "whole that is more than the sum of its parts" To demonstrate the interplay between quality and efficiency. To ensure that all of our colleagues feel confident to welcome the CQC into their service, to understand what a CQC inspection is about, how to act appropriately, to feel confident to talk about their service, its highlights, challenges and what the team is doing to address them.
Rationale	We have previously developed the "Better Never Stops" brand to sit as one of the few internal sub brands which the Trust uses. This brand has been in use for a little while and now is the right time to refresh and redefine it.
Risks of proceeding	Launching the newly refreshed branding will involve losing some of the brand capital built up in the "Better Never Stops" brand. However, the use of this brand has waned since COVID-19 and so it is still appropriate to refresh and replace it.
Risks of postponing	Lots of activity focussed on improvement is being undertaken across the Trust. Whether this is around developing CIP initiatives, performance initiatives, quality improvements and programmes to improve patient experience. Without a unifying brand they will all happen in isolation with no way of joining up all of this good work for staff, patients, service users and our community.
Cost estimate	We are anticipating that this can be developed in-house but there maybe some external support required to create high quality brand elements, but if this is required the costs should be around £500.

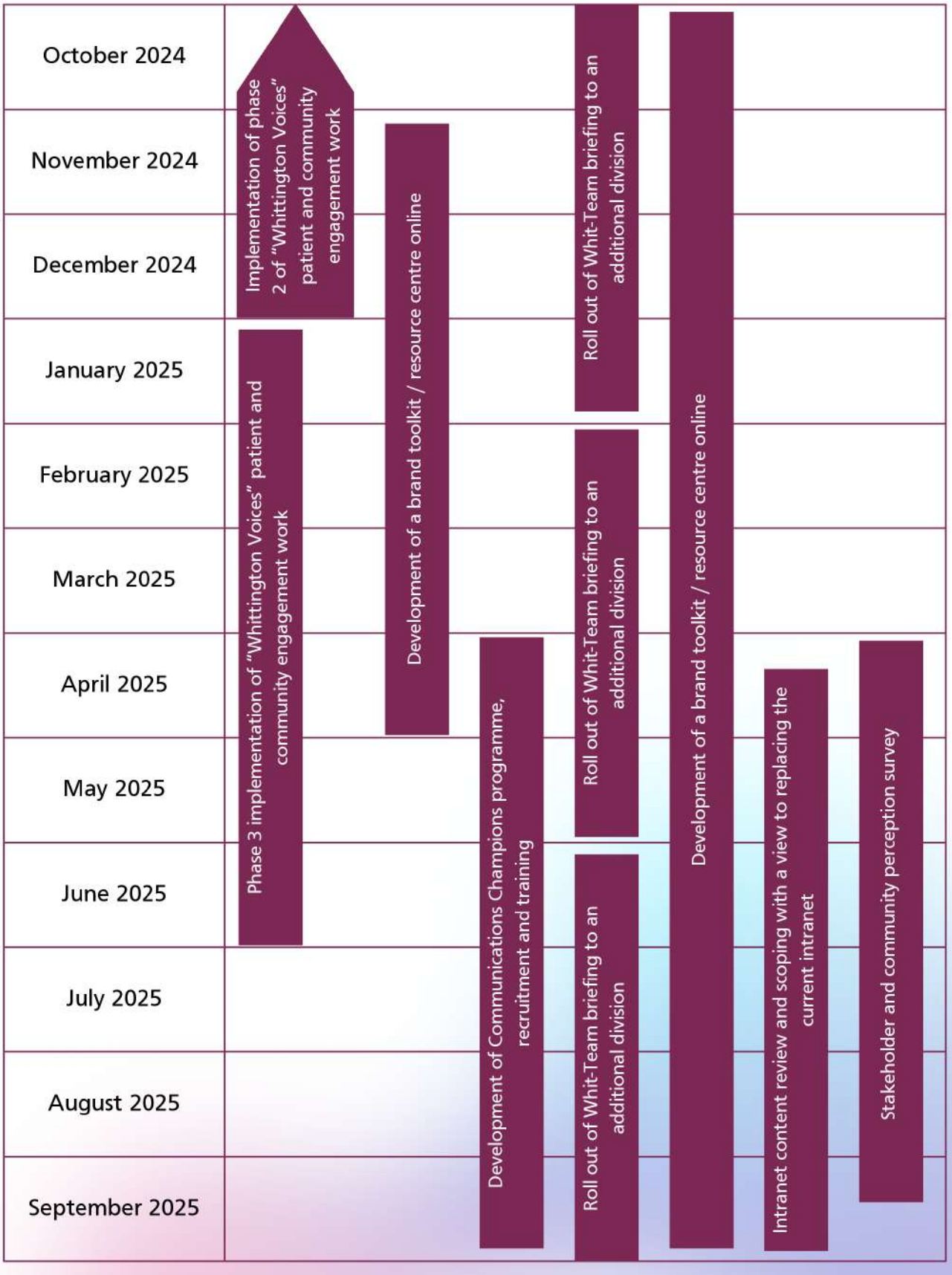
TItle	**Develop a suite of resources and tools to support teams to develop new ways of working that delivery improved patient care and greater efficiency.**
Aligns to objective:	Transform and develop sustainable and innovative services
Teams involved:	Improvement Unit
Aims	To develop a suite of resources to help the improvement unit to showcase the projects they are working on, to provide tools and resources for teams to help them to spread best practice, to create positivity around improvements and to keep internal stakeholders around improvement updated on developments.
Rationale	Utilising the look and feel developed above, we want to provide the tools, resources and support needed across the organisation to unlock the potential for teams across the organisation to deliver quality, efficiency and patient experience improvements.
Risks of proceeding	N/A
Risks of postponing	We continue to ask teams to become more efficient, deliver CIPS, and deliver improvements in quality and patient experience whilst not equipping them with the tools to do so.
Cost estimate	This should all be able to be delivered in-house, with no additional spend required.

Appendix B

Year 1 action plan

Sadly neither financial or human resources will allow us to deliver all of our plans straight away! We will use the first year of the strategy period to deliver some of the projects which do not require or only require minimal investment, as we seek funding to deliver the other projects in future years.

This is all in addition to the business as usual communication activities that we undertake day-to-day:



NHS
Whittington Health
NHS Trust

Communications Strategy

2024/28

Thank you for taking the time to read this Strategy. If you have any questions or would like to discuss anything further, please don't hesitate to reach out to us.

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Meeting title	**Trust Board – public meeting**	**Date: 27 September 2024**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 5**
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 11 September 2024 and was able to take good assurance from the following items considered: • Board Assurance Framework Quality and Integration 2 entries • Q1 Quality governance Report • Annual Serious Incident Leaning Review • Q1 Patient Experience Report • Maternity Board report • Q4 Learning from Deaths report • Annual Infection Control report • Bi-annual Nursing Establishment • Quality Impact Assessment on Cost Improvement Programme Committee members took partial assurance from the following agenda items: • Chair's assurance report, Quality Governance Committee • Trust Risk Register • Ligature risk assessment report • Mental Health Administration • Trust Fire Action Plan • NRS & SI Report for Coroner • Barnet 0-19 Service Update • Simmons House update Following discussion, the following areas were agreed to be reported to the Trust Board: 1. NRS equipment supplies 2. Simmonds House 3. Pest control	

	4. Scale of ligature risks 5. Mental health waits.
Purpose	Noting
Recommendation	Board members are asked to note the Chair's assurance report for the Quality Assurance Committee meeting held on 11 September 2024.
BAF	Quality 1 and 2 entries and Integration 2 entry
Appendices	1. Annual Infection Prevention Control Report 2023/24 2. Q4 Learning from deaths report

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	11 September 2024

Summary of assurance:

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

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.

The Committee approved the Board Assurance Framework

Annual Serious Incident Learning Review

The Committee considered the final summary report of all serious incidents declared between April 2023 to March 2024. Incident reporting had transitioned to the Patient Safety Incident Reporting Framework, a risk-based type of reporting which would also report on low levels of incidents with a focus on learning and improvement.

The Committee noted that in the last year the following events were reported:

- There were 10 serious incidents and one never event which had all been considered at the Committee via quarterly reports. The Committee received assurance that the number incidents indicated a good culture of reporting at the organisation which also included the reporting of incidents of low harm.
- All maternity incidents were reported through Maternity Newborn Safety Investigations (MNSI). In the last year one incident met the MNSI criteria in relation to a baby that suffered hypoxic ischaemic encephalopathy as a result of processes that were not followed during labour. A number of actions had since been implemented and learning shared with teams.
- The Perinatal mortality review considered four stillbirths, two pregnancy losses at 2 weeks and 23 weeks respectively, three neonatal deaths and three terminations of pregnancy for fetal abnormalities.
- The Trust was within the expected range for stillbirth and neonatal deaths at 3.5 per 1000 for 2023 which was slightly higher than 2021 at 2.47 per 1000 births. All the deaths were caused by genetic abnormalities.

The Committee noted the report.

Q1 Patient Experience Report

The Committee welcomed the CQC's findings of the National Adult Inpatient Survey which found several areas of improvement including sleeping at night and communication with patients. The Health Service Journal also cited the Trust as one of eight trusts nationally with the most improved scores. Five key areas of improvement had been identified around waiting times for beds, cleanliness and food.

Key highlights from the Patient Experience report included:

- The approval of recompense to patients for their participation and time taken to support the Trust with feedback and engagement.
- Complaints response times had improved to 73% against a target of 80%. Communication, attitude and medical care were main areas of concern.
- Outpatient transformation work had progressed with significant input from patient focus groups who had revised a suite of outpatient letters. A schedule of engagement work had been developed which would next focus on reasons for missed appointments.
- The installation of "welcome to the ward" boards in ward.
- A further 26 volunteers had started work at the hospital who contributed a total of 3,258 hours of voluntary work in quarter one.
- Friends and family test results had reduced to below the national target of 5%. Ongoing Work with teams would look at ways in which to address poor response rates. In maternity, one additional question was added on the recommendation of the National Maternity Survey in relation to support to feed the baby.
- Patient Advisory Liaison (PALS) continued to be in high demand by patients who use the services. More support had been given at ward level to resolve issues to avert the need to escalate to PALs.

The Committee learned that a positive patient experience story about a young patient with leukaemia, given at the last Board meeting in public, would now be shared with system partners in North Central London (NCL).

The Committee noted the report.

Maternity Board report

The Committee took good assurance from the comprehensive quarter one 2024/25 maternity report which detailed the following key issues:

- An action plan had been implemented to address the bottom five areas identified in the CQC patient survey. A monthly meeting would take place to monitor progress.
- The Trust was on track to complete the patient survey action plan. The patient survey for 2024 took place over the summer, the outcome would be published later in the year.
- The Maternity Incentive Scheme (MIS) for year 6 was published in April. Areas of concern had been identified around training for anaesthetists for obstetric emergencies which were not compliant. Extra prompt dates for training had been made available. The audit of the risk assessment at the onset of labour in respect of the Saving Babies Lives Care Bundle, identified areas of concern around the auditing compliance of reduced fetal movements and risk assessments at the onset of labour. A quality improvement project had been set up to address the concerns.
- Admission rates to the neonatal intensive care unit (NICU), was raised in May. All incidents were investigated, and all admissions were found to be unavoidable.
- There were no serious incidents or referrals to other hospital sites.
- All cases of obstetric haemorrhage had been investigated, no care or system issues had been identified. Reasons were related to a high-risk local population. Processes were followed appropriately.

- The listening to staff question found that there were midwifery forums in place at the Trust together with an action plan to address the outcomes of the National Staff Survey.
- Workforce – a restructure of the maternity department was launched in July and the results would be considered at the next meeting of the Quality Assurance Committee.
- The consultant compliance audit found that the Trust was fully compliant in situations that required the attendance of a consultant and in situations in which the consultant must attend unless the most senior doctor presented documented evidence a being signed off as competent.
- The quarterly review of neonatal transitional care activity and avoiding admissions to the Neonatal Unit found that very few admissions were deemed avoidable. All admissions were reviewed at weekly multi-disciplinary review meetings.

The Committee received assurance that the Trust was working towards full compliance of all 10 MIS safety actions by the deadline of 30 November 2024.

The Committee noted the report.

Learning from deaths report Q4 2023/24

Committee members took good assurance from the review of inpatient deaths from 1 January 2024 to 31 March 2024 and highlighted the following:

- It was confirmed that that the SHMI for the data period was reported as 1.02, however the most recent published data shows the indicator has reduced to 1 which placed the Trust within the expected range of inpatient deaths.
- Inpatient deaths were widened to include perinatal deaths and later paediatric deaths, no concerns were reported.
- There were 10 requests from structured judgement reviews (SJRs) which had all been completed.
- The number of adult inpatients that required mortality reviews had increased from 25% to 50%.
- Themes identified from SJRs revealed that there were none found an avoidable death for the reported period. There was also evidence of good communication with both patients and families and the involvement of mental health teams.
- A summary of themes and learning had been shared with all doctors.
- Palliative care coding was not included in SHMI due to the numbers and variation of patients that were referred. Further work would be undertaken to ensure that future reporting included palliative care patients.

The Committee discussed deaths from strokes where the Trust was highlighted as having a higher-than-expected number of deaths from strokes. An in-depth review of each death was undertaken, contributory factors related to the level of stroke resources at the Trust, which was not a commissioned stroke unit. Additionally, patients admitted had extensive stroke and multiple comorbidities or had experienced catastrophic strokes caused by bleeding which would not have been suitable for neurosurgery or transfer to a stroke unit. All patients died within a short time of arriving at the Trust, a transfer would not have made a different to their outcomes. It was also noted that it was important to place stoke patients within a stroke unit within 72 hours of the incident, otherwise patients were likely to remain at the Trust to be managed locally.

The Committee observed that the Trust had consistently higher SHMI over the past few years. Reasons had been thought to be related to a shift to low mortality non-elective care activity, which was not considered part of the SHMI compared to elective care which carried more risk and was included. Other contributing factors related to coding and the deaths of patients in the emergency department.

The Committee noted the report and would look forward to receiving

Infection Prevention Control Annual Report 2023/24

The Committee considered the report which covered the following key points:

- All nosocomial infections were investigated to determine a known cause, with a clear focus on learning and improving on practice within teams.
- There was mandatory reporting on all Health Care Associated Infections (HCAIs) on the following organisms:
  - Two MRSA infections was recorded, one was related to an infected vascular device.
  - Six methicillin-susceptible staphylococcus aureus (MSSA), four of which were related to associated devices, there were action plans in place to address both MRSA and MSSA hospital infections.
  - There were 37 incidents of gram negative blood stream infections, 13 of which related to urinary catheters. Quality Improvement work was planned.
  - There were 23 cases of clostridium difficile (c.diff) infections against a trajectory of 13. One was linked to time and place, and all cases received a multi-disciplinary review. There was also a related increase in c.diff rates nationally. The target for 2024/25 had been increased to 22.
  - One recorded surgical site infection following repair of neck of femur surgery.
  - There were 89 HCAIs of Covid-19 which were managed and reported to the integrated care board (ICB)
  - There were 25 flu A acquired infections from a total of 308.
  - 25 patients acquired respiratory syncytial virus (RSV) from a total of 279 cases.
  - Other outbreaks of infection included MRSA colonisation, exposure to measles, and pertussis.
- A number of audits were carried out throughout the year around hand hygiene, MRSA screening, management of peripheral vascular devices and environmental inspections.
- There was a year-round focus on education for student nurse training, advanced practitioner preceptorship programmes, medical doctor training and mandatory training.
- Fit testing numbers remained comparatively low.

The Committee sought assurance that measures were in place to reduce the incidence of c.diff infections. It was advised that while current work in place could not guarantee a reduction, planned sessions to discuss outbreaks and incidents were held. Work was also in progress to ensure that patients normal stool habits were noted on arrival and samples were sent off quickly for analysis.

In terms of fit testing the Committee learned that 40% of 4,976 staff members were fit tested. The infection prevention control team worked hard to encourage managers to send their staff for fit tests. Appointments for fit tests could also be arranged electronically. The Committee was assured that annual flu vaccination campaigns took place, but staff uptake was low. Pharmacy colleagues also encouraged patients to receive their vaccinations. Covid vaccinations are also available for front line staff at the Trust from 3 October should they choose to receive the vaccine.

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

Biannual nursing establishment staffing review

The Committee received good assurance on the Trust's response to the statutory requirement to have safe Nursing and Midwifery staffing levels in place. The following points were highlighted:

- The Trust encouraged talented nurses to undertake the Advanced Nurse Practitioner (ANP) course which was the equivalent to an MSe in clinical practice. However, there was not always a position at the end of the training to match the level of qualification. Discussions would continue to develop mitigations to enable nurses to complete the course.
- The requirement for enhanced care had increased post COVID at Whittington Health and nationally. This is currently carried out by 24 WTE temporary 1:1 nurses but this did not meet the need, where required temporary staff are used to fill the gap to maintain safety. Enhanced care is an area of focus across the acute setting. In addition, an expression of interest had been submitted to participate in project led by NHS England (NHSE) to support organisations around 1:1 modelling. Daily monitoring was undertaken to ensure that the Trust was providing the right level of enhanced care to the right patient.
- There was good engagement from ICSUs with the pilot of Health Roster which would be formally launched in October.

The Committee received assurance that the Trust had made significant investment into nursing staff across the organisation.

The Committee noted the report

Ligature risk assessment

Committee members reviewed progress against the current programme of ligature risk assessments. Work had been undertaken to mitigate risks in a number of high and medium risk areas and completion of work in the remaining areas was on target. An external assessor had identified two potential additional areas of risk in the roof space which would be sealed and made inaccessible for patients. The Committee received assurance that an improved programme of training for risk assessors had started and that the Ligature Risk Reduction Policy and Procedure would be finalised by October. A detailed programme of works would also be reviewed regularly by the Executive Team to track progress and any modifications that may arise.

The Committee noted the report and would look forward to receiving a detailed progress report and training plan at the next meeting.

2.	**Committee members took moderate assurance from the following agenda items:** **Chair's assurance report, Quality Governance Committee** The Committee reviewed the report of the meeting held on 23 July 2024 where significant or reasonable assurance was taken from most of the items discussed. The Committee noted the areas of risk escalated by the Quality Governance Committee (QGC): • Estates and Facilities; There is an issue with cockroaches and pest concerns / control across the Trust specifically in the Neonatal Intensive Care Unit (NICU) and in the bed store resulting in the contamination of pressure relieving mattresses. • Children & Young People Integrated Clinical Support informed that there had been continued pressures on the emergency care pathway across the summer period. This was driven by a mix of unwell children and an increase in complex mental health cases. The issues were exacerbated by staff attrition replaced by a more junior workforce across the emergency and paediatrics departments. The Committee also noted that demand for beds on the Ifor ward had exceeded the bed-base. • Effectiveness -National Heart Failure Audit, 2024 Report: overall assurance assessed as 'Red'. • Surgery & Cancer - Quality Impact Assessments of cost improvement savings had been identified but not yet been developed The Committee was informed that stringent measures had been implemented with the removal of mattresses from clinical areas, decontamination and the relocation of the bed store to contain the infestation. The Committee was assured that patient safety had been maintained and that new mattresses had been obtained for patients. The Committee received assurance that a number of mitigating actions had been implemented to manage operational pressures in the paediatrics department which ranged from increasing the number of beds from 17 to 23 on the Ifor ward and the recruitment of additional agency staff. Additionally, the nurse leadership team had been strengthened with the appointment of a matron and a new consultant paediatrician had been substantively recruited to lead the department. A slight decrease in operational pressures had been noted but the prevalence mental health cases continued. **The Committee noted the report** **Q1 Quality Governance Report** The Committee considered the quarter 1 report which provided an overview of patient safety, clinical effectiveness, quality improvement and assurance. The following aspects were highlighted: • A slight decrease in the number of categories 3 and 4 pressure ulcers had been reported in both hospital and the community. The Trust had revised its 2024/25 targets to reduce overall Trust pressure ulcer damage by 10% and full thickness pressure damage (Cat 3 & 4) by 25%. • Duty of candour numbers were high and compliance low with 82 matters related to physical harm and 12 related to psychological harm outstanding.

The majority of cases related to pressure ulcers and additional administrative support had been provided to help manage the backlog.

- The new Patient Safety Incident Reporting Framework (PSIRF) had embedded well across the Trust. A triaging system was planned which would help to prioritise and review incidents as they are reported appropriately. A new PSIRF training programme for staff had also been developed which would be made available for staff via an online platform.
- Two legacy serious incidents remained outstanding which related to Simmons house.
- Two incidents of hospital acquired MRSA infections were recorded.
- There were 2 incidents of hospital acquired c.diff during the first quarter. The Trust has received d its trajectory from 13 to 22 for the year 2024/25.
- A new clinical lead had been appointed to review the findings of the National Heart Failure Audit which found significant areas of poor performance which indicated ongoing safety concerns. The findings were recognised as a high risk and an action plan had been implemented.
- The number policies that were overdue for review had reduced , 6% clinical, 22% non-clinical and 3% operational.

The Committee discussed the utility of PSIRF reporting, it was suggested that reported incidents could be supported by a patient story to demonstrate the application of PSIRF. The Medical Director explained that PSIRF was a relatively new concept and that the full range and use of the framework was yet to be matured. Conversations had taken place with other hospital trusts that were further along in the implementation process and learning and ideas had been shared. Action plans had also proved to be a useful tool particularly for families who were not familiar with PSIRF terminology and the coroner.

The Committee sought assurance that mitigating actions had been implemented to address the risks identified in the National Heart Failure Audit. The Committee was informed that a detailed mortality review on heart failure deaths would be carried out.

The Committee noted the report.

Trust Risk Register

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

- A total of 230 risks were noted on the risk register.
- 39 risks ≥15 on the risk register.
- 6 risks were awaiting executive approval
- 33 fully approved risks,

The Committee noted:
The addition of two new high risks which related to:

- 1550 - Hornsey Central Community Communication Hub
- 1525 - Failures in the Domestic Services department to provide cleaning to a level compliant with National Standard of Healthcare Cleanliness 2021

Increased 15+ risks

- 826 - Cyber Security
- 683 - Crowding in ED

- 1513 - Lack of specialist knowledge for technical team (depth of cover)
- 1498 - Digital Imaging Software – Dental Service

Downgraded 15+ risks

- 1451 - Backlog of medical outpatients on the Partial Booking waiting list
- 1502 - Complaints Performance Surgery & Cancer ICSU

Closed 15+ risks

- 1491 - Levels of medical oxygen flow consistently surpasses the flow capacity of the Secondary VIE. (Vacuum insulated evaporator)
- 189 - Failure to meet ED 4-hour target of 95% in 2011, 78% 2000 and 76% 2024 (see new risk awaiting approval 1559)

The Committee discussed risk 1568 which related to hospital working at height and ineffective protective systems for contractors to work safely. A proposal to secure additional funding to implement safety measures. In the meantime contractors were prohibited from access to roof areas without supervision.

The Committee noted the report.

Mental Health Administration

The Committee received a verbal report on the provision of mental health care for patients at the Trust. The Committee learned that the numbers of patients that presented in the emergency department had increased, there were 192 in June, 215 in July and 210 in August. Of those numbers 10 patients were admitted under S. 2 of the Mental Health Act in June which increased to 17 in August and 11 patients were detained under S. 3 of the Mental Health Act in June which increased to 13 in August.

The Committee noted that waiting times for beds was under review. The Trust had reported two patients had waited over 30 hours for beds in June and July and three patients in August. While the numbers of mental health inpatients were low, there had been long waiting times for patients to be transferred to specialist mental health units. There were three patients under S. 2 of the Mental Health Act I June, two in July and three in August. There was one under S. 3 in June, three in July and six in August. Of the six, four were still wating for a transfer. The issues had been escalated to the ICB and local mental health trusts.

A clinically led piece of work was in progress to develop a mental health strategy

The Committee noted the verbal update and agreed that a detailed update would be brought to the next meeting.

Trust Fire Action Plan

Committee members received a verbal report on progress against the Fire Action Plan. The following points were highlighted:

- 26 actions remained outstanding.
- The London Fire Brigade had attended the Trust to discuss strategy plans and deficiencies in respect of fire safety.

- An action plan was developed from the meeting with 55 actions which would be reviewed on the LFB's return visit to audit Blocs A and L on 19 and 24 September 2024.

The Committee noted the verbal report and would look forward to receive a detailed report at the next meeting.

Quality Impact Assessment report on Cost Improvement Programmes.
Committee members received assurance that all quality impact assessments on savings schemes were reviewed on a monthly basis apart from through the summer. Areas of focus included changes to consumables, procurement and impact on staffing.

The Committee noted the report

NRS & Serious Incident Report for the Coroner
The Committee discussed the ongoing issues and delays with NRS who are contracted to supply pressure ulcer relieving equipment to the Trust and wider NHS organisations across London. The issues and concerns were first highlighted to the ICB by the Trust. Since then, monthly meetings were held with NRS, the ICB and the local authority which had agreed an action plan, however no real assurance from NRS that they were mitigating the issues had been forthcoming. Problems had been exacerbated by a recent cyber-attack on NRS which has complicated the supply of equipment.

The Committee was assured that the issues had been escalated with the ICB and the Heads of Social Care, across the Boroughs. It was noted that there were currently no reasonable alternative organisations available to supply pressure ulcer relieving equipment and the focus had been on resolution with NRS. Additional resources had been agreed to mitigate the risks to patients.

The Committee noted that since April 2024 issues related to the safety of NRS had been identified through coroner's inquests. To date, there have been 3 cases where the equipment concerns were so significant that the Trust was called to give evidence.

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

Barnet 0-19 Service
The Committee received a verbal update on the progress made with the service. Assurance was given that significant roles had been recruited, including 5 health visitors, administrative roles, school nursing leads and a locality manager. Band 6 health visitor posts continued to be difficult to recruit. Agency staffing issues had been addressed and training would now be made available to agency staff which would help to embed nurses as part of the service. Locality work was scheduled to begin in October which would improve accessibility for families and reduce travel time. The reduction of the backlog of new birth visits was on track to conclude by mid-October and babies were now seen within 30 days of birth. The backlog of one and two year old reviews was on track to conclude by January 2025. The first successful meeting with Commissioners took place in August, good progress had been made with the service while it was

	acknowledged that there was considerably more to do to take the service forward. **The Committee noted the verbal report** **Simmons House update** Committee members were apprised of the latest developments. Since the last report to the Committee a meeting with staff was held on 22 August which informed that the staff consultation process would commence in September. The meeting also informed on the future plans for the provision of mental health support for young people. The Trust had received notification from the CQC that they would not take any further action in respect of absconding incidents, the Trust would await their decision in relation to the ligature incident which was scheduled for the end of December. Discussions would continue with Haringey Learning Partnership in relation to the future of the school on site. The public engagement exercise in respect of the service would be led by NHSE with input from NCL ICB, and the Trust. **The Committee noted the update**
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 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 Isabelle Cornet, Director of Midwifery Marielle Perraut, Assistant Chief Nurse Dr Sarah Gillis, Associate Medical Director Learning from Deaths Kyle Durkin, Interim Deputy Director of Estates & Facilities Swarnjit Singh, Joint Director of Inclusion & Trust Company Secretary Jeanett Barnes, Associate Director of Nursing, Children & Young People ICSU **Apologies** Paddy Hennessey, Director Estates & Facilities Kat Nolan-Cullen, Compliance and Quality Improvement Manager

Meeting title	Quality Assurance Committee	**Date: 11 September 2024**
Report title	Infection Prevention and Control Annual Report 2023/24	**Agenda item: 4.6**
Executive director lead	Sarah Wilding Chief Nurse & Director of Allied Health Professionals Director of Infection Prevention and Control (DIPC)	
Report author	Julie Singleton Head Nurse Infection Prevention Control Deputy DIPC	

Executive summary

The Infection Prevention and Control (IPC) Annual Report reports on infection prevention and control activities within Whittington Health (WH) NHS Trust for April 2023 to March 2024. The report covers IPC for the Integrated Care Organisation (ICO). The publication of the IPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability.

Key points are included around nosocomial infections and detail is provided on the investigations undertaken to determine if there was a known cause of the infection and there is a clear focus on learning at a ward and team level to maintain safe standards around infection risks and prevention. Themes in practice are used as education and audit opportunities for IPC development, training and shared learning across the Trust.

1. Healthcare-associated infection (HCAI) mandatory reporting and surveillance

The following organisms are subject to mandatory reporting. These are MRSA, MSSA, Gram-negative bloodstream infections (Escherichia coli (E. Coli), Klebsiella species (Kleb. spp), Pseudomonas aeruginosa (P. aeruginosa)), and Clostridiodes difficile (C. difficile).

a) Methicillin Resistant Staphylococcus aureus (MRSA)

There have been two Trust assigned MRSA bacteraemia's, against a target of zero, in quarter three and four. Post infection review identified one as unavoidable, relating to the peripheral vascular device (PVD). There is a quality improvement (QI) project underway.

b) Methicillin Susceptible Staphylococcus aureus (MSSA)

There have been six hospital-onset MSSA bacteraemia for the year, over a 50% decrease on last year's 15 cases. There is no NHS standard contract for MSSA. Four are associated to an invasive device. An action plan is in place.

c) Gram-negative blood stream infections (GNBSI)

NHS long-term plan aims to reduce GNBSIs by 50% by 2024/25. There were 37 hospital-onset GNBSI (E. Coli, Kleb. spp, P. aeruginosa) identified in 2023/24. Two cases up from last year but an overall decline over the last five year. 13 cases are associated to a urinary catheter. A urinary catheter QI planning is underway.

d) C. difficile infection (CDI)

The total number of cases assigned to the WH was 23, which is above trajectory of 13 cases. The NHS Standard Contract 2023/24: Minimising Clostridioides difficile and Gram-negative bloodstream infections, set out the requirements to minimise rates of CDIs to threshold levels set

by NHS England. There has been one probable transmissible infection linked to a lapse in policy. There have been an unprecedented number of unviable samples (six) with one possible link in time and place. Antimicrobial Stewardship (AMS) review of individual cases highlighted antibiotic choices were appropriate for the indication however improvement for the duration was required.

e) Surgical site infection surveillance system (SSISS)

National mandatory surgical site infection (SSI) reporting for the year is one quarter / one surgical procedure. The Trust opt to report four quarters on repair of neck of femur fracture surgery. There was one infection reported for 23/24, thought to be via self-care. Voluntary reporting for Caesarean section is under review for 24/25 submission.

2. Acute Respiratory Infection (ARI), including Covid-19

f) Covid-19

Year end 23/24, there have been 89 definite COVID-19 HCAI cases and a reduced number of COVID-19 outbreaks (n=30) requiring management. Transmission incidents / outbreaks were identified, managed, and reported externally to UK Health Security Agency (UKHSA) and Integrated Care Board (ICB).

g) Influenza

Year end 23/24, 25 patients acquired influenza A from a of total 308 (276 type A and 34 type B) influenza cases in the hospital. With 'flu season' starting in December (n=73), January peaked with 107 cases falling in February (n=55) and March (n=21) and reporting a total four outbreaks of influenza A (Dec23 – Mar24).

h) Respiratory syncytial virus (RSV)

Year end 23/24, 25 patients acquired RSV from a of total 279 RSV cases in the hospital. Incidence of RSV began in November (n=105), December (n=94), dropping in January (n=30). There was one outbreak.

3. Clinical activity, incidents, and outbreaks

A vast number of investigations were undertaken during the year, including outbreaks of Covid-19, RSV, C. difficile, MRSA colonisation, Carbapenemase Producing Enterobacteriaceae (CPE), and exposures to Measles, Tuberculous (TB), invasive Group A strep (iGAS) and Pertussis. Actions resulting from these investigations have been implemented.

4. Audit

The IPC team (IPCT) undertook many audits throughout the year including hand hygiene, MRSA screening, management of PVDs, and environment inspections for hospital and community sites. Results of the individual audits were fed back for monitoring and compliance.

5. Education

There is a year-round education focus on the prevention of infection. The IPCT ran nursing and medical student, link practitioners and preceptorship programmes, supported WH inductions and mandatory training. Ad hoc teaching was provided for high profile infection, outbreaks, and incidents of importance. Stalls and activities were put on by the IPCT for World Hand Hygiene Day and International Infection Prevention Week. QI projects for improving central line associated

blood stream infections (CLABSIs) in adult intensive care unit (AICU), and PVD documentation have continued this year.

6. Face Fit test (FFT) and resilience program

There are approximately 4976 staff employed by the trust, it is estimated only half may routinely be exposed to Aerosol Generating Procedures (AGPs). There is low FFT compliance (40%) of staff performing AGPs.

Recommendations
The committee is asked to receive this report, to note the content of information and take assurance from the information that the IPCT is responsive to all reports of nosocomial infections. That the investigations are robust, and that adequate learning is pulled out and acted upon.

Purpose:	For information
Recommendation(s)	The Committee is requested to (i) Interrogate and review the annual report (ii) Approve for reporting to the trust Board
Risk Register or Board Assurance Framework	Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.
Report history	Quality Governance Committee Quality Assurance Committee Trust infection prevention and control committee
Main paper **Appendices**	Annual Report – Discussion / key points 1a. Healthcare-associated infection surveillance and mandatory reporting 1b. Summary of key contributory factors to Clostridioides difficile 2. Mandatory training dashboard

Contents

Measles Paediatric ED 46 contacts Jan24
C. difficile GDH Thorogood Jan24
Measles Paediatric ED Feb24
C. difficile GDH & Toxin AICU 5 patients Feb24
Tuberculosis MSSO Feb24
CPE Thorogood 89 contacts Feb24
MRSA Bacteraemia COHA 15/02/2024 ED Unavoidable
CPE Victoria 19 contacts Mar 24
MRSA Bacteraemia #2 12/03/2024 Thorogood Avoidable

6. Compliance to policy: Audit
   IPC Clinical audit
      - Hand hygiene
      - Sharps audit
      - MRSA Screening audit in admissions ward
      - Glove use during IV drug preparation audit in surgical ward
      - Hand Hygiene audit supporting CVC QI Project in AICU
      - PVD audit in surgical ward

   Audit in planning for 2024/25
   IPC Environment audit
      - Tendable
      - Clinic environmental audit
      - Necessary public facing and non-facing areas environmental audit
      - Community environmental audit

   Surgical Site Infection Surveillance Service
      - Mandatory - Fractured Neck of Femur Repair SSI Rates
      - Voluntary - Caesarean Section SSI preliminary data

7. Compliance to policy: Education
   Mandatory training
   IPC Competency Assessment Booklet
   Ad hoc teaching and forums for high profile infection, outbreak, incident of importance
   Clinical Inductions
      - UCLH Medical Students
      - Internationally Educated Nurses (IEN)
      - Intensive Care Unit

   Supporting professionals
      - Preceptorship Programme
      - Level 2 and Level 3 Healthcare Support Workers (HCSW)
      - Student Nursing forums
      - Ambitious college
      - IPC Link Study Day

   Awareness days
      - World Hand Hygiene Day
      - NHS75 Next Generation
      - International infection prevention Week

   2023/24 QI projects
      - CVC QI Project in AICU

1. Purpose

1.1. The IPC annual report reports on IPC activities within WH NHS Trust for April 2023 to March 2024. The report covers IPC for the integrated care organisation (ICO). The publication of the IPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability.

1.2. A zero-tolerance approach continues to be taken by the Trust towards all avoidable HCAIs. We ensure that good IPC practices are applied consistently and are part of our everyday practice meaning that people who use WH services receive safe and effective care.

1.3. This report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving the quality of patient and stakeholders experience as well as helping to reduce the risk of infections. Additionally, the Trust continues to work collaboratively with outside agencies as part of its IPC and governance arrangements including:

- NHS North Central London (NCL) ICB
- London Region Health Protection Team (LRHPT)

1.4. The Infection Prevention and Control Committee (IPCC) reports to the Quality Governance Committee which to the Quality Assurance Committee, and up to Trust Board

1.5. Committees reporting to the IPCC are:

- Water and Ventilation Safety committees
- Decontamination committee
- Antimicrobial steering group

1.6. Regular reports to IPCC are detailed in the Business Cycle (Appendix 1) and include:

- Soft Facilities Management
- Dental Services
- Occupational Health
- Waste Management

1.7. IPCC continues to meet on a quarterly basis, via MS teams and is chaired by the DIPC.

2. Infection Prevention and Control Team and Staffing

2.1. The IPC service is delivered by a small but enthusiastic and dedicated team led by the Head nurse for Infection Prevention and Control (IPC) services, in collaboration and under the direction of the Chief Nurse and Director of Allied Health Professionals, who is the Accountable Officer, and DIPC.

2.2. The IPCT provide an IPC service to the hospital, dental and community services across WH NHS Trust, Monday to Friday with an out-hour support from Microbiology and the site team.

2.3. The IPCT staffing at the end of March 2024 is as follows:

- Head Nurse IPC and deputy DIPC (band 8B) 1.0 WTE
- Operational Lead Nurse IPC (band 8A) 1.0 WTE
- Infection Prevention and Control Nurse specialist (band 7) 3.0 WTE

    - Education Lead
    - Audit Lead
    - IPC Nurse specialist in training (band 6)
- Infection Prevention and Control Administrator (band 3) 1.0 WTE
- Surveillance and Data Analyst (band 5) 1.0 WTE
- Fit test lead and tester (band 5) 1.0 WTE
- IPC auditor (band 4) 1.0 WTE
- SSI volunteer (vacant)

2.4. The organisational structure chart below (Diagram 1) illustrates the line management for the Infection Prevention and Control team.

2.5. Whom together, whilst supporting national, regional, and local reporting on HCAI, ensure the focus is firmly on infection prevention through surveillance, audit, education and training. Operationally, every day the service is demanding with microbiological results, surveillance of trends, PIRs, outbreaks, external reporting of high-profile incidents (non-exhaustive). To maintain this challenging level of effectiveness whilst still meeting audit and educational commitments, the IPC nurses alternate the operational workload (i.e., bacteriology, virology, projects) between them, keeping a visible presence throughout the hospital.

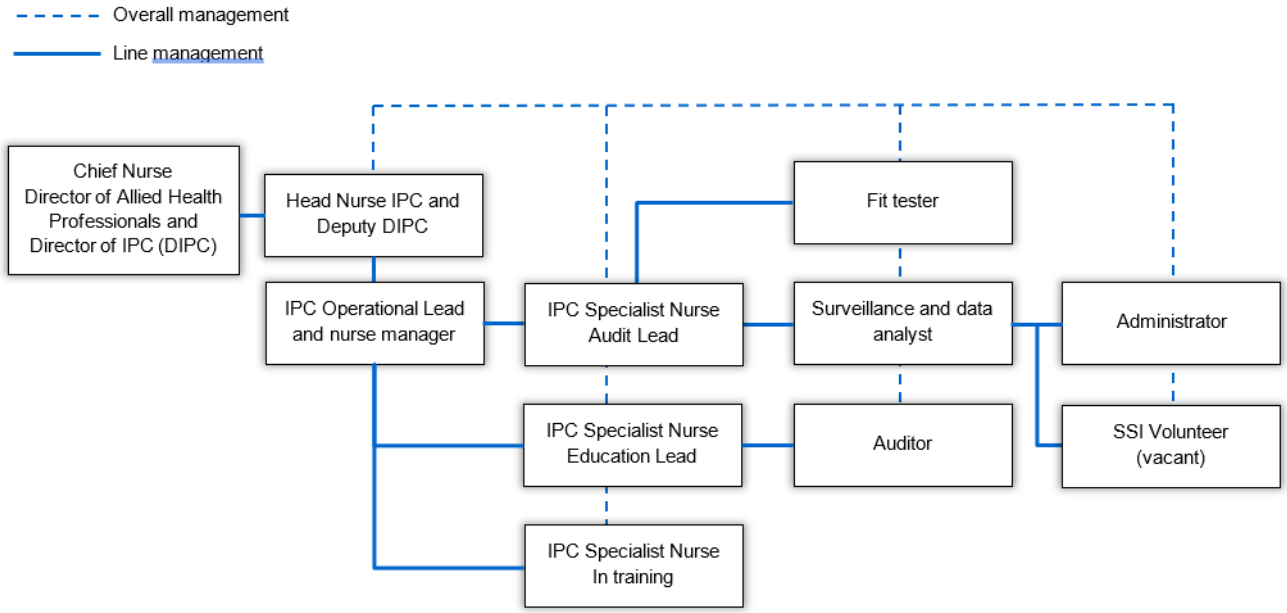
2.6. In October 2023 an upload of new intranet page for Infection Prevention and Control (whittington.nhs.uk) occurred, in line with the National IPC Manual (NIPCM).

2.7. The IPC Dashboard - Power BI a digital visibility platform replaced Qlikview Covid tracker in 2024. The new platform, as well as tracking acute respiratory viruses, visualises patients positive with enteric precautions (e.g., C. difficile) and enhanced contact precautions (e.g., CPE) that must be isolated, empowering staff on the ground to act.

2.8. Celebrations for the team this year include:

- Danel Meno Garcia, winner of British Journal of Nursing, Infection Prevention Nurse Award. Danel (IPC Education Lead) is now in his final year of his IPC MSc at University of Western London.
- IPC nurse, Maria Albuquerque (IPC Audit Lead), passed her post-grad IPC qualification with distinction.
- Tracey Groarke was successful in the recruitment for the IPC operational lead.
- Juan Lawicki (newest team member) was successful in the recruitment for a training IPC nurse.

Diagram 1. IPC organogram end of 2023 – 2024.



3. Organisms subject to mandatory reporting

3.1. Mandatory UKHSA Data Capture System

This is an integrated data reporting and analysis system for the mandatory surveillance of Staphylococcus aureus, E. coli, Kleb. spp., P. aeruginosa bacteraemia and CDIs, with the intention of reducing such infections through building better evidence base and allowing us to target problem areas. See appendix one for breakdown of surveillance and mandatory reporting of data for Trust attributable Healthcare-associated infection by ward and month. See table one for UKHSA DCS summary.

Table one. Healthcare associated infection mandatory reporting summary for Blood Stream Infection (BSI) and CDI. Whittington Health. 2023 – 2024.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	YTD	
	No. cases	No. cases	No. cases	No. cases	No. cases	No. cases	No. cases	No. cases	No. cases	No. cases	No. cases	No. cases	No. cases	Ceiling
Clostridium difficile infection (CDI)														
Hospital onset - healthcare associated (HOHA)	3	2	2	1	0	0	1	3	1	1	5	4	23	13
Community onset - healthcare associated COHA	0	0	0	0	0	0	0	0	0	0	0	1	1	-
Gram positive blood stream infections (GP BSI)														
Trust MRSA BSI	0	0	0	0	0	0	0	0	1	0	0	1	2	0
Trust MSSA BSI	0	0	0	1	0	1	1	1	1	1	0	0	6	
Gram negative blood stream infections (GN BSI)														
Trust Escherichia coli	0	2	3	5	1	3	0	1	1	0	1	4	21	19
Trust Klebsiella BSI	1	1	1	3	0	0	4	0	0	0	2	1	13	13
Trust Pseudomonas aeruginosa BSI	0	0	1	0	0	1	0	0	0	0	1	0	3	2

'Trust' refers to cases that are identified after two days of hospitalisation and so are defined epidemiologically as "healthcare-associated". A further delineation is made for C. difficile whereby non-Trust toxin (EIA)-positive cases where the patient has had a previous hospitalisation within 4 weeks are

classified as 'Community-Onset Healthcare-Associated (COHA), distinguishing it from 'Healthcare-Onset Healthcare-Associated' (HOHA) cases. National thresholds are set for MRSA BSI and CDI.

Methicillin-Resistant Staphylococcus Aureus (MRSA bacteraemia)

3.2. Notwithstanding, NHS England's Patient Safety document, to deliver zero tolerance on MRSA bloodstream infections (BSI), the Trust have two bacteraemia's this year end 2023/24.

3.3. Case one (December 23) was an unavoidable BSI in a very unwell adult intensive care unit (AICU) patient who was previously not known to WH as colonised with MRSA. The blood culture, screening and treatment was carried out as per protocol.

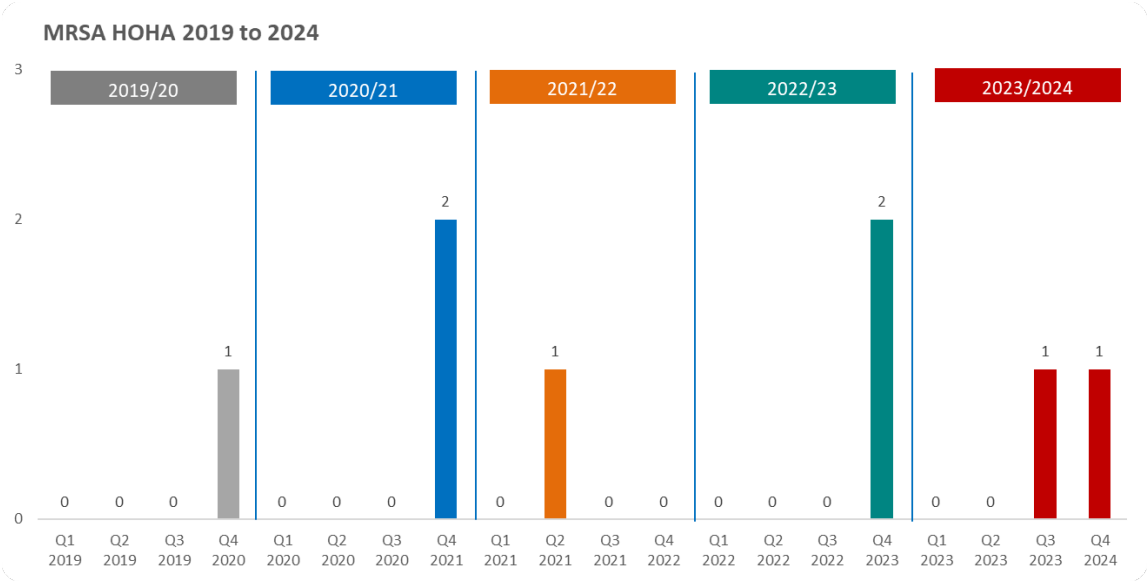
3.4. The source of the second MRSA BSI (March 24) was from an infected peripheral vascular device site with delayed suppression treatment given. This case was deemed avoidable.

3.5. There is an extensive peripheral vascular device (PVD) quality improvement (QI) project underway within the Trust, incorporating education, training, audit, and feedback around PVD care and documentation. Communications through posters and reminders are given in handovers, and huddles reinforcing PVD care standards. This work will have implications for all BSI acquired through a PVD.

3.6. MRSA screening audits were conducted over a three-week period on the admission wards. The aim was to capture compliance of MRSA screening within the first 24 hours of admission as per national policy. However, the audit outcome (5% non-compliance to policy) was inconsequential, as the methodology contained at least two significant errors. Firstly, the same patient's data was collected daily, extending the 24-hour period and secondly the IPC nurse unintentionally biased the data by requesting suppression therapy daily if it had not been given.

3.7. More work is in planning for MRSA screening, suppression therapy and compliance in 2024/25. There is no comparison of MRSA BSI over the last five years. Diagram one.

Diagram one. Healthcare associated MRSA BSI cases over five years. Whittington Health. 2019 – 2023.

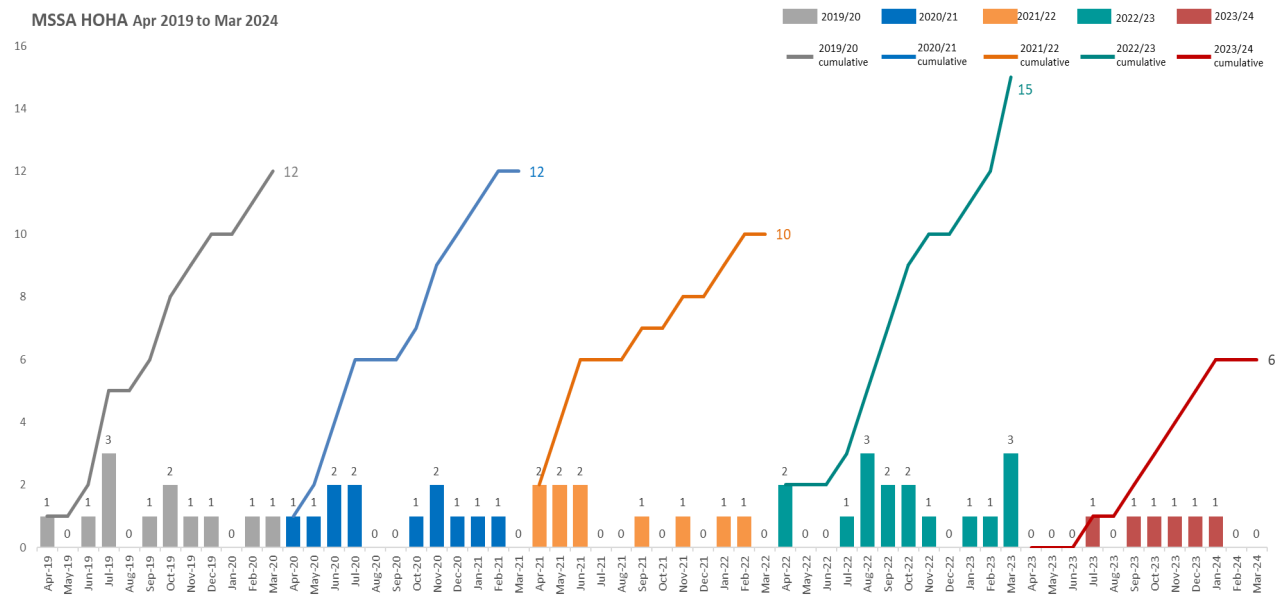


Methicillin Sensitive Staphylococcus Aureus (MSSA bacteraemia)

3.8. WH saw six healthcare-acquired cases of MSSA for 2023/24. Post infection reviews (PIR) found four were associated with a vascular device. Shared learning was disseminated appropriately, and a PVD QI project is underway Trustwide.

3.9. There is no NHS standard contract for MSSA, however, there has been a 50% decrease in cases over the last 5 financial years (12 vs 6). Diagram two.

Diagram two. Healthcare associated MSSA BSI cases over five years. Whittington Health. 2019 – 2023.



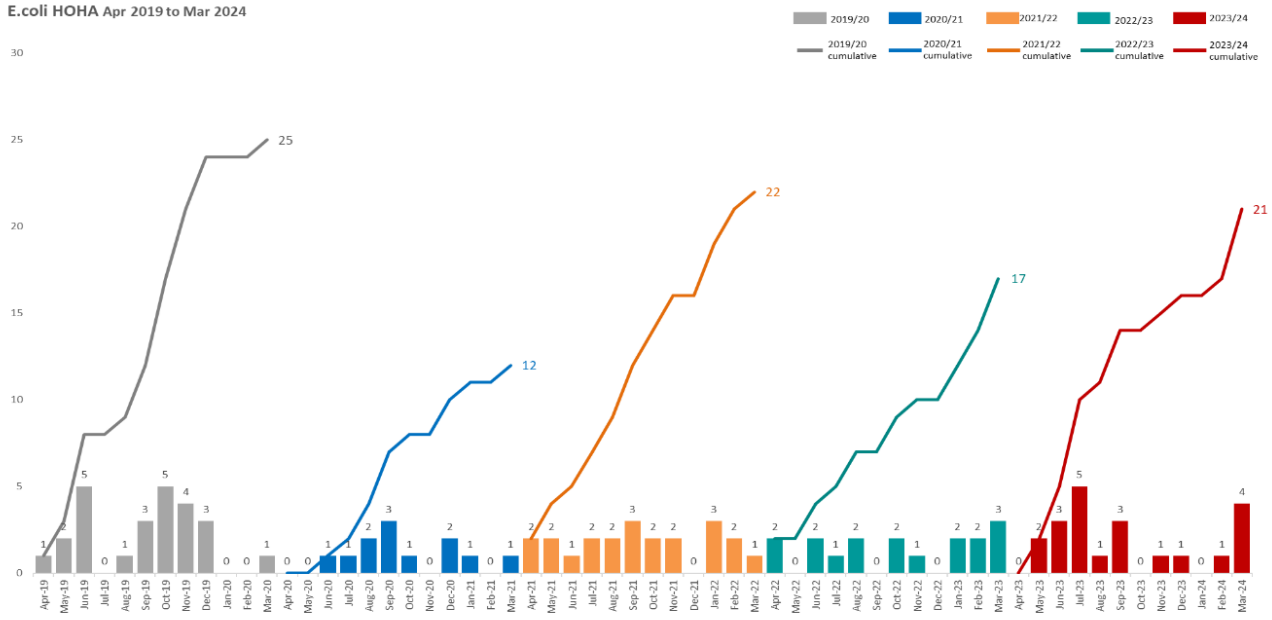
Gram-negative Blood Stream Infection (GNBSI)

3.10. Due to the national rise in GNBSIs; namely E. coli, Kleb. spp., and P. aeruginosa, and their increasing resistance to key antibiotics, the NHS long-term plan aims to reduce GNBSIs by 50% by 2024/25.

3.11. The national increase is reflected in our Trust levels of healthcare acquired GNBSIs. Although over annual thresholds (P. aeruginosa and E. coli) and equal to threshold (Kleb. spp.) set by the NHS Standard Contract, numbers are considerably low. Year-end 2023/24 figures for WH against the NHS standard contract thresholds are as follows:

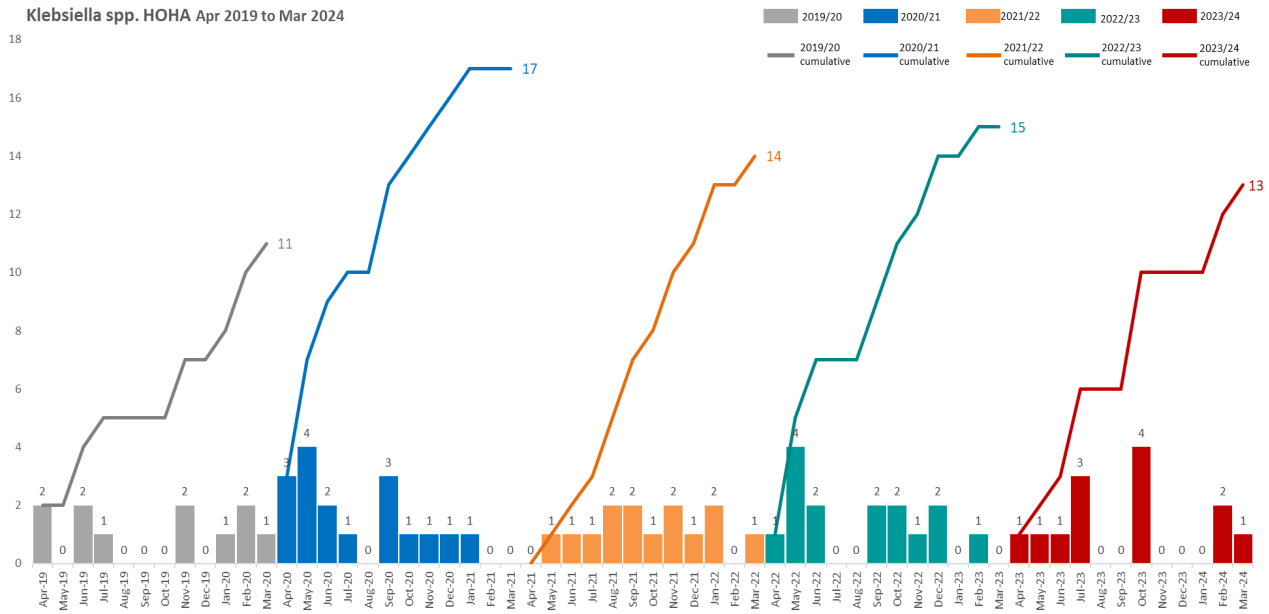
3.12. WH saw 21 healthcare-acquired cases of E. coli for 2023/24 against an annual threshold of 19. Ten are associated to urinary catheter. There has been an 16% decrease in cases in the last five financial years (21 vs 25). Diagram three. A lookback exercise was undertaken by the second intake of microbiologist registrars which yielded a higher incidence of urinary catheter associated BSIs (5 vs 10). Clinical audit for urinary catheter care and management is in planning for 2024/25.

Diagram three. Healthcare associated E. Coli BSI cases over five years. Whittington Health. 2019-2023.



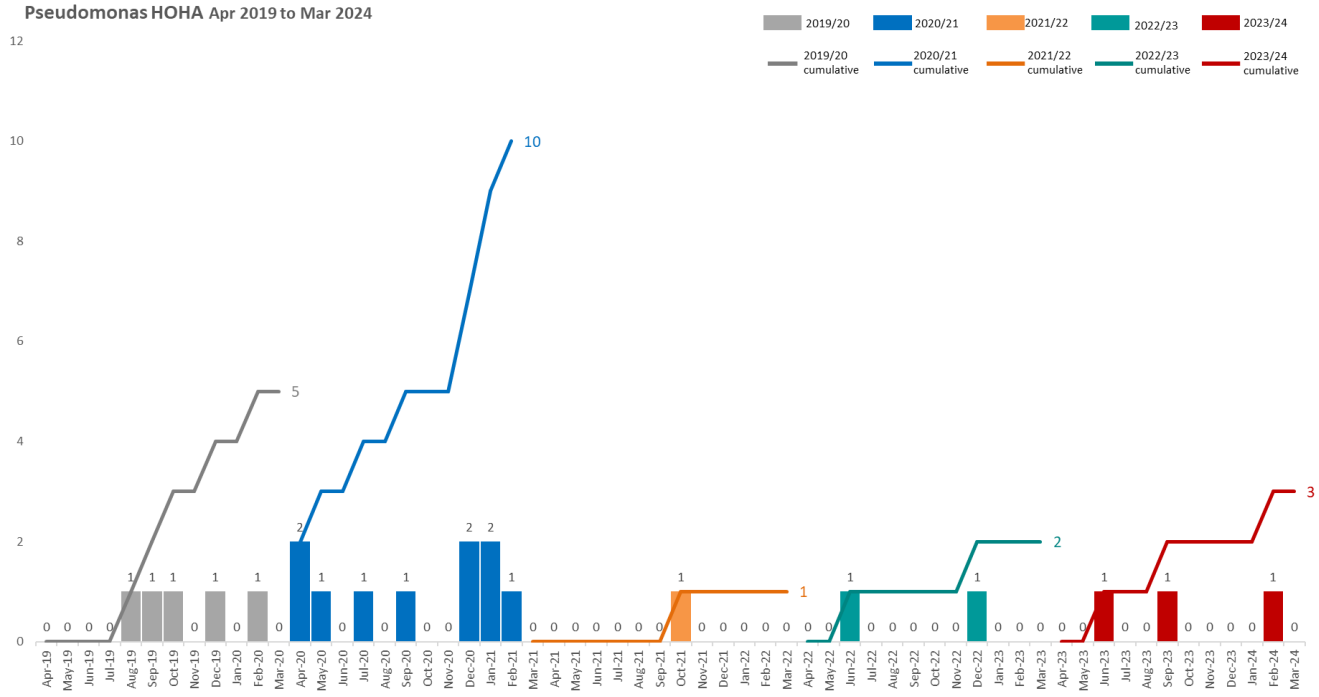
3.13. WH saw 13 healthcare-acquired cases of Kleb. spp. for 2023/24 against an annual threshold of 13. Three are associated to urinary catheter. There has been a 16% increase in cases in the last five financial years (13 vs 11). Diagram four. Clinical audit for urinary catheter care and management is in planning for 2024/25.

Diagram four. Healthcare associated Kleb.spp BSI cases over five years. Whittington Health. 2019-2023.



3.14. WH saw 3 healthcare-acquired cases of P. aeruginosa for 2023/24 against an annual threshold of 2. There has been a 40% decrease in cases over the last 5 financial years (3 vs 5). Diagram five.

Diagram five. Healthcare associated P. aer BSI cases over five years. Whittington Health. 2019-2023.



Clostridioides difficile Infection (CDI)

3.15. The [NHS Standard Contract 2023/24: Minimising Clostridioides difficile and Gram-negative bloodstream infections], set out the requirements to minimise rates of CDIs to threshold levels set by NHS England.

3.16. WH have passed the hospital acquired CDI trajectory [13], with 23 cases.

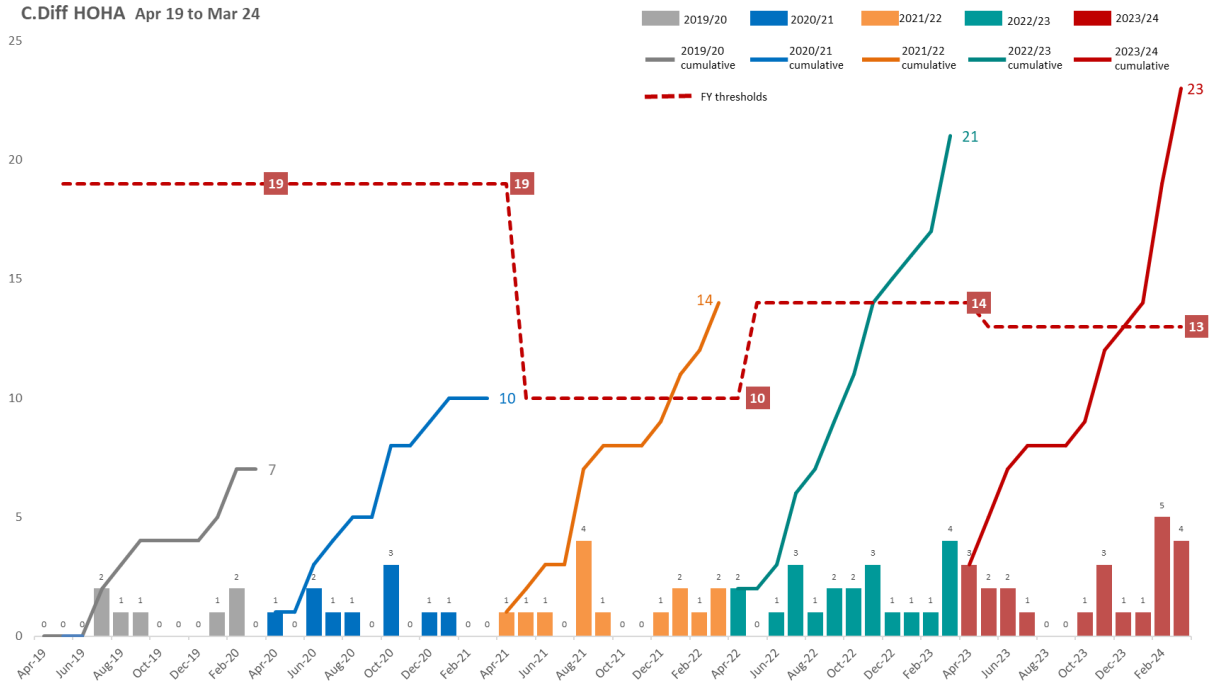
3.17. Year end 23/24, with one case not sent for typing (missed internal process, unrelated to other cases in time and location), there are 10 different ribotypes from 16 cases, whereby six could not be tested (unviable). Ten cases, who although shared the same ribotype(s) (002, 015, 014, 106, 023) were not linked in time or location, illustrating very low patient to patient transmission in hospital. There has been one probable transmissible infection (076) linked to a lapse in policy (delay to isolate a relapse case of CDI). Due to the unprecedented unviable samples a review of the standard operating procedures for CD testing is being undertaken by WH microbiology laboratory. A summary of key contributory factors to C. difficile reported to UKHSA is shown in appendix two.

3.18. GDH (Glutamate dehydrogenase)) positive, toxin negative cases (meaning C. difficile carriage), coupled with GDH positive, toxin positive (meaning infection and reportable) represented seven (n=19 cases) individually reported outbreaks to UKHSA.

3.19. UKHSA state ‘Since January 2021 there has been an increase in CDI for which there is no clear explanation. In addition to this national increase, a local change to testing in November 2022, resulting in more testing, is reflected in our Trust levels of hospital onset, healthcare associated (HOHA) CDI toxin+ cases as demonstrated in diagram 6.

3.20. A CDI exception review was carried out in July 2023 and again in February 2024. Key findings indicate speed of diagnosis is important for the efficient use of isolation facilities, and that clinicians should ensure that stool specimens are sent for toxin testing as soon as infective diarrhoea is suspected. The latter potentially preventing HOHAs if within the first 48 hours of admission. In addition to these findings, a hypothesis around poor compliance of environment and patient equipment cleanliness is currently under Trust review.

Diagram 6. Trust levels of hospital onset, healthcare associated (HOHA) CDI toxin+ cases with yearly thresholds, over five years. Whittington Health. 2019 – 2023.



4. Management of Acute Respiratory Illness (ARI)

4.1. ARI is defined as the acute onset of one or more of the respiratory symptoms listed at People with symptoms of a respiratory infection including COVID-19 and a clinician's judgement that the illness is due to a viral acute respiratory infection (for example COVID-19, influenza A and B, RSV).

4.2. Following national guidelines for ARI, WHs guidance is consistent with the approach of managing COVID-19 increasingly in line with other ARIs, made possible by high vaccination coverage, high immunity amongst the population, and increased access to COVID-19 treatments.

4.3. WH winter planning, twice weekly respiratory meetings, covered the winter season from November and ended on the 12 March 2024. The general uptake was low in attendance.

Covid-19

4.4. Year end 23/24, there have been 89 definite COVID-19 HCAI cases and a reduced number of COVID-19 outbreaks (n=30) requiring management. Staff uptake for Covid-19 vaccination was 32.3% (provided by Deputy Director of Workforce).

4.5. Table two shows a significant decrease in Covid-19 hospitalisations from 22/23, also seen nationally, reduced COVID-19 mortality, and a reduced clinical severity of COVID-19 infection.

Table two. Comparison of Covid-19. Whittington Health. 2022 – 2024.

	22/23 No of cases	23/24 No of cases
Total Number of positive cases:	1682	666
Community Acquired - *Pre-admission or up to day 2*	1271	431
Intermediate HAI - *Day 3 – 7 (hospital onset)*	130	79
Probably HAI - *Day 8 – 14 (hospital onset)*	111	67
Definite HAI - *Day 15 or more (hospital onset)*	169	89

Influenza A and B

4.6. Year end 23/24, 25 patients acquired influenza A from a of total 308 (276 type A and 34 type B) influenza cases in the hospital. With 'flu season' starting in December (n=73), January peaked with 107 cases falling in February (n=55) and March (n=21) and reporting a total four outbreaks of influenza A (Dec23 – Mar24). Staff uptake of influenza vaccine was 37.5% (provided by Deputy Director of Workforce).

Respiratory Syncytial Virus (RSV)

4.7. Year end 23/24, 25 patients acquired RSV from a of total 279 RSV cases in the hospital. Incidence of RSV began in November (n=105), December (n=94), dropping in January (n=30). There was one outbreak.

4.8. The guidance on testing for respiratory infections was updated in April 2023 and patients not experiencing respiratory symptoms no longer required PCR testing. WH isolate positive patients (or cohort if same ARI), not closing bays to contacts but terminally cleaning the bedspace and admitting to, if appropriate.

4.9. If capacity allows, WH isolate ARIs for a period of five days and a minimum of 10 days (except RSV) isolation if immunocompromised. Prior to de-isolating, the IPCT review with the clinical team of individual appropriateness to lift the precaution. Contact time of patients exposed to positives is seven days. If a second patient is known from the bay to be positive and / or symptomatic, this is considered an outbreak, managed appropriately, and reported externally. Outbreaks are monitored for 10 days (initiated as per guidance at the time 2022/23 report).

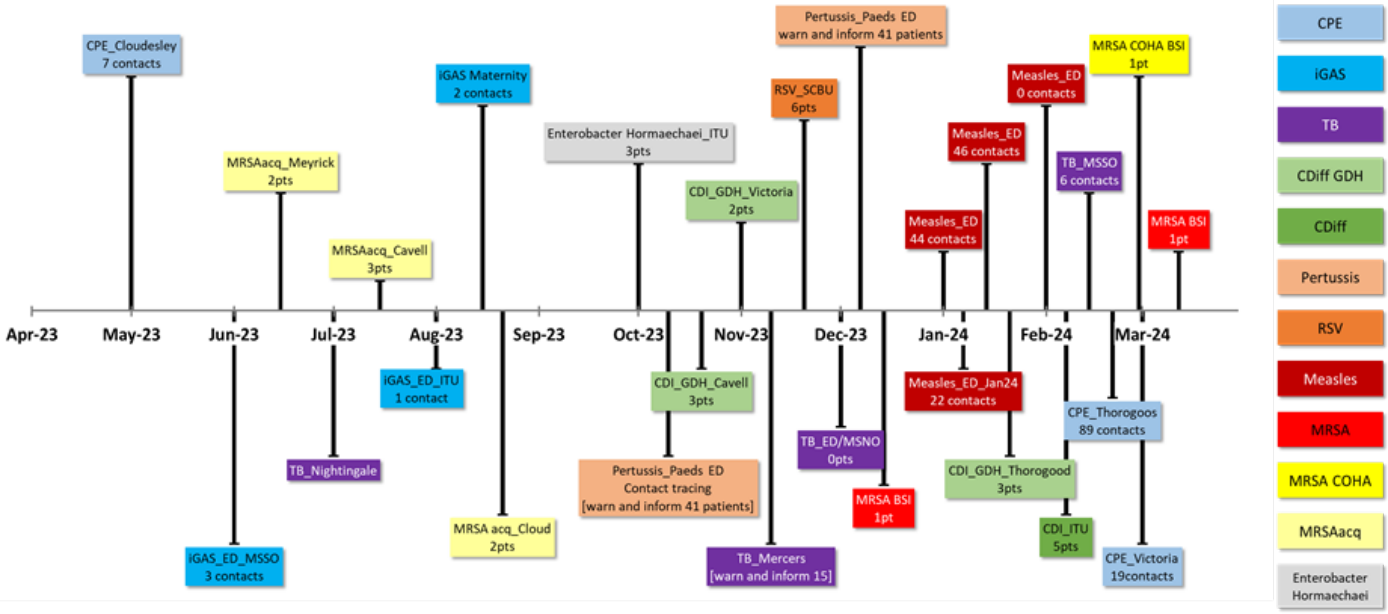
5. Investigation of infection prevention and control incidents and outbreaks

5.1. Details of IPC incident and outbreak investigation are found below and include MRSA bacteraemia, MRSA colonisation, Influenza, Covid-19, RSV, Measles, Pertussis, CPE, iGAS, TB.

5.2. The timeline for IPCT 2023-2024 activity (diagram 7) is non exhaustive. C. difficile individual cases (n=23), reported in detail on the quarterly IPCC reports plus PIR meetings at the time

of infection, and a great number of incidents investigated by IPC that have not yielded infection and / or patient contacts have not been included in this report.

Diagram 7. Timeline incidents and outbreaks, with patient -/+ contacts by organism. Whittington Health. 2023– 2024.



Quarter one (Apr – Jun)

5.3. CPE Cloudesley_7 contacts May23

This is a hospital onset, hospital associated (HOHA) case of CPE as the admission screen was not attended. Patient admitted in April 2023 with shortness of breath and worsening pulmonary oedema days after a rehabilitation admission at another hospital post fall and fracture. A urine specimen taken in May 2023 confirming an Enterobacter Cloacae CPE. Sadly, the patient died and was referred to HM coroner his death was treated as a post operative death. There were seven contacts who on follow up screening had a least one negative result, most up to four.

5.4. iGAS Bacteraemia_ED_MSSO_3 contacts Jun23

There was a confirmed iGas BSI in a patient who attended ambulatory care and subsequently admitted to MSSO in a bay. The blood cultures were appropriately taken on admission. Contact tracing identified three contacts in bay who were given warn and inform letters to them and factsheets given to their clinical team for observational surveillance of signs and symptoms and action if present. Case closed.

5.5. MRSA acqusition_Meyrick_Jun23_2pts

Two patients on Meyrick ward acquired MRSA, which was found on the ward's weekly MRSA screening. On investigation, four other known MRSA cases were identified on the ward at the same time, two of which had negative swabs and two remained positive. In total four isolates sent to reference laboratory Colindale. These isolates are closely related genetically and belong to the 10SNP cluster CC22-2993.3509.X.X suggesting a transmission event. Outbreak management was followed. Findings of investigation included 50% of admission screening not completed. Education (MRSA, screening, suppression) and audit took place.

Quarter two (Jul – Sept)

5.6. iGAS ED_AICU 1 contact_July23

Confirmed iGas in WH patient. Attended ED and sample taken on admission. Contact tracing identified one contact who was sent a warn and inform letter and factsheet. Email shared to clinical staff containing exposure letter advice for observational surveillance of signs and symptoms and action if present. Case closed.

5.7. MRSA acquisition Cavell 2 patients July 23

On a care of the elderly ward, the weekly screening program identified two patients found to be colonised with MRSA bacteria. Both had not been known previously to be colonised however, there were other patients (four) on the ward at the same time known to be MRSA positive. All cases had specimens sent to the National Reference Laboratory whereby two were typed as having the same strain, demonstrating a probable cross contamination event had occurred. On investigation, only 50% of patients had been screened for MRSA.

A Trust MRSA admission screening audit targeting the admission wards was carried out to identify who has / has not been screened on admission. A shared learning proforma was disseminated appropriately.

5.8. iGAS) Maternity 2 contacts_Aug23_

Confirmed iGas in WH patient. Attended a Maternity ward and sample taken. Contact tracing identified two contacts in bay who were sent a warn and inform letter and factsheet. Email shared to clinical staff containing exposure advice for observational surveillance of signs and symptoms and action if present. Case closed.

5.9. MRSA acquisition_Cloudesley_2 patients Aug 23 (pilot)

- Two patients on Cloudesley ward acquired MRSA, which was found on weekly screening regime. The IPCT piloted a multidisciplinary round table approach to discuss on what can be done in our roles to reduce transmission. Knowledge gaps and myths were to be identified as well as key points for learning which were to be shared in a learning proforma. Despite this being the second MRSA acquisition (note July's), it was the pilot of the round table. As July's Cavell case, at the time of Cloudesley incident, was not known pending reference laboratory typing.

One of the two patients had been screened for MRSA on admission. Both had appropriate suppression therapy given. Although patient one may have been known from the admission screen had it been taken. An IPC environment audit attended showed 81%. Weekly MRSA screening compliant.

Trust MRSA acquisition shared learning disseminated.

Quarter three (Oct – Dec)

5.10. *Enterobacter Hormaechaei*_AICU 3 patients Oct23

Three cases of *Enterobacter hormaechaei* in AICU. First case sputum fully sensitive, second case blood culture with CPE and the third case from sputum, an ESBL. All antibiograms were not identical. The trust saw two further *enterobacter hormaechaei* across organisation (outpatients and Neonatal ICU (NICU)). The laboratory manager detailed that 'The identification system has a particular problem with splitting this organism form other highly related strains [*Enterobacter cloacae*] (published data says 20% accuracy). The strains we

have isolated have different antibiograms so likely different strains and possibly a mixed group of *Enterobacter* species.' IPC looked for these bacteria in the drains of AICU and did not find it. Environmental sampling, laboratory identified familial strain, de-escalated post investigation. Shared learning disseminated on clinical hand wash basin misuse. Case closed.

5.11. Pertussis Paediatric ED 41 contacts Oct 23

Patient was admitted to a side room on Ifor following a Paediatric ED attendance in September 2023 for six hours. After a short admission they were seen again in Paediatric ED 3 days later for 2.5 hours and discharged home. 41 contacts were identified and warn and inform letters sent to all. Five of these were <6 months and required prophylaxis so GPs contacted to provide this for these cases. Case closed.

5.12. C. difficile GDH Cavell 4 patients Oct 23

A HOHA GDH positive toxin positive case noted in October 2023 and GDH positive toxin negative case noted from admission sample. Two further GDH positive toxin negative cases noted on ten days later. Ribotyping results on three GDH cases did not isolate C. difficile, and the toxin case was 106. Surveillance continued. No further cases. Case closed.

5.13. C. difficile GDH Victoria 2 patients Nov 23

A HOHA GDH positive toxin positive case noted in November 2023 and GDH positive toxin negative case noted six days later. An outbreak meeting was held to determine if transmission had occurred. No lapses in care identified. Ribotype results for Toxin case was 014 and the GDH ribotype was unable to grow C. difficile. Surveillance continued with no further cases. Case closed.

5.14. Tuberculosis Mercers 15 contacts Nov 23

This patient who attended ED in November 2023 was admitted to an open bay on MSSO, transferred to an open bay on Victoria ward before they were isolated on Mercers positive with Mycobacterium Tuberculosis. 15 contacts were identified and discussed at an incident meeting. Warn and inform letters were sent by the TB team. Occupational Health team to send inform and advise letters to staff contacts in all wards patient attended. Case closed.

5.15. RSV SCBU 6 patients Nov 23

Two cases of RSV and four further symptomatic cases. First case unwell with respiratory symptoms, tested positive and was transferred to isolation room in NICU in November 2023. A second case became positive the next day and was also transferred to NICU. Both cases had been on SCBU for some time. An incident meeting occurred on with four other cases raised as symptomatic. The two known cases were not in bed spaces close to each other however first cases mum had respiratory symptoms and had to walk through the unit. Also, three members of staff had respiratory symptoms. Grandparents and siblings asked not to visit due to increase in cases. Surveillance continued. IPC measures implemented. No further cases. Case closed.

5.16. Pertussis Paediatric ED 41 contacts Dec 23

Microbiology informed IPCT of patient who attended Paediatric ED in December 2023 for approximately 13 hours. 41 contacts were identified and warn and inform letters sent to all. No further actions. Case closed.

5.17. MRSA #1 Bacteraemia HOHA December 2023 AICU Unavoidable

Patient attended ED in December 2023 with shortness of breath for six days prior to admission. The patient recently had returned from travel overseas to with other family who were also unwell. The patient was admitted to AICU, ruling out Middle Eastern Respiratory Syndrome (MERS) they were diagnosed with Flu A and rhinovirus. The patient was screened for MRSA on admission as per trust policy which was positive. Blood cultures were taken five days later as part of septic screen and was MRSA positive. The most likely source of this bacteraemia is patients own colonisation status.

This was an unavoidable BSI in a very unwell AICU patient who was previously not known to WH and who was colonised with MRSA. The blood culture, screening and treatment was carried out as per protocol. Duty of candour completed by the clinical team. No recommendations that would have prevented this case or a similar case in the future.

Quarter four (Jan – Mar)

5.18. Measles Paediatric ED 44 contacts Jan 24

Received notification from NENCL HPT advising WH of a confirmed measles case. Patient attended Paediatric ED in January 2024. Notifications shared with Occupational Health (OH) team and ED colleagues to ensure staff contact tracing done as required. Patient contact tracing undertaken identifying 44 contacts therefore warn and inform letters sent to all. Case closed.

5.19. Measles Paediatric ED 22 contacts Jan 24

Paediatric patient attended ED in January 2024 with clinical diagnosis of measles. Notification sent to OH and ED colleagues to ensure staff tracing done as required. Patient contact tracing undertaken identifying 22 contacts sent warn and inform letters. MMR vaccine given to two babies who were under six months old. Case closed.

5.20. Measles Paediatric ED 46 contacts Jan 24

Infant patient attended ED twice in January 2024 with suspected measles. Notification sent to OH and ED colleagues to ensure staff tracing done as required. Patient contact tracing undertaken with identified 46 contacts sent warn and inform letters. Case closed.

5.21. C. difficile GDH Thorogood Jan 24

CDI GDH positive toxin negative cases noted in January 2024 and further case noted six days later. An incident meeting held noting that patients shared same bedspace and likely transmission occurred from patient to patient via the environment. Surveillance continued. Education and IPCT support given to ward staff. No further cases noted. Case closed.

5.22. Measles Paediatric ED Feb 24

25-week-old infant attended ED in February 2024 with suspected measles. Notification sent to OH and ED colleagues to ensure staff tracing undertaken. No patient contacts identified as patient timely isolated. Case Closed.

5.23. C. difficile GDH & Toxin AICU 5 patients Feb 24

2x HOHA GDH positive toxin positive cases noted in February 2024, as well as 3x GDH positive toxin negative cases noted in January 2024. Meeting held to determine if

transmission had occurred. No lapses in care identified. Ribotype results for Toxin cases were unable to grow C. difficile. Laboratory processes examined as a result with no identifiable issues noted. Surveillance continued with no further cases. Case closed.

5.24. Tuberculosis MSSO Feb24

Patient attended ED in February 2024 abnormal CXR query malignancy, weigh loss of 15Kg over three months, and mild anaemia. IPCT aware of TB diagnosis later in February 2024. Contact tracing undertaken and six patient contacts identified. Case meeting occurred in April 2024. Patient contacts followed up by TB team. Staff also involved will be sent letters from OH. Follow up meeting to be scheduled within 8-12 weeks to ensure all actions occurred and any further outcomes.

5.25. CPE Thorogood 89 contacts Feb 24

Patient attended ED in December 2024 and was admitted due to hypertensive emergency episode with pulmonary oedema and proteinuria on background of poorly control hypertension. During admission patient was transferred to bays in Mary Seacole South, Mary Seacole North and Thorogood. Had no previous admissions to WH. Had previous admissions to other hospitals so CPE screen was missed on admission. A rectal screen detected CPE Klebsiella Pneumoniae Oxa48 in February 2024. 89 contacts were identified, and alerts added to EPR system advising for regimented CPE screening on future admissions. Contacts followed up as appropriate. Case closed.

5.26. MRSA Bacteraemia COHA BSI Feb 24 ED / Unavoidable /

Patient admitted from home via ambulance after a fall and had a long lie as well as abdominal pain with a GCS of 7/15. Impression was likely terminal event with multiorgan failure Blood culture was taken on admission in ED and MRSA detected and treatment for MRSA bacteraemia was not started as result was not available. Patient passed away in February 2024. Cause of death was 1a decompensated alcoholic liver disease, 1b. sepsis of unknown aetiology 1c and 2 type 2 diabetes mellitus.

Post Infection review completed. The patient was not screened in line with MRSA policy on admission. The patient had a recent admission due to alcohol liver disease (ALD) related cirrhosis in January 2024 therefore it is a community onset hospital associated case. It was agreed this was an unavoidable case as was a community acquired case on a patient with a complex medical history. Source of bacteraemia is unknown.

5.27. CPE Victoria 19 contacts Mar 24

Patient attended ED in March 2024 and was admitted due to severe AKI. No previous admissions to WH or obvious link with any known CPE cases at the WH. During admission the patient was transferred to open bays in two wards. Non-compliant of national guidance, CPE screening as known admissions to other UK hospitals, was missed on admission. During patient's admission a sputum sample was sent which detected CPE Klebsiella Pneumoniae Oxa48. 19 contacts were identified, and alerts added to EPR advising for regimented CPE screening on future admissions. Contacts followed up as appropriate. Case closed.

5.28. MRSA Bacteraemia #2 BSI Mar 2024 Thorogood/Avoidable

Patient admitted from home due to abdominal and chest pain, was experiencing nausea, vomiting, and had a four-day history of constipation. Impression was sickle cell pain and / or

crisis and hyperemesis. The patient was screened in line with MRSA policy on admission. Patient was previously known to be colonised with MRSA in January 2024. During the patient's admission they became pyrexial, was shivering and tachycardic therefore blood culture taken, and MRSA detected. There was a delay in starting suppression therapy on this admission, not starting until five days later as staff were awaiting prescription.

After the sample was taken doctors noted that induration and erythema and infection were present on the right arm cannula that had been removed. PVD were required and there were notable gaps in documentation relating to maintenance of these devices. VIP scores all recorded as 0. Patient was difficult to cannulate, but this detail not included in clinical notes. It was agreed by the multidisciplinary team meeting during post infection review that this was an avoidable BSI case due to discrepancies in cannula care which was likely source. IPCT have undertaken cannula care training and audit with ward staff. MRSA policies shared with teams involved to ensure that further patients are given suppression therapy if required.

6. Compliance to policy: Audit

6.1. The IPCT undertook many audits throughout the year including hand hygiene, MRSA screening, PVDs, and environment inspections for hospital and community sites. Results of the individual audits were fed back to the clinical areas at the time and individual areas are asked to monitor and improve compliance. ICSUs are responsible for their own Action plans and to present back to the Clinical Effectiveness Group and Quality Governance Committee.

IPC clinical audit

6.2. Hand hygiene audit for high profile infection and outbreak.
In event of any healthcare associated infection, hand hygiene audits are carried out in the area of concern, reported back to the incident meeting and training is agreed.

6.3. MRSA Screening audit in admissions ward
Several BSI post infection reviews (PIR) recognised non-compliance with MRSA screening. MRSA screening audits were conducted over a three-week period on the admission wards. The data demonstrated a low non-compliance rate, with a recommendation of a repeat audit in the future. IPCT reinforced MRSA screening through ad-hoc teaching sessions and ward meetings. The clinical area team have also implemented reviewing patients to ensure the screening is done on each admission.

The aim was to capture compliance of MRSA screening within the first 24 hours of admission as per national policy. However, the audit outcome (5% non-compliance to policy) was inconsequential, as the methodology contained at least two significant errors. Firstly, the same patient's data was collected daily, extending the 24-hour period and secondly the IPC nurse unintentionally biased the data by requesting suppression therapy daily if it had not been given.

6.4. Glove use during IV drug preparation audit in surgical ward
After successful removal of unnecessary nonsterile gloves for routine IV drug preparation in Adult Intensive Care Unit (AICU) an audit was undertaken in February 2024 as baseline data

for the upcoming Gloves off campaign. Over two weeks, 67 opportunities were observed, and all staff wore gloves for the preparation IV drugs.

6.5. Hand Hygiene audit supporting CVC QI Project in AICU
Process mapping for the CVC QI project required hand hygiene audits to be carried out over three months in AICU.

6.6. PVD audit in surgical ward
In January, to improve standards around PVD care to aid reduction of BSI, the IPCT audited these devices. Baseline data has already been captured and several change ideas are currently being implemented to improve standards.

6.7. Clinical Audit in planning for 2024/25

- Compliance to CPE screening
- Urinary catheter care and management
- Repeat MRSA screening compliance
- MRSA suppression therapy appropriateness

IPC environment audit

6.8. The IPCT supports the trusts Tendable audit platform. The ICSUs are responsible for their own Action plans and to present back to the Clinical Effectiveness Group and Quality Governance Committee.

6.9. Staff record their audit findings directly into a smartphone or tablet and once completed, automated reporting enables teams to have an immediate view of what is working well and areas that need improvement within the following areas:

- environmental
- urinary catheter
- vascular device

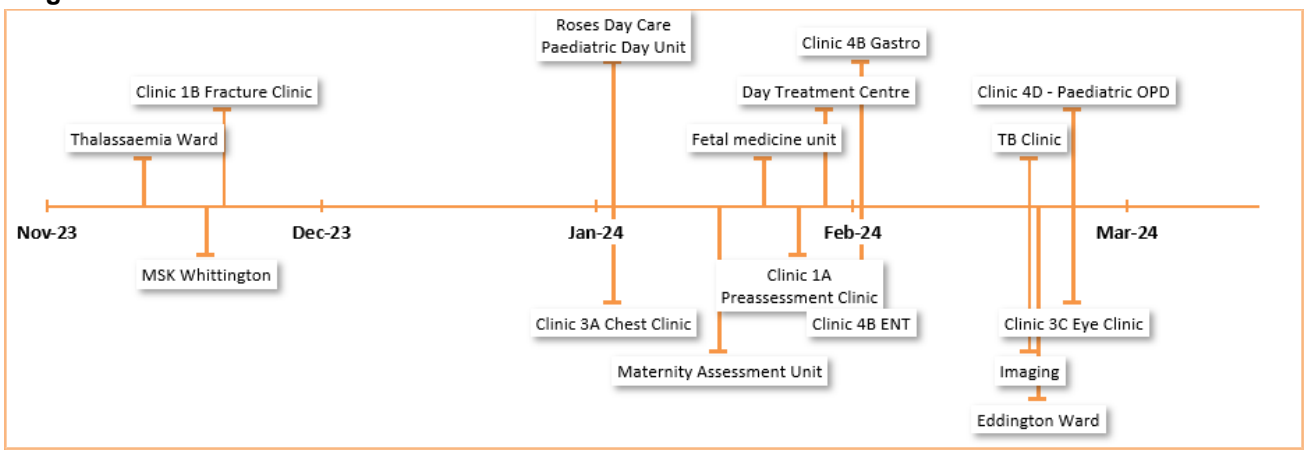
6.10. Recruiting an IPC auditor (February 2023) has been a triumph for improving patient safety and experience through performing a quality check of the departmental environment audits on Tendable.

6.11. By ensuring the environment and equipment are fit for purpose and clean, the IPC quality check audits have instigated numerous cleaning reactive works, the refurbishment of several Mary Seacole's side rooms, Ifor side room and bathrooms, Meyrick ward flooring and walls, among other upgrades. Fault with the processes for the bedpan washers (no detergent means no effective cleaning; this is critical in preventing the spread of enteric infection) have been raised because of IPC audit. As to waste management, ensuring the correct processes and holding handlers to account of their responsibilities is ongoing, many of the waste segregation holds are unlocked, and not kept clean.

6.12. IPCT have recently written a community environmental audit for Children and Young People (CYP) which is expected to be rolled out on the Tendable platform to all services in the community, clinics and other necessary public facing and non-facing areas.

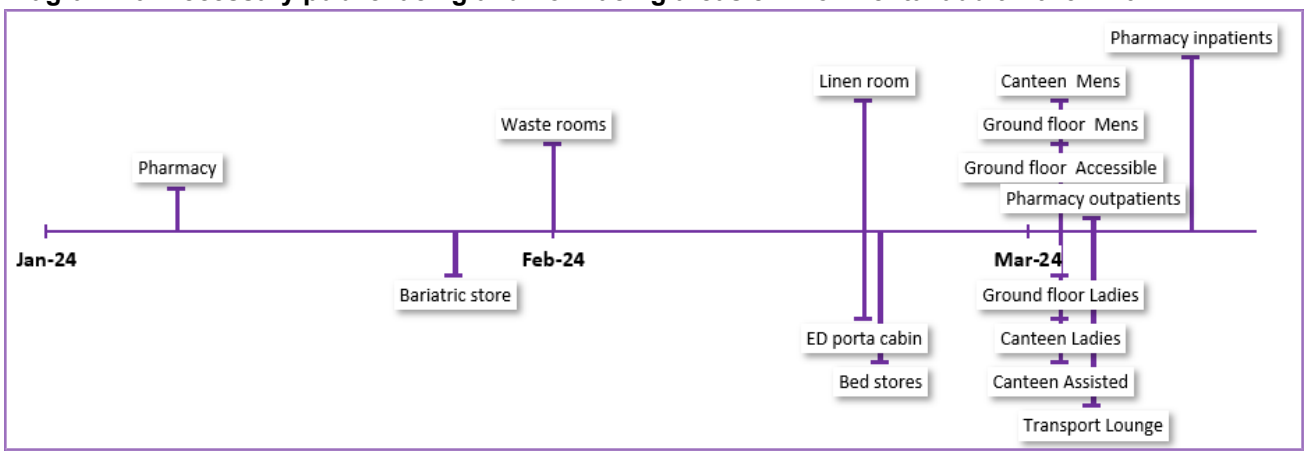
6.13. Meanwhile, the auditor has audited 16 clinics. See diagram nine for location of these.

Diagram 9. Clinic environmental audit. 2023 – 2024.



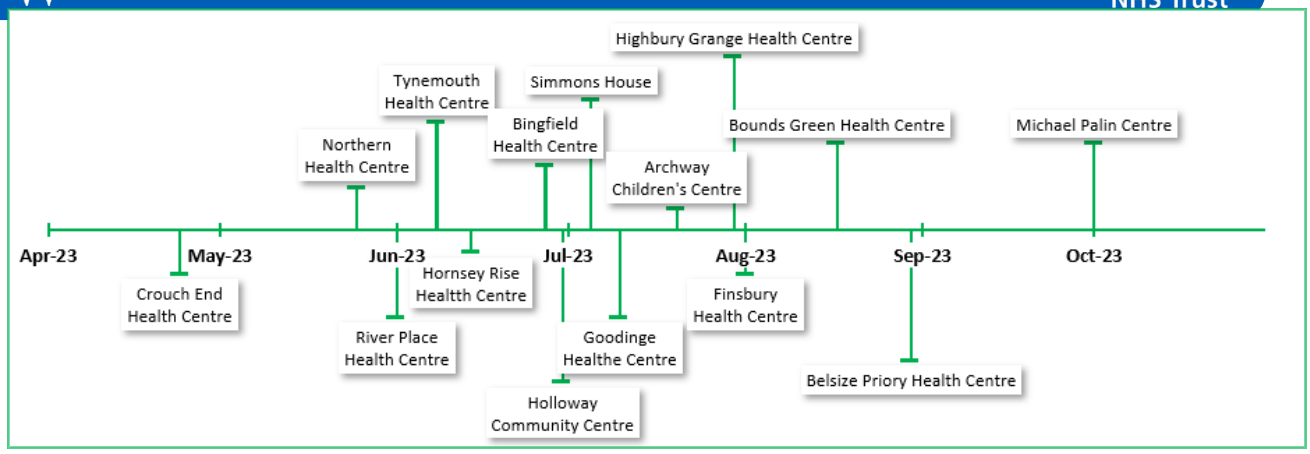
6.14. 15 necessary public facing, and non-facing areas audits have been carried out. See diagram ten for location of these.

Diagram 10. Necessary public facing and non-facing areas environmental audit. 2023 – 2024.



6.15. 15 community audits were attended (see diagram 11). The community audits are not scored. The visits are used for networking with WH community staff. Learning what are their local concerns are and how IPCT can support them. The health centre managers are responsible for their own Action plans with escalation support via the IPCT. Biannual reports are provided to the IPCC.

Diagram 11. Community environmental audit. 2023 – 2024.



6.16. Surgical Site Infection Surveillance Service

Jointly run by UKHSA HCAI and antimicrobial resistance department (AMR) this service helps hospitals in England record and follow up incidents of infection after surgery and use results to review or change practice as necessary. This service supports both the mandatory surveillance of SSI in four categories of orthopaedics and voluntary surveillance in 13 categories of surgical procedures.

It is recommended by UKHSA that surveillance should be undertaken in more than one consecutive period or continuously so that 'more precise rates can be estimated from a larger set of cumulative data' (UKHSA 2013 – Protocol for the Surveillance of Surgical Site Infection).

Mandatory - Fractured Neck of Femur Repair SSI Rates

WH opted to report four quarters in 2023/24 on repair of neck of femur fracture surgery, with zero reported infection in quarters one (operations n=20), two (operations n=20) and four (operations n=21). There was one infection reported in quarter three from 31 operations performed.

Case: two days post right hip hemiarthroplasty patient started to develop signs of SSI, including pain, and swelling at the operation site. It was noted that the patient had removed the dressing and was inserting fingers into the wound. Patient required a reoperation where samples were sent for MC+S with staph epidermidis plus few pus cells. Patient was appropriately treated with antibiotics though unfortunately became unwell due to a cardiac event and passed away. SSI was not considered as cause of death. A microbiology consultant has confirmed that this was a deep incisional infection (meeting criteria two of the SSISS UKHSA Protocol – positive tissue sample with pus cells present).

Voluntary - Caesarean Section SSI preliminary data

A sample review of Caesarean section operations (n=123) was undertaken in the month in October 2023 for consideration to opt into the voluntary surveillance category of surgical procedures in 2024/25. This data is under review with key stakeholders.

7. Compliance to policy: Education

7.1. Shared learning proformas

Investigating the cause of HCAIs can be time consuming, but important to identify to minimise the risk of harm caused by spreading to others. Sharing what is learnt within the investigation helps the understanding of what we do well and what can be improved on. The following shared learning was disseminated to relevant staff:

- MRSA acquisition
- MSSA bacteraemia
- Misuse of the clinical hand wash sink
- CDI
- MRSA bacteraemia

7.2. Mandatory Training

The IPCT provided mandatory IPC training for non-clinical staff (level 1) every two months in a face-to-face session with a compliance of 94% (6% improvement on last year). The level two group of clinical staff receive on alternate months mandatory IPC training with a 2% improvement on last year compliance at 86%. The organisational target expectation is for all mandatory training compliance to be >92% compliance rate, which makes it particularly challenging for clinical staff as this training must be updated on an annual basis. Access to these courses is via Elev8. See appendix two for ICSU detail.

7.3. IPC Competency Booklet

The IPCT has updated existing IPC competencies complete with a new design, added theory and competency workbook that provides the Trusts IPC Link Practitioners with the IPC foundations required to ensure their competency around key principles in IPC. These competencies have been approved at the Nursing and Midwifery group (26 February 2024) with next steps being to task healthcare worker groups to complete as an action outcome to incident and outbreaks.

7.4. Ad hoc teaching and forums for high profile infection, outbreak, incident of importance

Bespoke IPC teaching sessions are continuing to be offered according to service needs and / or because of outbreak management. Attendance varies depending on location and workloads and requires repeated sessions to capture more staff. These sessions are given in the classroom, at the nurse's station and one to one.

7.5. New MDT round table forum

A forum used for MRSA acquisition, a multidisciplinary open discussion focusing on how your role may have contributed to the transmission of a pathogen; and what could you do to prevent HCAIs, regardless of where you work or what interaction your role has with patients. A shared learning proforma comprising: What happened, why was this an issue, what was done, the learning outcomes and next steps, is disseminated to the clinical area, to the clinical areas throughout the patients journey and to members of the IPCC.

7.6. New MDT round table forum

CDI Summit snapshot of 24/25

In April, IPC hosted a successful CDI summit specific to the patient, CDI processes including cleanliness. Engagement and positivity were themed throughout the Summit, namely:

- An AMR review of all GDH +ve cases were reviewed (n=60) by the infection team. Antimicrobial length of treatment a focus for improvement post Covid-19. Fidaxomycin

which is a first line treatment for relapse national is used more frequently in other organisations, though is expensive (1.5K / 10 tabs). NHS Trusts are looking to ICB for funding.

- The probable rise of national colonisation of the population will have an effect on people coming into the hospital colonised. As WH are testing more, there are more CDI.
- Documentation plays a key role in recognising trends and empowering bedside staff to act fast. Since removing the paper stool chart, this visibility is no longer there, and this is a recuring theme in PIR by all disciplines.
- Environmental and equipment cleaning is often difficult to prove as a source for transmission. Audit is recognised as vast in the Trust but not joined up and collaborative.
- All agreed 'back to basics' is fundamental across all disciplines, with visibility of leadership.
- Work is underway to incorporate the ideas and strengthen ways of working for 24/25.

Clinical Inductions

7.7. UCLH Medical Students IPC

In September 2023 the IPCT provided the trust induction of over 250 medical students from UCLH around fundaments of IPC.

7.8. Internationally Educated Nurses (IEN)

To ensure early engagement with our internationally recruited nursing workforce, 56 staff were inducted to an extensive theory session around fundamentals of IPC, followed by practical sessions based on specific case scenarios. These interactive bimonthly sessions were developed in collaboration with the education team, to ensure that staff are aware on how to implement IPC theory to practice.

7.9. Intensive Care Unit new staff

During the month of July, the IPCT provided a teaching session to our newly recruited nursing workforce in intensive care. This tailored IPC teaching session is provided to ensure consistency and high standards around IPC from AICU nursing staff.

7.10. Trainee Nurse Associate (TNA)

24 TNAs received IPC induction in 2023/24.

Supporting professionals

7.11. Preceptorship Programme (Monthly)

The IPCT taught IPC principles to 164 newly qualified staff including nursing, physiotherapists, occupational therapist as part of the preceptorship programme.

7.12. Level 2 and Level 3 Healthcare Support Workers (HCSW) IPC session

IPCT support the development of WH Health Care Support Workers (HCSW) workforce by providing teaching sessions around fundamentals of IPC and role specific related topics for this cohort. This year 95 staff participated at our interactive sessions.

7.13. Student Nursing forums

Every year WH welcome students from Middlesex, Kingston, and London South Bank Universities. It is imperative that wherever they work now, and, in the future, they have good IPC foundations. The IPCT provided IPC training for 158 nursing students this year.

7.14. Ambitious college IPC session

On the 14 September 2023 the IPCT provided an introduction of IPC to 10 Ambitious college students.

7.15. IPC Link Study Day

On the 23 January 2024, the IPCT organised a study day for our precious IPC Link Practitioners workforce. A total of 42 link practitioners attended on the day. During the study day, link staff received expertise from internal and external speakers on a mixture of relevant topics within this field. Some of the highlights included a session around ectoparasite (bed bugs), appropriate waste management and new updates on appropriate use of gloves during IV drug therapy preparation.

Photo 1. IPC Link Study Day. Dr Alex Kew (Infection Consultant) HTD, Royal Free. Talk on bed bugs. Photo used with permission. January 2024.

Awareness days

7.16. World Hand Hygiene Day 5th May (annual)

On the 5 May 2023, the IPCT delivered several activities across the trust with the aim to increase staff awareness and knowledge around Hand Hygiene. These activities included having a quiz amongst community and hospital staff to participate on a Hand Hygiene quiz to win a Kindle. Several educational activities were performed on the day to increase staff engagement and understand the importance of Hand Hygiene.

Photo 2. World Hand Hygiene Day 5th May. IPCT. Photo used with permission. May 2023.

7.17. NHS75 Next Generation (annual)

On the 11 July 2023 the IPCT provided a teaching session to a group of over 40 students from a local school around the exciting career opportunities in the NHS.

7.18. International Infection Prevention Week (annual)

On the 17 October 2023, the IPCT hosted a public facing staff event at the main hospital site. This year's theme was around appropriate glove use with the aim to show case several trust wide initiatives aimed in reducing inappropriate glove use and improve hand hygiene standards.

Photo 3. International Infection Prevention Week. IPCT with a nurse associate. Photo used with permission. October 2023.

Quality Improvement (QI) projects

7.19. CVC QI Project in AICU. Commenced October 2022, ongoing.

Due to an increased number of Central line associated blood stream infections (CLABSIs) in AICU, the IPC and AICU colleagues initiated a QI project with the aim to improve standards of care of Central Venous Catheter's (CVC's). During the audit phase of this project, staff were observed missing crucial hand hygiene moments (before touching CVCs), due to inappropriate glove use (for routine IV drug preparation).

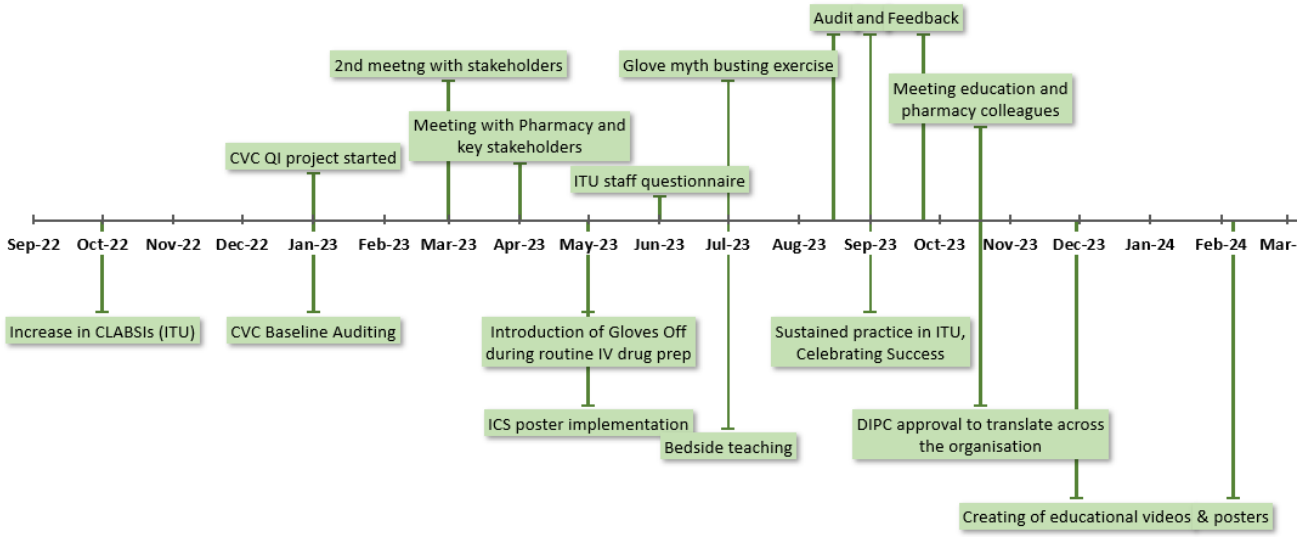
The first change idea of this initiative was to remove the use of nonsterile gloves for IV drug preparation unless required (cytotoxic drug, anti-monoclonal therapy etc.). After Several weeks of teaching, audit-feedback and implementation of a myth busting exercise, over 90% of the nursing staff observed during the past six weeks are no longer wearing unnecessary gloves during routine IV drug preparation.

Sustaining this practice has been through maintaining staff engagement using education posters displayed in treatment rooms with embedded QR codes directing staff to a video demonstration of how to carry out IV drug preparation, and Medusa, the online guide for the preparation and administration of injectable medicines.

After successful removal of unnecessary nonsterile gloves for routine IV drug preparation, IPC and AICU colleagues are currently exploring ways of starting the second phase of this QI project and continue increasing standards of CVCs.

The success of this initial phase has been the starting block for WH Gloves off Campaign (2024/25 QI project) contributing to hand hygiene compliance as well as improved sustainability reducing glove use. See diagram 12 for these QI journey.

Diagram 12. Combined QI projects CVC in AICU and Trust Gloves Off timeline. Whittington Health. 2023– 2024.



7.20. PVD Documentation QI project (Commenced 2022, ongoing)

Following an audit on an admission ward, investigating standards of PVDs due to increased BSIs relating to devices, several PVD documentation issues were noted to be a causal factor of mismanagement of the device. Over the past 18 months, in collaboration with IT colleagues, IPCT have been closely involved in the development of a new PVD documentation pathway on Vitals Application. This project is pending approval at the Digital Transformation Group and Trust Board prior to trialling this new application on one of the wards. Beneficial for patient safety, this will enable staff at point of care to accurately and efficiently document PVDs while reducing the risk of errors caused by delayed, missing or incorrect documentation.

Future QI projects

7.21. Gloves off campaign

WH strategy to improve hand hygiene compliance must engage a wide audience if it is to be successful. The IPCT are keen to translate the successful Glove QI strategy (removing nonsterile gloves during routine IV drug preparation) across the organisation, incorporating themed and speciality focus on appropriate use of gloves. Removing gloves is key to improving hand hygiene and reducing their impact on the environment. Educational posters, videos and training have been prepared to assist this transition. A back to the floor (BTTF) session is prepared for the 8 May 2024 with the intended live date implementing phase one ‘removing nonsterile gloves during routine IV drug preparation’ on 1 June 2024.

8. Face Fit test (FFT) and resilience program

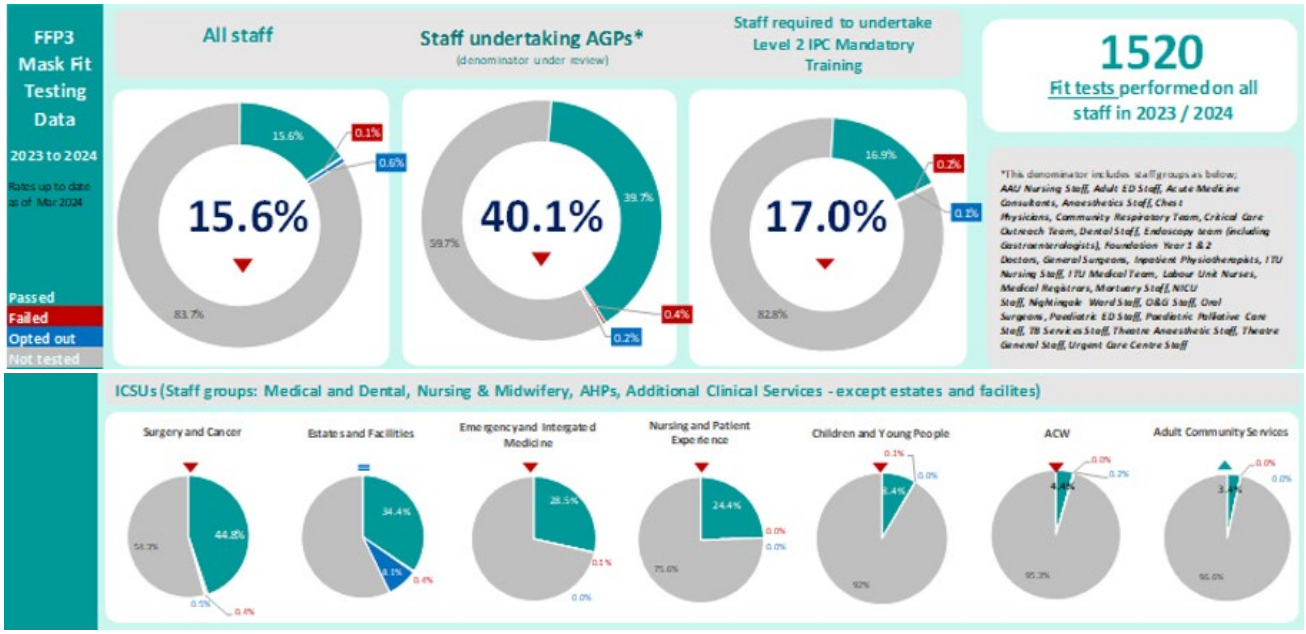
8.1. Filtering Facepiece (FFP3) respirator masks are required as part of Covid-19 personal protective equipment (PPE) worn where AGPs are undertaken. Fit testing of FFP3s for a safe fit is required by law.

8.2. There are approximately 4976 staff employed by the trust, it is estimated 1,000 staff routinely may be exposed to AGPs and approximately 3,500 are clinical staff.

8.3. There is low FFT compliance (40%) of staff performing AGPs.

8.4. Since the urgency of the pandemic where compliance was at its highest at 73.5% (May 2022), FFT compliance yield has fallen to 39% (2022/23) and 40% (2023/24) for staff exposed to AGPs and 17% (2023/24) for level two staff. The overall FFT compliance for the hospital is 15.6%, which can be seen broken down by ICSU in diagram 13.

Diagram 13. FFP3 mask fit testing compliance data by Trust and by ICSU. Whittington Health. 2023– 2024.



8.5. In recognition of the low compliance, a peer review was carried out by the FFT Service Manager serving London Northwest University Healthcare Trust. The trust has approximately 10,000 employees and a FFT compliance of over 80%.

8.6. The top three recommendations to enhance local compliance were:

- Divisional leads must be responsible for the safety of their staff. They must ensure risk assessments are carried out to identify potential risk and levels (emergency preparedness or AGP) and thus eliminate such hazards.
- Implement a trust wide FFT policy. Clear guidance to all staff members mandating universal compliance and expectations.
- Reduce the target number of staff per fit tester or increase fit testing hours to enhance compliance levels. One staff member is responsible for fit testing approximately 5,000 employees. Each fit test for two masks takes a minimum of 30mins. Maintaining a high compliance level will be challenging much less achieving it in the first place.

8.7. A small impact due to staff fluctuation of leavers, new staff and the need to repeat FFT on staff biyearly is expected.

8.8. FFT compliance is reported monthly to the Trust Management Group (TMG) as an interactive dashboard (appendix three). As well as providing Trust and AGP level data (denominator

under constant review), the dashboard format provides who is compliant. This enables ICSU leads to examine who must have a FFT within their teams.

8.9. FFP3 resilience principles in acute settings (June 2021) became a core priority for both NHS trusts and the Department of Health and Social Care (DHSC), in the event of any future variant occurring that may lead to a pandemic or epidemic.

8.10. In the past year, WH complied with the following principles:

- All FFP3 users should be fit tested and using at least two different masks.
    - Staff are recommended to switch between masks once they have been fit tested and have passed the FFT for two FFP3 masks. A leaflet is provided for staff who may experience pressure sores or skin conditions due to prolonged mask usage.
- UK Make masks will be used for all new FFTs when appropriate for the individual.
    - In March 2024, the distribution of complimentary Covid-19 PPE was ceased. Masks are currently obtainable through the NHS supply chain on a usage-based payment. FFP3 masks can now be accessed via PECOS. WH currently have eight different brands of FFP3 in stock.
- Trusts will register FFP3 users and FFT results in ESR and review individual usage every quarter.
    - WH compliance is also recorded through the Trusts Elev8 platform. Elev8 alert staff to when their next FFT is due and records their approved FFP3 mask.

8.11. Exceeding these principles, WH fit test lead has ensured the FFT service is:

Accessible to the ICO through:

- Elev8 platform allowing staff to schedule FFT appointments in advance.
- Drop-in appointments five days / week
- Bespoke tests pre-arranged with managers for groups (i.e., twilight)
- 31 March 2024 saw the end of FFP3 masks being supplied through NHS chain and are now available through NHSCC. Stores will continue to order for the wards, fit testing and departments such as Dental will order via Pecos.

Safe

- An Opt-out form was introduced for staff members who, for various reasons, chose not to have an FFT. An appointment is still required so that the staff member is well informed of what opting out means and what mitigations and areas of avoidance they need to maintain to their safety.

9. Recommendation

9.1. The Trust Board is asked to receive this report and note the content.

10. Report prepared by

Julie Singleton Head Nurse for Infection Prevention and Control

11. Abbreviations

Aerosol generating procedures	AGP

Adult Intensive Care Unit	AICU
Antimicrobial Stewardship	AMS
Acute Respiratory Infection	ARI
Blood stream infection	BSI
Clostridiodes difficile	C. difficile
Clostridioides difficile infection	CDI
Central line associated blood stream infections	CLABSI
Carbapenemase Producing Enterobacteriaceae	CPE
Central venous catheter	CVC
Department of Health and Social Care	DHSC
Director of Infection Prevention and Control	DIPC
Escherichia coli	E. Coli
Filtering Facepiece	FFP3
Face fit test	FFT
Glutamate dehydrogenase	GDH
Gram negative bloodstream infections	GNBSI
Healthcare associated infection	HCAI
Healthcare Support Workers	HCSW
Hospital onset healthcare associated	HOHA
Integrated Care Board	ICB
Integrated Care Organisation	ICO
Internationally Educated Nurses	IEN
Invasive Group A strep	iGAS
Infection Prevention and Control	IPC
Infection Prevention and Control Committee	IPCC
Infection Prevention and Control Team	IPCT
Klebsiella species	Kleb. spp
London Region Health Protection Team	LRHPT
Methicillin Resistant Staphylococcus aureus	MRSA
Methicillin Susceptible Staphylococcus aureus	MSSA
North Central London	NCL
National IPC Manual	NIPCM
Neck of Femur	NoF
Pseudomonas aeruginosa	P. aeruginosa
IPC Dashboard – Power Bi	Power BI
Personal protective equipment	PPE
Peripheral vascular device	PVD
Quality improvement	quality
Respiratory syncytial virus	RSV
Surgical site infection	SSI
Surgical site infection surveillance system	SSISS
Tuberculous	TB
Trust Management Group	TMG
University College London Hospital	UCLH
United Kingdom Health Security Agency	UKHSA
Whittington Health	WH

12. Appendices

Appendix 1a – Surveillance and mandatory reporting of data for Trust attributable HCAI by ward and month.

MRSA bacteraemia

Ward	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
AICU									1				1
Thorogood												*1	1
TOTAL	0	0	0	0	0	0	0	0	1	0	0	1	**2/0**

*Vascular line related.

MSSA bacteraemia

Ward	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
AICU				*1									1
MSNO						*1							1
AICU							*1						1
NICU								1					1
CCU									*1				1
AICU										1			1
TOTAL	0	0	0	1	0	1	1	1	1	1	0	0	**6/-**

*Vascular line related.

E. coli bacteraemia

Ward	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
MSNO		*1											1
Nightingale		1				*1							2
ED Adults			^1										1
Victoria			1	1	1	1							4
Coyle			1	2									3
Cloudesley				1								*1	2
Thorogood				1								1	2
Meyrick						1			1				2
Montuschi								1				1	2
Mercers											1		1
Cavell												1	1
Total	0	2	3	5	1	3	0	1	1	0	1	4	**21/19**

*Urinary catheter related

^ HOHA documentation error

Kleb. spp., bacteraemia

Ward	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Nightingale	1												1
Victoria		1		1									2
AICU			1										1
Meyrick				1									1
MSSO				1									1
Coyle							1						1

AICU							1				1		2
Mercers							*1						1
MSSO							*1						1
Thorogood											1		1
Montuschi												*1	1
TOTAL	1	1	1	3	0	0	4	0	0	0	2	1	**13/13**

*Urinary catheter related

P. aeruginosa bacteraemia

Ward	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
AICU			1								1		2
Cloudesley							1						1
TOTAL	0	0	1	0	0	0	1	0	0	0	1	0	**3/2**

C. difficile community onset hospital acquired (COHA) infection

Ward	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
TOTAL	0	0	0	0	0	0	0	0	0	0	0	1	**1**

C. difficile hospital onset hospital acquired (HOHA) infection

Ward	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
AICU	2							1			2		5
MSSO	1												1
Nightingale		1									1	1	3
Victoria		1	1					1				1	4
Cavell			1				1				1	1	4
Thorogood				1									1
Meyrick								1			1		2
Coyle									1				1
Mercers										1			1
Montuschi												1	1
Total	3	2	2	1	0	0	1	3	1	1	5	4	**23/13**

Definitions for responsibility of a CDI case:
HOHA - Hospital onset, healthcare associated (Day 2 or later since admission)
COHA - Community onset, healthcare associated (Up to 28 days since discharge)
COIA - Community onset, intermediate associated (From 29 to 84 days since discharge)
COCA - Community onset, community associated (More than 12 weeks since last admission)

Case definitions:

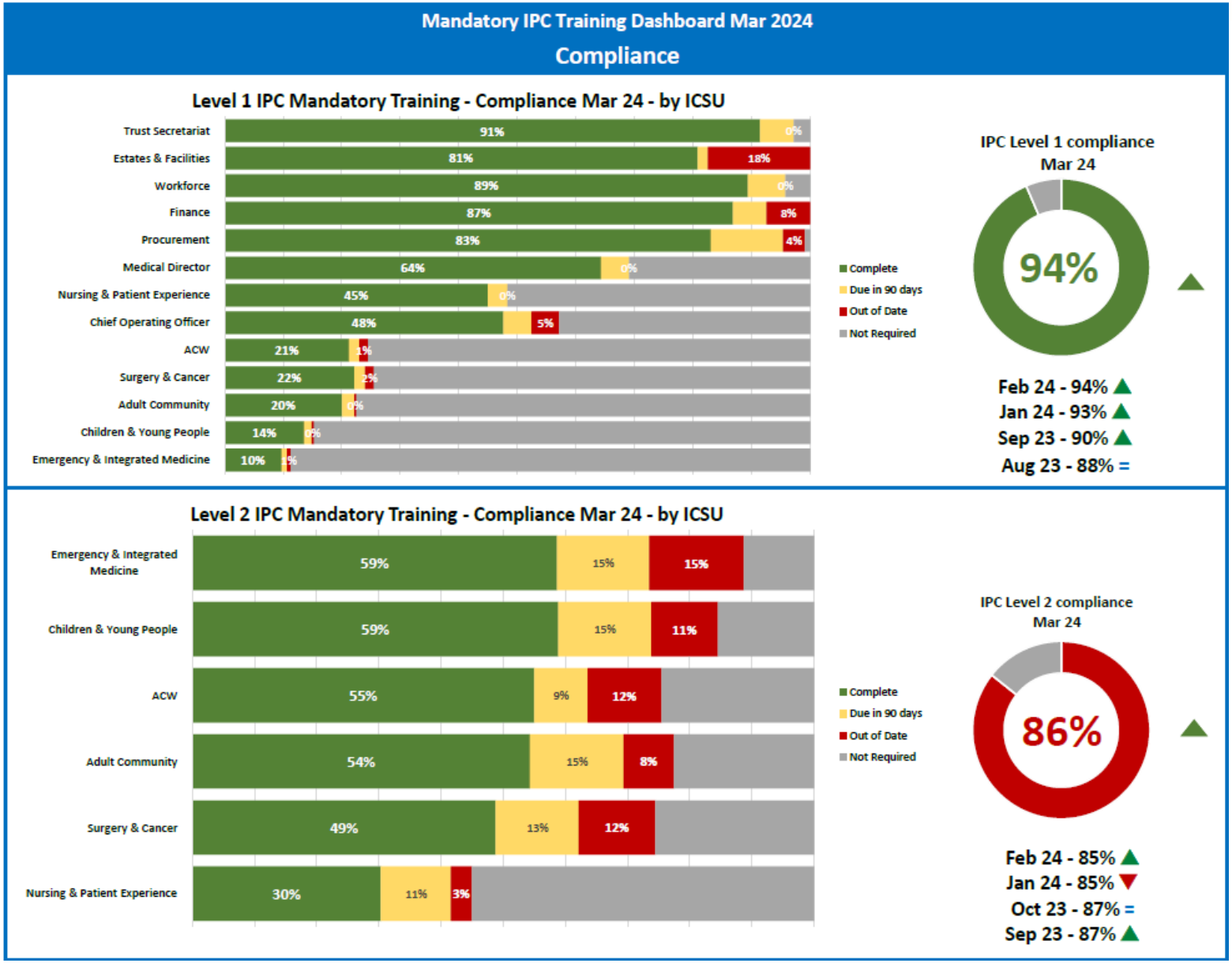
Mild disease: <3 stools of type 5, 6 or 7 on the Bristol Stool Chart per day
Moderate disease:3 to 5 stools of type 5, 6 or 7 on the Bristol Stool Chart per day AND a raised WCC that is <15X109/L
Severe disease:WCC >15X109/L OR temperature of > 38C or albumin <25g/L OR acute rising serum creatinine (>50% increase above baseline) OR evidence of severe colitis (abdominal or radiological signs). The number of stools may be a less reliable indicator of severity.
Life-threatening disease:Hypotension (systolic BP <95mmHg) OR partial / complete ileus OR toxic megacolon OR CT evidence of severe disease

Appendix 1b – Summary of key contributory factors for Clostridioides difficile infection (CDI)

	Cases 2023-24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
	Date	Apr-23	Apr-23	Apr-23	May-23	May-23	Jun-23	Jun-23	Jul-23	Oct-23	Nov-23	Nov-23	Nov-23	Nov-23	Jan-24	Feb-24	Feb-24	Feb-24	Feb-24	Feb-24	Mar-24	Mar-24	Mar-24	Mar-24
	Ribotype	23	154	*NG	2	76	14	76	15	106	14	81	5	2	*NG	*NG	*NG	*NG	*NG	15	23	1110	106	pending
	Severity	Mild	Mild	Mild	Mod	Mod	Mild	Mod	Mod	Mod	Mild	LT	Mod	Mild	Mod	Mod	Mild	Mod	Mod	Mild	Mild	Mod	Mod	Mild
	Location	ITU	ITU	MSSO	N'GALE	VICT	CAVELL	VICT	T'GOOD	CAVELL	VICT	MEYR	ITU	COYLE	MERC	ITU	N'GALE	CAVELL	ITU	MEYR	N'GALE	VICT	CAVELL	MONT
	LOS prior to result	3	38	5	11	7	95	38	28	25	18	15	7	8	7	57	22	8	5	6	32	18	10	33
	Avoidable	N	N	N	N	N	N	Y	N	Unk	N	Unk	N	N	N	*Unk	N	N	*Unk	N	Unk	N	N	Unk
Contributory Factors	Over 65 years	●		●	●	●		●	●	●	●	●	●		●	●	●	●	●	●		●	●	●
	In-patient stay > 7 days		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●			●	●	●	●
	Co-morbidity																			●				Gout rx
	Recent antibiotics	●	●	●			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	NG feeding / other enteral feeding		●				●	●																
	PPI Use		●		●		●	●	●		●	●	●	●	●	●	●	●	●				●	●
	Recent admission to hospital / LTCF	●		●																				
Lapse in care	Stool sent within 2 hours of suspected infection	n	n			n	n		n	n					n			n						
	If not, was rationale documented	n	n			n	n		n	n					n			n						
	Timely isolation	n	n	n	n	n	n	n	n	n	n	n					n		n	n		n		
	If not, was rationale documented	n	n	n	n	n	n	n	n	n	n	n												
	Appropriate antibiotics								unk															
	Normal bowel habit recorded on admission			n	n		n										n			n				n

*Not Grown
*Unknown as NG

Appendix 2 – Mandatory level one and two IPC training dashboards



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Meeting title	**Quality Assurance Committee**	**Date: 11th September 2024**
Report title	**Quarterly Learning from Deaths (LfD) Report** Q4, 1st January 2024 to 31st March 2024	**Agenda item: 4.5**
Executive director lead	Dr Charlotte Hopkins, Executive Medical Director	
Report authors	Dr Sarah Gillis, Associate Medical Director LfD Gabrielle Akuffo, Project Lead for Learning from Deaths	
Executive summary	During Quarter 4, 1st January 2024 to 31st March 2024, there were 110 adult inpatient deaths (excluding deaths in ED) reported at Whittington Health (WH) versus 118 in Q3 2023/24. 10 adult structured judgement reviews (SJRs) were requested for Quarter 4 and 10 of these have been completed and presented at department mortality meetings. The Summary Hospital-level Mortality Indicator (SHMI) for the data period at Whittington Health is 1.02. Please note that while this is in the expected range, this is an increase on previous SHMIs for the Trust. We do not have a new figure yet for Q4 as there is a delay in this data being released	
Purpose:	The paper summarises the key learning points and actions identified in the mortality reviews completed for Q4, 1st January 2024 to 31st March 2024	
Recommendation(s)	Members are invited to: • Recognise the assurances highlighted for the robust process implemented to strengthen governance and improved care around inpatient deaths and performance in reviewing inpatient deaths which make a significant positive contribution to patient safety culture at the Trust. • Be aware of the areas where further action is being taken to improve compliance data and the sharing of learning.	
Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register	
Report history	Has been presented at Mortality Review Group	
Appendices	Appendix 1: NHS England Trust Mortality Dashboard Appendix 2: Newsletter	

1. Introduction

1.1 This report summarises the key learning identified in the mortality reviews completed for Quarter 4 of 2023/24. This report describes:

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

2. Background

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

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

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

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

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

3. Mortality Review Quarter 4, 2023/24

3.1 During Quarter 4, 2023/24 there were 110 adult inpatient deaths reported at Whittington Health versus 118 in Q3 of 2023/24.

3.2 During Quarter 4, 2023/24 there were 2 neonatal deaths reported at Whittington Health. There were 2 deaths of children at the Whittington in Q4. The first was a neonatal death at 38 weeks of a baby with an antenatal diagnosis of anencephaly, diagnosed at 11 weeks gestation. The mother wished to continue the pregnancy, understanding the outcome, with the baby due to receive palliative

care. There was involvement of multiple teams during the pregnancy, and a symptom management plan was made for the baby in advance. The baby was born alive, she showed no signs of distress and died at just over 2 hours of age.

This death went through PMRT process (perinatal mortality review tool). The parents are invited to submit questions and give their comments as part of the process, and these were very positive. The learning was from good practice, benefitting from an MDT approach.

The second baby was a stillbirth following a medical feticide for severe cerebral ventriculomegaly. The baby does not fit criteria for a PMRT review as this was a termination of pregnancy. The family are currently being followed up by the team at UCH FMU.

There were no maternal deaths.

There were also 4 deaths of children reviewed by our paediatric team (Dr Neeta Patel and Prof Fertleman) as they resided in Haringey and Islington. None of these children died at the Whittington.

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

Table 1: *Death by Department/Team*

Department/Team	Number of deaths
Acute Admissions Unit (Mary Seacole North and South)	18
Cavell	13
Cloudesley	11
Meyrick	9
ITU	18
Nightingale (respiratory)	9
Coronary Care Unit (Montuschi)	11
Thorogood	11
Victoria	6
Coyle	1
Mercers	2
Eddington	0
Cearns	0
Theatres Recovery	1
Child/neonatal	2
Maternal	0
Total:	**Adults = 110 Paediatric/Neonatal = 2**

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

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

	Number of reviews required	Completed Reviews	Outstanding reviews
Adult Mortality Reviews	100	48	52
Paediatric Mortality Reviews	2	1	1
SJR	10	10	0

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

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

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

Department	Number of SJRs	Number outstanding
Acute Admissions Unit (Mary Seacole North and South)	1 – Inpatient died at Barts	0
Cavell	1	0
Cloudesley	-	-
Meyrick	-	-
ITU	1	0
Nightingale	3	0
Coronary Care Unit (Montuschi)	1	0
Victoria	-	-
Coyle	-	-
Mercers	1	0
ED	-	-
Thorogood	-	-
Theatres Recovery	1	0
Other	1 – Ambulatory Care	0
Total:	**10**	**0**

Table 3: *Reasons for deaths being assigned as requiring an SJR during Quarter 4, 2023/24*

Criteria for SJR	Number of SJRs identified	Completed SJRs	Comments
Staff/clinician raised concerns about care			
Family raised concerns about quality of care	3	3	
Death of a patient with Serious mental illness	3	3	
Death in surgical patients	1	1	
Paediatric/maternal/neonatal/intra-uterine deaths			
Deaths referred to Coroner's office without proposed cause of death	1	1	
Deaths related to specific patient safety or QI work			
Death of a patient with a Learning disability	1	1	
Medical Examiner concern	1	1	
Serious Incident investigations			
Unexpected Death			

Concerns raised through audit, incident reporting or other mortality indicators			
Definite COVID-19 Health Care Acquired Infection (HCAI)			
Total including Neonatal Deaths	**10**	**10**	

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

3.7 The aim of this review process is to:

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

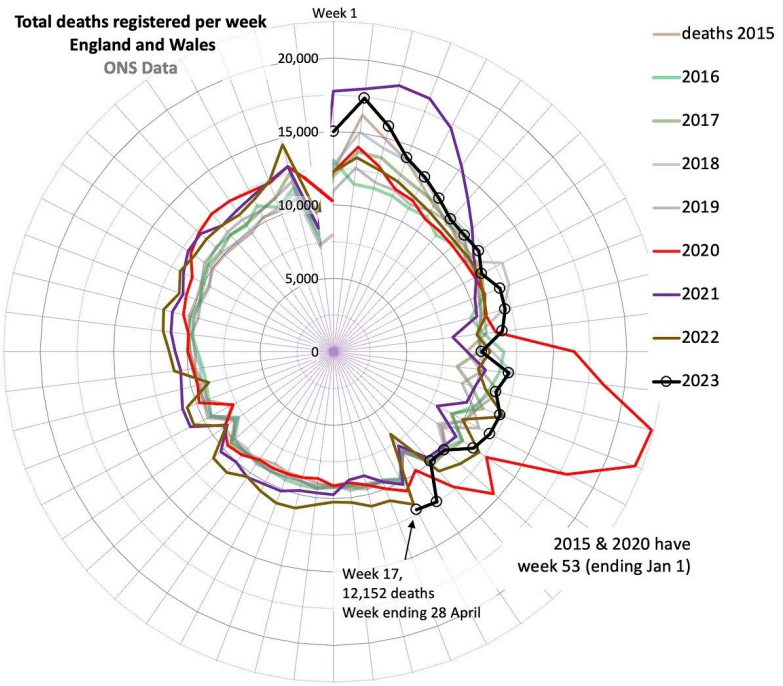
4. Mortality Dashboard

4.1 There were 110 inpatient adult deaths recorded in Quarter 4, 2023/24 at Whittington Health.

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

4.3 In the week ending 5 April 2024 (Week 14), 9,703 deaths were registered in England and Wales (including non-residents), an increase from 9,393 in the week ending 29 March 2024 (Week 13). The number of deaths registered in the week ending 5 April 2024 (Week 14) was 11.9% lower than the expected number (1,310 fewer deaths). In the week ending 5 April 2024 (Week 14), 15.5% of registered deaths involved influenza or pneumonia (1,502 deaths), while 1.1% involved coronavirus (COVID-19) (102 deaths).

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

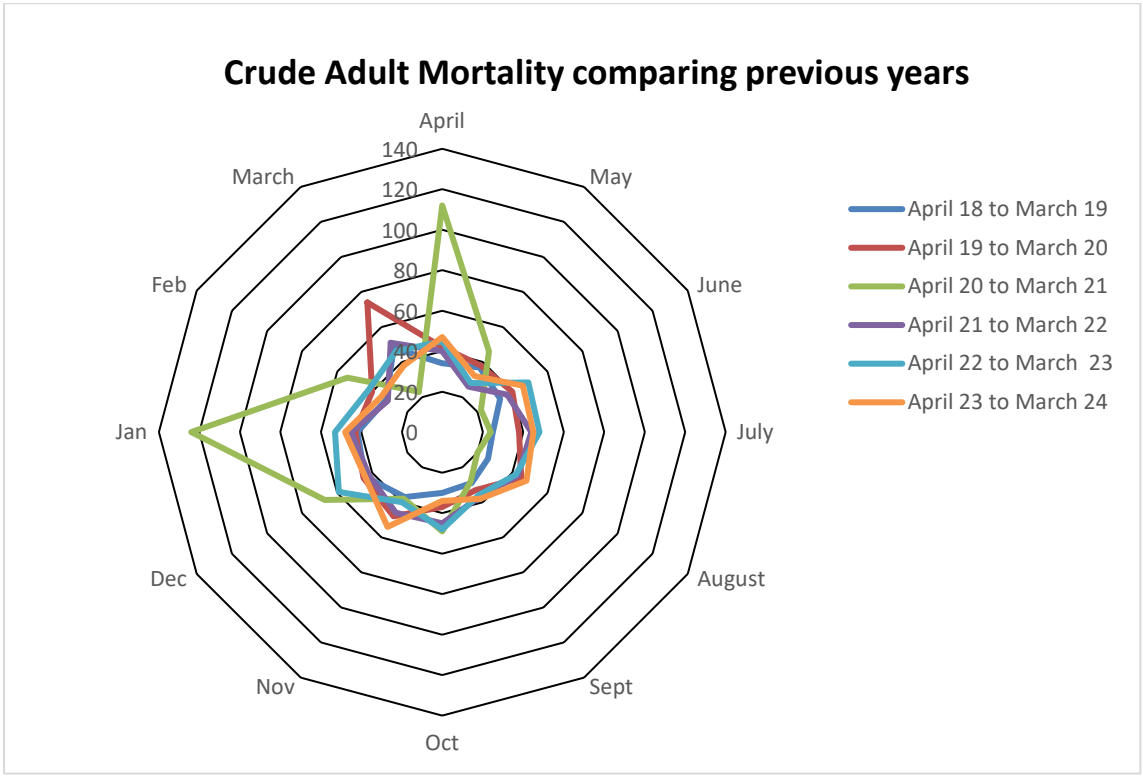


4.7 The radial graph below compares all causes of deaths (including ED deaths) in the Whittington hospital in 2018-19, 2019-20, 2020-21, 2021-22 with the year considered in this report 2022-23.

4.8 The number of inpatient and ED deaths in Q4 2023/24 was 123.

4.9 There was 1 learning disability death during Quarter 4.

Graph 2: Crude Adult Mortality at Whittington Health comparing previous years (April 2018-March 2024)



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

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

Month	April 18 to March 19	April 19 to March 20	April 20 to March 21	April 21 to March 22	April 22 to March 2023	April 23 to March 2024
April	34	42	112	40	45	47
May	37	38	46	26	28	32
June	33	40	22	37	49	46
July	25	38	24	44	48	45
August	26	45	20	43	42	48
Sept	29	33	28	37	36	37
Oct	30	37	49	45	48	34
Nov	37	48	38	46	40	54
Dec	44	45	67	42	59	44
Jan	42	43	124	45	53	47
Feb	32	40	54	31	42	36
March	48	74	23	51	46	38
Total	**417**	**523**	**607**	**487**	**536**	**508**

5. Summary Hospital-level Mortality Indicator (SHMI)

5.1 The Summary Hospital-level Mortality Indicator (SHMI) for the data period January 2023 to December 2023 at Whittington Health is 1.02 which is as expected.

6. Themes and learning from mortality reviews Quarter 4 of 2023/2024

6.1 Management of patients with SMI

In one patient with severe COPD there was a good standard of care where all options for treatment were considered or trialled. The patient's autonomy was respected, and comfort was prioritised at the end of life. The Mental health liaison team were involved. The patient's mental health disorder was managed and did not affect the outcome of the admission.

However, another patient had an SMI wasn't referred to the MHLT until 10 days into their admission. The reviewer wondered if we should consider a 'does this patient have a history of SMI?' as a prompt with flag to notify MHLT of admission, however this is not a common theme in SJR reviews so we will discuss at MRG.

Another patient with SMI and substance abuse presented to the surgeons with a fungating tumour. Community support was called on to enable him to attend clinic and subsequently admission to hospital. He had an extremely poor prognosis because of late presentation, but the surgeons were hopeful that they could help him with a palliative surgical procedure, but despite their best efforts he deteriorated and was appropriately palliated after discussion with him and his family.

6.2 Other SJRs

Many reviewers commented on excellent MDT working and highlighted good communication with both patients and families for patients nearing end of life.

Importance of documentation and consideration of Clinical Frailty Score (CFS), and awareness that this may be difficult to completely assess on admission.

Awareness that the admission diagnostic list is 'pulled through' to subsequent ward rounds. This needs to be regularly edited and/or updated by clinicians completing ward round notes as otherwise this may not reflect the updated situation or further knowledge gained about the patient.

Emphysema on CT scan should prompt team thinking around underlying diagnosis of COPD (NICE guidance 2019)

Low threshold for using SaO2 aim of 88-92% in patients with emphysema on CT scans.

Caution and seek advice when prescribing opioids in patients being actively managed for respiratory failure.

Where there is an agreed trial of NIV trial regular review should continue and it should be stopped as soon as it is recognised that a patient is dying. Palliative care helpful with symptom control

Importance of informing patient/ family re safety netting and ensuring documentation of this at discharge.

Ensuring there is a plan for who will review results of investigations especially in a scenario when a patient is discharged before that result is available.

Ensure blood tests requested are taken promptly and results reviewed in a timely manner.

If a patient's CK levels are rising, ensure there is a low threshold for requesting and reviewing troponin and serial ECGs are reviewed.

Good adherence to ALS protocols.

Continue to ensure good adherence to the rib fracture pathway.

Avoiding nonclinical transfers, if possible, but, if necessary, ensure documentation of rationale.

Flag importance of recognition of ileus and other abdominal issues where vomiting may occur, as aspiration of gastric fluid is associated with a high risk of death.

Delivering FIB (fascia iliaca blocks), with equipment available, for our patients with fracture neck of femur in the Emergency Department.

Planning theatre list cover so that (ideally) there is 1 anaesthetist allocated to a theatre for the whole day so there is good continuity of care.

7. Dissemination of Learning

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

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

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

8. Mortality Review Group

8.1 Please see the attached Mortality Review Group minutes.

Appendix 1

Whittington Health: Learning from Deaths Dashboard - March 2023-24

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

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
39	36	4	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
123	129	9	32	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
501	504	87	71	0	1

Time Series: Start date 2017-18 Q1 End date 2023-24 Q4

Total Deaths Reviewed by RCP Methodology Score

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

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

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

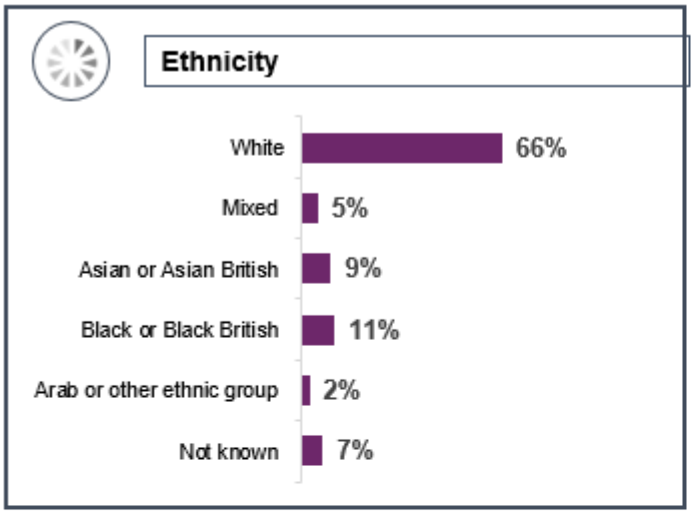
Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	1	1	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	2	7	0	0	0

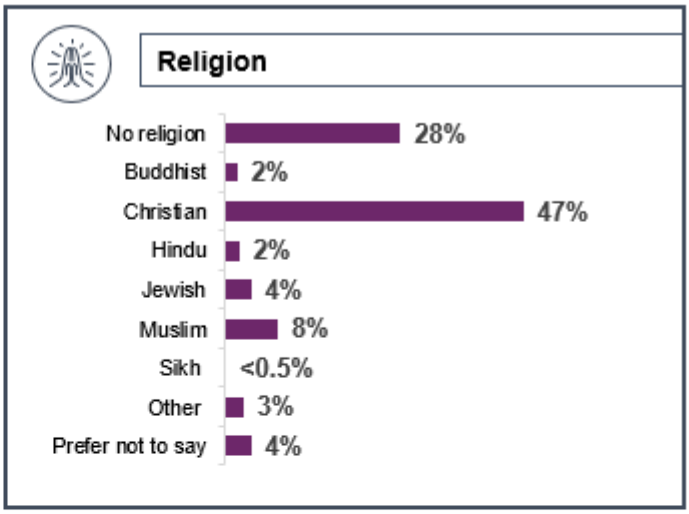
Meeting title	**Trust Board – public meeting**	**Date: 27.09.2024**
Report title	**National Adult Inpatient Survey 2023**	**Agenda item: 6**
Executive lead	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals	
Report authors	Antoinette Webber, Head of Patient Experience, and Nicola Sands, Deputy Chief Nurse	
Executive summary	The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services and is commissioned by the Care Quality Commission (CQC). These surveys are scheduled annually, bi-annually or every three years. As part of the NPSP, the Adult Inpatient Survey has been conducted annually since 2002. The Adult National Inpatient survey sample for the 2023 were patients who had spent one or more nights as an inpatient during November 2023 and the fieldwork was undertaken between January – April 2024. The findings were published nationally by the CQC in our benchmarking report on 21 August 2024. Information from national patient experience surveys is one way for the Trust to gather feedback from patients and understand their experiences during their recent care and treatment. Survey results can be used to check progress and improvement of care providers, and to hold us to account for the outcomes we achieve. Who took part in the survey – 1,250 invited to take part with a response rate of 29% (337 responses, 77% urgent/emergency admission, 23% planned admission), a slight decrease on 2022 (350). Ethnicity – no significant changes with 66% White (as with 2022). Gender – again no notable change with the majority of responses being from women, 53% and 47% men. The full CQC benchmark report can be found here **Success** – of the 215 trusts nationally, Whittington Health sits within the top eight for significantly improved scores as reflected in the Health Service Journal (HSJ) going from 7.5 to 8.0.	

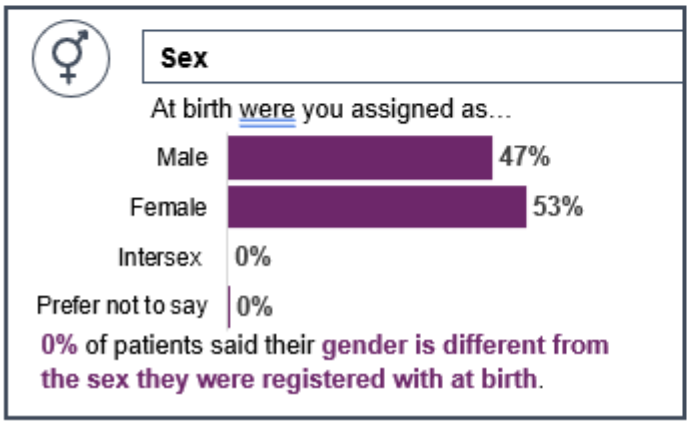
Purpose	Noting
Recommendation(s)	Board members are asked to note the outcome of the 2023 CQC adult inpatient survey, in particular: i. the positive statistical increase in our overall score from 7.5 to 8.0; ii. the top five and bottom five scores when benchmarked against the national average; and iii. that an action plan will be developed to improve on the bottom five scores and will be brought back to TMG, in due course.
Risk Register or Board Assurance Framework	Our strategic goal • Deliver outstanding safe, compassionate care. Ensuring that we put patients at the heart of all we do, starts with communication and compassion. 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	Executive team, 02.09.2024; Trust Management Group, 10.09.2024
Appendices	None

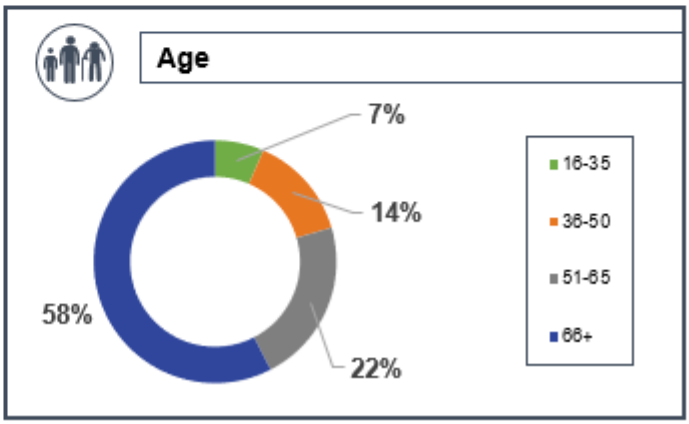
Introduction.
The Adult Inpatient 2023 survey was conducted using a push-to-web methodology (offering both online and paper completion). There were minor questionnaire changes, including six new questions and changes to question wording.

1,250 inpatient were invited to take part, with a response rate of 29% (337 responses), a slight decrease on 2022 (350). There were no significant changes in respondents' demographics, albeit with a slight increase in those aged 36-50 and a slight decrease in those of a Christian religion.









Summary
This report details top and bottom five scores (benchmarked against all trusts nationally by the CQC). Our Adult Inpatient 2023 survey results show that against all other trust nationally, we scored worse for five questions, and about the same for 44 in comparison. This is an improvement on the 2022 results where we were "about the same" for 26," somewhat worse or worse than expected" for 18 and "much worse than expected" for 1. In comparison with our 2022 results, we scored significantly better for 5 and no difference for 33.

Top five scores (compared with national average)
With reference to sleeping, there are a total of five questions related to "were you prevented from sleeping at night" after which there are sub-questions such as room temperature, noise from other patients, noise from staff, hospital lighting and I was not disturbed, some of which are new questions.

Question	2023 score	National Average	2022 results
Q6_8 I was not prevented from sleeping	4.1	2.9	New question
Q6_6 Room temperature	9.3	8.3	New question
Q14 Did you get enough help from staff to eat your meals	8.1	7.4	7.1 ↑
Q8 Did the hospital staff explain the reasons for changing wards during the night in a way you could understand	7.1	6.7	6.1 ↑
Q34 Before being admitted onto a virtual ward, did hospital staff give you enough information about the risks and benefits of continuing your treatment on a virtual ward	7.1	6.4	New question

Bottom five scores (compared to national average)
Of our bottom five these related to the following sections admission into hospital, the hospital or ward and your care and treatment and centred on information/communication, food and cleanliness.

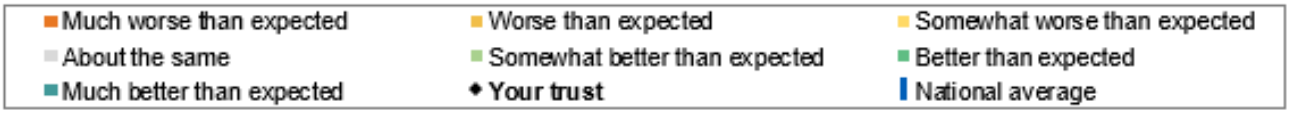
Question	2023 score	National Average	2022 results
Q4 How would you rate the quality of information you were given while you were on the wating list to be admitted to hospital? This includes verbal, written or online information	6.7	7.5	New question
Q5 How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital	5.9	6.7	6.0 (Q4) ↓
Q9 How clean was the hospital room or ward that you were staying in	8.2	9.0	8.1 (Q8) ↓
Q15 Where you able to get food outside of mealtimes	4.5	6.0	4.6 ↓
Q27 Did you feel able to talk to members of hospital staff about your worries and fears	6.9	7.7	6.8 (Q26) ↑

Comparison to other Trusts within our region by section

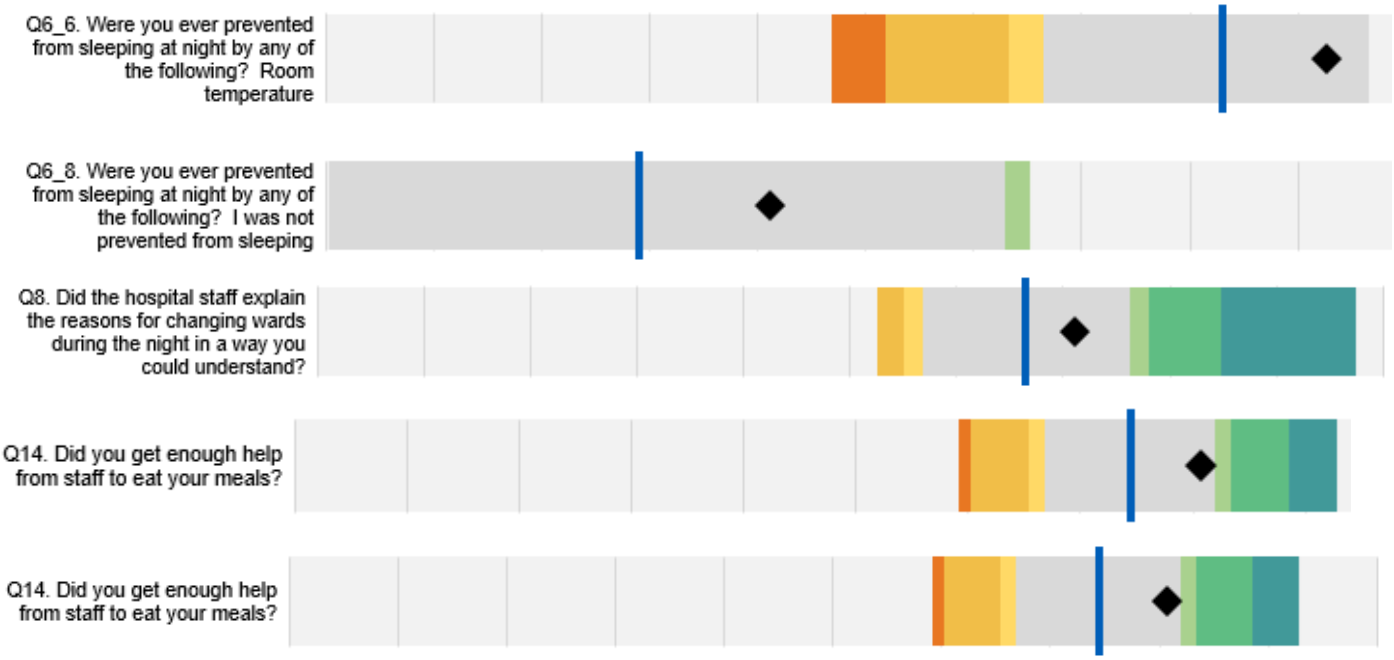
Section No	Title	WH score	Expected range and 2022 comparison	Highest Score	Lowest Score
Section 1	Admission into hospital	**6.3** ◆	(worse than expected) bottom five. *similar, for 2022*	8.9 The Royal Marsden	**6.2 North Middlesex University Hospital (NMUH)**
Section 2	The hospital and ward	**7.4**	(about the same) ◆*bottom five in 2022 (7.1)*	8.3 The Royal Marsden	**6.7 (NMUH)**

Section No	Title	WH score	Expected range and 2022 comparison	Highest Score	Lowest Score
Section 3	Doctors	**8.7**	(about the same)	9.5 The Royal Marsden	8.4 London North West University Hospital
Section 4	Nurses	**8.1**	(about the same) ◆ *bottom five in 2022 (7.8)*	9.3 The Royal Marsden	7.6 London North West University Hospital
Section 5	Your care and treatment	**8.0**	(about the same) ◆ *bottom five in 2022 (7.7)*	9.0 The Royal Marsden	7.6 London North West University Hospital **NMUH 7.8**
Section 6	Virtual wards	**7.6**	(about the same)	9.0 The Royal Marsden	6.0 Epsom and St Hellier University Hospital **UCLH 6.5** **Royal Free Hospital 6.9**
Section 7	Leaving hospital	**6.8**	(about the same) ◆ *bottom five in 2022 (6.7)*	8.3 The Royal Marsden	6.4 Kings College Hospital
Section 8	Feedback on the quality of care	**3.0** ◆	(about the same) and bottom five	5.8 The Royal Marsden	3.0 Epsom and St Hellier University Hospital **Royal Free Hospital 3.1**
Section 9	Kindness and compassion	**8.8**	(about the same)	9.7 The Royal Marsden	**8.5 NMUH**
Section 10	Respect and dignity	**8.9**	(about the same) ◆ *bottom five in 2022 (8.4)*	9.8 The Royal Marsden	8.7Kings College and NMH
Section 11	Overall experience	**8.0**	(about the same) ◆ *bottom five in 2022 (7.5)*	9.1 The Royal Marsden	7.6 London North West University Hospital **NMUH 7.6**

Questions where we exceeded the national average.

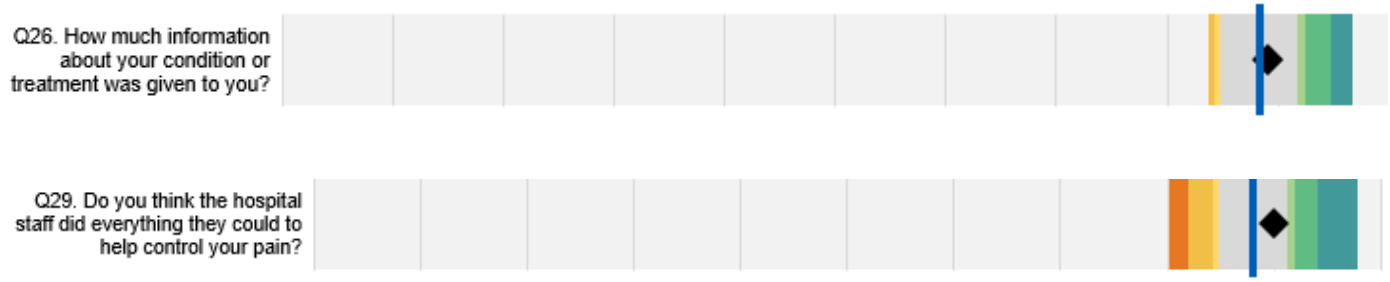


Section 2 – The hospital and ward

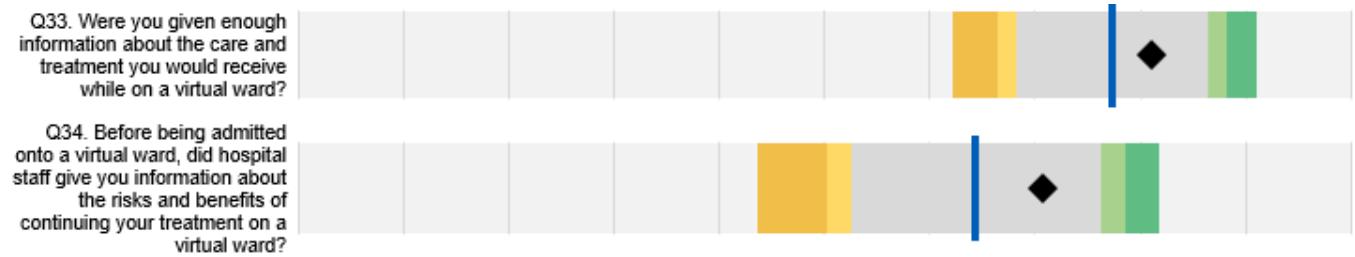


Section 3 – Doctors

Section 5 – Your care and treatment



Section 6 – Virtual Wards



Section 7 – Leaving Hospital

Next steps

Following the publication of the benchmarking report the Patient Experience team will develop a task and finish group to consist of key stakeholders as with the 2022 results, to address the bottom five areas for improvement, which centres on information/communication, cleanliness and food.

Meeting title	**Trust Board – public meeting**	**Date**: **27.09.2024**
Report title	**Whittington Health and UCLH collaboration**	**Agenda item: 7**
Executive lead	Jonathan Gardner, Chief Strategy, Digital and Improvement Officer	
Report author	David Cheesman, Programme Director	
Executive summary	The collaboration team is making steady progress since the appointment of a dedicated Programme Director in May 2024. This report provides a progress report with a focus on: • Progress against the five priority areas; • Non-clinical opportunities; • Joint communication efforts across the two trusts; • Patient engagement; and • Programme risks. The report concludes with a summary of immediate next steps required to achieve programme deliverables.	
Purpose:	The attached report provides a progress report on the Trust's collaboration with UCLH.	
Recommendation(s)	Board members are asked to take assurance from the paper.	
Risk Register or Board Assurance Framework	The five priority workstreams described in the report are expected to address the following BAF risks: • Quality 1 – quality and safety of services • Quality 2 – capacity and activity delivery • Integration 1 – ICB/S and Alliance changes • Integration 2 – population health and activity demand	
Report history	This report is presented for the first time at both Whittington Health and UCLH trust boards.	
Appendices	Proposed programme plan for the Collaboration (Carnall Farrar, March 2024).	

Whittington Health and UCLH collaboration

1. Purpose of report

This report provides a progress report for the Collaboration between Whittington Health (WH) and UCLH. It is designed so that Board members can take assurance that the collaboration is proceeding according to plan.

The report concentrates on the following:

- Progress against the five priority areas;
- Other areas of clinical focus beyond the five priority areas;
- Non-clinical opportunities;
- Joint communication efforts across the two trusts; and
- Patient engagement.

2. Background

The programme team has been in place since mid-May and has initially focused on working closely with clinical teams to help establish a clinically compelling case[1] for collaboration. The team is also exploring opportunities for back-office harmonisation but this has only recently commenced and remains at a nascent stage (see section five of report).

The programme team has defined collaboration as *working together to improve clinical outcomes and ensure greater sustainability for local services*.

3. Priority areas of opportunity

Five clinical areas have been prioritised because of their strategic importance and/or the opportunity to deliver a quick win because of previous focus and attention.

i. Joint theatre capacity plan;
ii. Opportunities for increased community provision from WH;
iii. Care closer-to-home for patients with cancer;
iv. Establishing resilient women's health pathways; and
v. Joint outpatient dispensary across UCLH and WH

A summary progress report is included in table 1.

[1] This approach echoes the North London Mental Health Partnership which changed its early focus on back-office harmonisation (which was expected to be less controversial) to working with clinical teams to ensure a more compelling and engaging case for change.

Table 1 Summary assessment of progress for five priority areas

Workstream	Background	Objective	Key deliverables	Status	Progress against plan
1. Joint theatre plan	UCLH elective backlog / patient treatment list (PTL) continues to grow while WH's PTL has stabilised. There is limited UCLH theatre capacity[2] during the working week while there is spare capacity at WH	Reduce patient waiting times by providing WH theatre capacity to UCLH's surgical teams	Agree new theatre timetable with dedicated WH lists for UCLH teams	First draft of timetable presented to Southern Surgical Hub 5/9/24	Green
			Agreed joint financial model that calculates equitable allocation of cost and income/cost avoidance;	Analyses of casemix assumptions require completion	Amber
			A new recovery suite at WH that is equipped to treat patients with a stay <24 hours	Costings have been included as part of joint business case Future design and operating model requires sign off from infection control and nursing leads	Green
			Full alignment with the UCLH focused 42/50 and Saturday working programmes	Respective transformation teams working together with operational leads	Green

[2] UCLH runs 34 theatres across Tower, Westmoreland St and Grafton Way.

Workstream	Background	Objective	Key deliverables	Status	Progress against plan
2. Increased community provision from WH	35% of total UCLH patients[3] (49% non elective) live in either Camden, Islington & Haringey WH is the main provider of community services for Islington and Haringey and also provides the UCLH at home service	Reduce unplanned hospital admissions and provide more care in the patient's own home.	Establishment of a more effective care-at-home model with increased step up provision for patients on emergency pathways	Data confirms relatively low percentage of referrals on step up pathway Assessing a) impact on overall ALOS b) utilisation by surgical teams Teams considering changes to existing contractual arrangements	Amber
		Establish a unified MSK pathway across both WH and UCLH with consistent triage and referral guidelines	Mutually agreed, unified MSK pathway across both WH and UCLH	Joint approach agreed with respective teams in response to new NCL model NCL business case still outstanding / required to understand future contractual model	Amber
3. Care closer-to-home for patients with cancer	Almost all oncologists working at WH have joint contracts and also work at UCLH More patients living locally could be treated at the WH if there was investment in both staffing and estate.	To establish an excellent local cancer treatment service at WH that benefits from UCLH's specialist expertise and releases capacity at	Agreed demand and capacity model that supports care closer to home for WH patients and releases pressure at UCLH.	Principle of 'patient not passing WH for diagnosis & treatment' has been agreed GI, breast & lung will be prioritised Post code analysis due for review at next joint meeting on 25th September Post code filters will be supported by clinical protocols	Green

[3] Activity from 2022/23 and 2023/24)

Workstream	Background	Objective	Key deliverables	Status	Progress against plan
	The Macmillan Cancer Centre at UCLH currently has limited capacity to grow.	UCLH to increase specialist activity		Working assumption for start date is 1 April 2025 (pending business case approval)	
			Agreed investment plan for a workforce model that delivers necessary resilience for WH oncology	WH has confirmed investment in new junior staff and pharmacy support Additional investment is expected once results of demand and capacity work is complete (see above) Business case will require respective Trust approval	Amber
4. Establishing resilient women's health pathways across UCLH and WH	There are a number of well-integrated services already in place[4] Although there is good joint working across agreed pathways there is currently only one joint appointment across the partnership. As such access the UCLH robotic capacity (eg for complex endometriosis) is very limited resulting in	Establish a new robotic surgical pathway supported by joint appointments and new clinical rotations. Establish improved, faster access to	New joint appointments with access to a new robotic pathway UCLH to undertake review of elective procedures with long waits where WH can provide mutual aid Establish a joint community of practice for specialist nursing to	UCLH undertaking uro-gynae staffing review to assess potential for joint post with interest in endometriosis Some mutual aid agreed as part of joint theatre plan, further plans to be made following UCLH review. WH and UCLH matrons to meet in September to explore opportunities initially for uro-gyane nursing	Green

[4] Examples of well regarded joint pathways & specialist hubs:
- Laparoscopic Bilateral Salpingo Ophorectomy (BSO) pathway at WH for women with BRCA1 or BRCA2 genes
- Specialist termination service for late fetal abnormalities at WH
- C section pathway across UCLH and WH supported by clear patient information
- Sharing of best practice for same day hysterectomy service
- Joint management of hysteroscopy capacity
- Lower Urinary Tract Symptoms (LUTS) specialist service based at WH

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Workstream	Background	Objective	Key deliverables	Status	Progress against plan
	inconsistent pathways and recruitment challenges.	specialist service with appropriate community based discharge support when required	provide peer support and share cross organisational learning WH to align Gynae Rapid access model with UCLH	UCLH to agree training offer for WH consultants to carry out pipelle biopsies in October 2024	
5. Closer alignment of UCLH and WH's outpatient dispensary	Current WH service dispenses 90,000 items pa while UCLH dispenses 270,000 items pa UCLH currently subcontracts its outpatient dispensary to Lloyds Pharmacy. WH has established its own community interest company (CIC) to manage its dispensary.	Establish an evidence based case for change determining whether closer working could deliver mutual benefit for the partnership	An agreed position on whether joint working across UCLH and WH in relation to outpatient pharmacy would be beneficial	UCLH's existing contract is coming to an end. WH exploring logistics and capability required to support UCLH's wider tertiary catchment	Amber

4. Other areas of clinical focus beyond the five priority areas

The collaboration team has begun working with a variety of other clinical teams that appear in the collaboration matrix. The areas include:

Area	Extent of support	Next steps
Children & young people	Agreed programme of joint workshops	Agreement to explore following joint opportunities: • Mgt of International Medical Graduates • Medical training • Pathways for 16-18 yr olds • Best practice standards & peer review • Opportunities for faster CAMHs support • Joint rotations for nursing staff
Support for the WH rheumatology service	Developing proposal for targeted support from UCLH clinical lead	• Agree scope of support with WH Medical Director & commitment required
Queen Sq support for the WH neurophysiology service	Development of case for establishing a hub & spoke model with Queen Sq.	• WH executive team has agreed to pursue an SLA model. • UCLH to complete its own consolidation of service at Queen Sq (due Dec 24)

5. Nonclinical opportunities

The Carnall Farrar report highlighted collaborative opportunities for non-clinical areas including procurement, data and business information, estates, finance & HR. As described above the collaboration team will focus on non-clinical areas in the latter half of the initial four month plan (i.e. once the clinical priority areas are up and running.)

Following identification of e-rostering and legal services as opportunities for collaboration, the finance teams will work with the collaboration team to prioritise functional areas to take forward in the next six months. These meetings will be scheduled over the next few weeks.

6. Communication

The two communications teams hold regular joint sessions and have agreed an inventory of stories about the collaboration. The TB MDT service was featured in August[5] with items due soon on the joint haematology service and the recently established NCL community neuroscience service.

7. Patient engagement

There has only been limited focus to date on patient involvement and engagement. However, now that the priority workstreams are better established, there will be increased engagement efforts, starting with the UCLH Patient Partners meeting on 24th September. The meeting already includes patients treated at both UCLH and WH and colleagues from WH have been invited to attend.

[5] https://my.uclh.nhs.uk/page/29420?SearchId=9249134

8. Risks

The following risks have the highest risk score:

- Collaboration opportunities stall / remain undelivered due to lack of management bandwidth (at either Trust) and/or business as usual (BAU) pressures; and
- Organisational income (at Trust level) adversely affected by new pathways e.g. with the consolidation of specialist orthopaedic work

Despite both risks scoring nine, there is suitable mitigation and the necessary controls in place.

9. Next steps

The programme team continues to align its work with the original plan outlined in the CF report - summarised in appendix 1

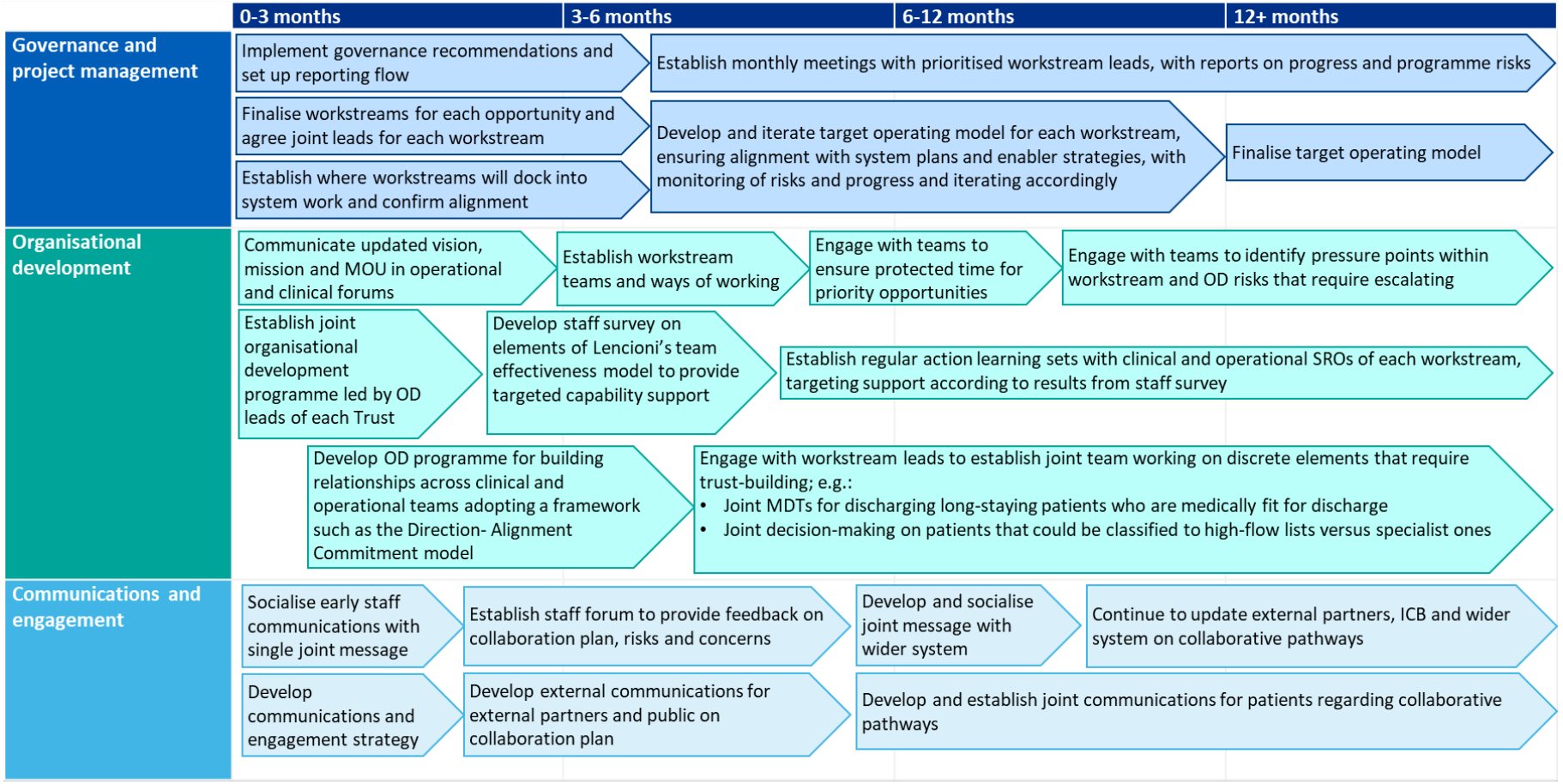
Key next steps between now and November include:

- Finalise theatre timetable and associated financial model for joint theatre plan. Ensure that operational plans in place to support mobilisation are aligned with planned ventilation replacement;
- Complete first draft of oncology investment plan;
- Establish small project team with representatives from UCLH and WH to coordinate the response to the MSK Live Well Review;
- Test original CF assumptions for non-clinical areas including procurement, data and business information, estates, finance & HR;
- Ensure that the collaboration has a compelling narrative about both patient and public engagement in advance of the Joint Health Overview & Scrutiny Committee on 11th November.

10. Recommendation

Board members are asked to note the report and provide feedback.

Appendix 1 - Proposed programme plan (Carnall Farrar, March 2024)



Meeting title	**Trust Board – public meeting**	**Date: 27.09.2024**
Report title	**Improvement Performance & Digital Committee Chair's report**	**Agenda item: 8**
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 19 September 2024 and took significant assurance from the following items considered: • A deep dive on Surgery and cancer performance summary • Improvement programme update • Board Assurance Framework • Timeline and considerations for strategic IT decisions • Patient Systems, Infrastructure and Information Update There are no items for which the Committee is reporting limited assurance to the Board. Following discussion, the following areas were agreed to be reported to the Trust Board: 1. The update on issues around cancer performance and dermatology. 2. The recommendation for a three year contract extension with System C or an EPR System.	
Purpose	Note	
Recommendations	Board members are asked to note the Chair's assurance report for the meeting held on 19 September5 2024.	
Board Assurance Framework	Sustainable 3 – Digital strategy and interoperability strategic objective entry	
Appendices	None	

Committee Chair's Assurance report

Committee name	Improvement Performance & Digital Committee
Date of meeting	19 September 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 cancer and surgery pathway. The Committee received a presentation on cancer performance in the surgery and cancer clinical division which was based the validated performance data up to the end of July. It was reported that cancer performance across North Central London (NCL) remained challenged. For the reported period the Trust achieved the following: • 68.87% of cancer referrals were seen under the faster diagnosis standard against a target of 75.57% • 98.11% patients commenced treatment within 31 days of a decision to treat their cancers against a target of 95% • 68.91% patients commenced treatment within 62 days of an urgent referral against a target of 85%. • Nationally, approximately 75% of patients received a formal diagnosis the aim was to increase. • Dermatology was challenged in the faster diagnosis pathway and once the issues were resolved the Trust would become compliant. The Committee learned that a new timeline and trajectory that would take into account revised performance metrics, had not yet been agreed. In the meantime, demand and capacity modelling for all tumour groups and benign services would continue to support the improvement work needed. The Committee discussed the key drivers behind cancer performance specifically in dermatology, which was impacted by seasonal variation, as more referrals were made in the summer months compared to winter. Core capacity for dermatology was approximately 35 patients per week, however the numbers of patients seen in clinic was between 70 and 80 a week. Referrals for quarter one in 2024 had increased by 20% compared to the same period in the previous year. The Committee was assured that a number of mitigating actions had been developed to address demand and the backlog of referrals which included: • Implementation of weekend clinics during the months of September and October. • Recruitment of a senior clinical fellow and consultant • Increased one stop capacity with three extra rooms to hold mid-week clinics together with the extension of funding for one locum doctor which would see an extra 52 patients in dermatology. Committee members were advised that resources would need to be redeployed from benign (general dermatology) activity to ensure sufficient capacity to cover additional activity across cancer pathways. The plans around demand and

	capacity modelling would consider both cancer and benign activity to determine workforce requirements. Committee members were informed that developments in new digital and AI technology would be regularly explored as well as programmes of work in place across the NHS that were in development aimed at resolving long waiting lists and increased demand for clinical services. The Committee welcomed plans to trial a tele-dermatology service within cancer in November. The service would start with 20 appointments out of which it was estimated that five would be referred to the one stop clinic, more would be known once the trial had started. Additionally, the Trust had received an innovation grant from the NCL Cancer Alliance to explore the use of AI in tele-dermatology. A decision on an application for phase two funding would be made in January. **The Committee noted that work would continue to improve on cancer performance across all cancer pathways.**
	Improvement programme update. The Committee was apprised of the progress made on the delivery of the Trust's improvement priorities, as follows: • **Elective improvement programme** – A significant amount of work had been carried out to improve efficiency and productivity within the elective pathway. The introduction of booking scripts for booking co-ordinators would provide patients with more information and assurance. This has helped to transition over 500 long wait patients onto the electronic pre-operative assessment pathway. The Committee welcomed the addition of four new spinal injection clinics which would optimise existing clinic capacity and the completion of a business case to support the delivery of 13 additional theatre sessions. The Committee noted that the numbers of cases booked six weeks in advance of patient procedures had consistently increased since mid-June. • **Outpatient improvement programme** – It was reported that the average number of procedures carried out at the Trust had gradually increased, which was helped by correct coding and training in e-outcoming and procedure codes. The Robotic process Automation (RPA) system had been implemented in two out of five, two-week services and in 10 out of 25 routine services. This would vastly reduce the risk around information governance. RPA also transferred 1000 patients from the Appointment Slot Issues (ASI) lists to Careflow which would ensure better visibility and tracking of patients. • **Flow improvement** - Jonathan Gardner advised that good progress had been made with the work to improve the transition of patients from the emergency department through to discharge from hospital. The Committee learned that improvement against the emergency care four hour standard had been sustained through the embedding of the rapid assessment and treatment model and the pilot of Same Day Emergency Care. Within the hospital, the ward board escalation chat facility had been embedded which would improve communication between wards and site teams. A face-to-face model of long length of stay reviews was in place which has had a positive impact on length of stay over 21 days and those patients who did not meet the criteria to reside.

	The Committee were assured that improvements were underpinned by good engagement between transformational and operational project teams who were also encouraged by the positive outcomes achieved and improvements made to patient experience. **The Committee noted the update on improvement activities**
	Timeline and considerations for big strategic IT decisions The Committee considered the report on the imminent expiration of the contract with System C for the provision of an electronic patient records (EPR) system at the Trust. The current contract would expire in April 2025 and a decision on whether to extend the contract for a period of three or five years would need to be made. The issues had been discussed with the Executive Management Team where the recommendation for an extension of three years was supported. In addition, the Trust would also need to determine whether there was still an appetite to procure a new EPR system that would fit with the Trust's clinical strategy and partnership with University College London (UCLH). The Committee noted: • System C would not support Badgernet and as a consequence the development of maternity services. • The need to proceed with the digitalisation of medical records. The national funding allocation for frontline digitalisation was not yet known. In the meantime, the Trust would continue to absorb the costs of Iron Mountain's offsite storage due to the lack of on-site storage. • Funding from NHSE for digital projects was uncertain. • System C is investing heavily on cloud infrastructure to develop new products and improve current solutions. Depending on the length of the contract the Trust would need to decide on whether the EPR system would be hosted on the premises or in the System C Azure cloud at an additional financial and workforce cost. Committee members were informed that the difference in the costs of a three-year contract and five-year contract extension were not substantial. However, a contract extension with System C would mean that the Trust would not invest in Badgernet and other projects. Additionally, there was no guarantee that the Trust would secure funding for a new EPR system at the end of the five-year contract. **The Committee agreed that given the benefits of a new EPR system, the likelihood of securing funding in three years rather than five years and the potential to link with UCLH timeframes, a three-year contract extension with System C was the preferable option.**
	Board Assurance Framework (BAF) The Committee considered the quarter two Board Assurance Framework, which remained unchanged since it was last discussed when the Committee met on 25 June 2024. At that meeting it was agreed that the likelihood score for the Sustainable 3 entry was increased from 3 to 4 to reflect the increase of the likelihood of a cyber-attack and that the impact score remained at 5. The

	Committee agreed that the risks to cyber security should be discussed more broadly in the context of the Trust's business objectives at the next meeting of the Committee. **The Committee approved the Sustainable 3 Q2 2024/25 Board Assurance Framework entry and agreed the current total risk score.**
	Information Management and technical patient systems infrastructure and business intelligence update The Committee considered an update on IMT activities as of 10 September 2024 which highlighted the following: • The Trust had a total of 187 listed projects, 63 which were active. • A review of paused projects would be undertaken on 17 September 2024. • A new Power BI dashboard was in the user acceptance testing stage. The dashboard would provide more transparency of IMT activity across the organisation. • The replacement of telephony consoles was completed on 4 September 2024. This would ensure a more resilient telecommunication system and take the Trust a step closer to the retirement of old legacy systems. • A new server visualisation platform Mutanix had been installed. This would help to simplify data centre management and visualising storage and services. • Security firewalls had been replaced to strengthen cyber-security. • Self-enrolment for smart card self-registration was now live. • The successful implementation of cannula management of vitals via an app to carry out e-observations. • Zesty questionnaires for inpatient waiting list validation had gone live • The migration of pathology services from HSL Elix to winpath. • The reduction of the backlog clinical coding and creation of a clinical coding policy. An external audit of clinical coding was currently in progress. • A substantive appointment of the chief information officer was made in August which would bring much needed stability to the teams and organisation. • An increase in IT incidents had been reported the majority of which had been caused by external factors. **The Committee noted the update.**
2.	**Present:** Junaid Bajwa, Non-Executive Director (Committee Chair) Nailesh Rambhai, Non-Executive Director **In attendance:** Iolanda Pedrosa, Chief Information Officer/Chief Nursing Midwifery & AHP Information officer Jonathan Gardner, Director of Strategy and Corporate Affairs Sam Barclay, Chief Clinical Information Officer Chinyama Okunuga, Chief Operating Officer Camilla Dobinson, General Manager Surgery and Cancer Services Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary

	Marcia Marrast-Lewis, Assistant Trust Secretary **Apologies** Clare Dollery, Acting Chief Executive Mark Livingstone, Chief Allied Health Professional Charlotte Hopkins, Acting Medical Director. Paul Attwal, Head of Performance Naomi Fulop, Non-Executive Director

Meeting title	**Trust Board – public meeting**	**Date: 27.09.2024**
Report title	**Medical Appraisal and Revalidation: Annual Board Report: 2023-24**	**Agenda item: 9**
Executive lead	Dr Charlotte Hopkins, Acting Medical Director	
Report authors	Dr Sola Makinde, Associate Medical Director for Workforce and Responsible Officer, Taniya Nasmin, Revalidation Support Officer	
Executive summary	This paper is the annual Medical Appraisal Board Report, in the format suggested by NHS England, as part of the quality assurance process for medical appraisal and revalidation. This report reviews appraisals completed, and revalidation recommendations submitted in the financial year 2023/24.	
Purpose:	The Board is asked to approve the report and note the actions.	
Recommendation(s)	The Board is asked to approve the report. Once approved this Report will be submitted to the higher-level Responsible Officer for NHS England, London Region. The deadline for submission to NHS England is the 10th of October 2024.	
Risk Register or Board Assurance Framework	Not applicable	
Report history	Annual report to the Board	
Appendices	Nil	

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.2 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of Whittington Health NHS Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Dr Sola Makinde became the Responsible Officer on the 1st of May 2024. Comments: Dr Clare Dollery the previous Responsible Officer became the acting CEO on 1/4/24 and stepped down as responsible officer after the appropriate approval processes for Dr Makinde had been completed on 31st of April 2024. Action for next year: N/A

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Dr Sola Makinde has been the Associate Medical Director with a responsibility for workforce since April 2020. She became the Responsible Officer on the 1st of May 2024. Ms Taniya Nasmin has been the Revalidation Support Officer since November 2019 Action from last year: Ms Manju Mandirathil took up the post of business manager for the Medical Director's Office on the 13th of June 2024. She replaced Ms Vicki Pantelli who left the Trust on the 14th of June 2024. Action for next year: Not applicable.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Nil. Comments: The Trust implemented a new appraisal and revalidation system in September 2023. The system runs daily updates of the Trusts GMC connections. In addition, the Revalidation Support Officer actively ensures that all doctors who work or have honorary contracts at the Trust are connected appropriately (via the GMC Connect portal) by cross-checking with the Electronic Staff Record (ESR) reports, and Bank Partners for doctors who connect to the Trust by virtue of their work on the Bank. Action for next year: Not applicable.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The Trust was in the process of approving the updated Medical Appraisal and Revalidation policy. Comments: The Medical Appraisal and Revalidation Policy has been approved and is next due for review in January 2026. Action for next year: Not applicable.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Not applicable. Comments: The Trust completed a peer review of appraisal outputs with a neighbouring Trust in 2023 and included a commentary of the results in Annual Board Report and statement of compliance for the year 2022 – 2023 (last year). Action for next year: Nil applicable.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: There was a focus on ensuring that the small number of doctors who work in the Trust but have a prescribed connection to another organisation are aware of the work of the Revalidation Team and the support offered.

Comments: The Revalidation Teamwork closely with the workforce information team to ensure that all doctors working at Whittington Health, including those on short-term contracts are appropriately connected to the organisation, and that they receive appropriate support in preparing for their appraisal and revalidation.

Many of the doctors who work in the Trust on short-term locum contracts do so through Bank Partners, with whom the Trust has a close relationship via a dedicated Bank Business Partner. Some of these doctors have a prescribed connection to another organisation, but many connect to Whittington Health, and all receive the same support as other connected doctors

If a governance related issue arises for a doctor who is working within the Trust, but is connected elsewhere, the Trust would take the lead in any investigation with input from Bank Partners, if required

The Trust plan to introduce active scrutiny of the very small number of doctors who obtain short-term placements via an Agency. This will include monitoring of the duration and nature of their placement monthly They will continue to receive clinical governance information.

Action for next year: The Trust will introduce active scrutiny of the small number of doctors who are employed via an agency by reviewing the number and their duration of employment monthly. The Trust also recognises that doctors who are new to the appraisal process may have difficulty understanding its requirements and plans to introduce targeted support for this group.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: A survey of both appraisees and appraisers to understand the impact of the Appraisal 2022 model was considered.

Comments: The Trust's appraisal and revalidation software has the "Appraisal 2022", as set out by the Academy of Medical Royal Colleges, embedded within it, the input form includes all the relevant areas relating to a doctor's fitness to practice. It has a continued focus on a doctor's wellbeing. The software is in the process of being updated further to reflect the updated 2024 Good Medical Practice domains, as set out by the General Medical Council. These new domains came into use at the end of January 2024.

A survey of medical staff using the software has not been conducted as firstly, appraisees and appraisers were becoming accustomed to the new software which had Appraisal 2022 embedded within it. Secondly the software is now having an update to reflect the new Good Medical Practice domains. This has not yet been embedded and used by all the software users.

Doctors are sent any complaints and compliments that the Patient Advocacy and Liaison service are aware of so the information can be uploaded to the appraisal software and reflected upon.

Clinical Governance information is routinely sought from any organisation where a doctor works independently, and this is viewed both at their appraisal, and secondly when their revalidation submission is considered.

There are regular medical workforce meetings where any clinical governance information or concerns related to individual medical staff are discussed.

Action for next year: Nil applicable

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Not applicable Comments: Action for next year: Not applicable

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: To agree and implement the updated Medical Appraisal and Revalidation policy (with the Local Negotiating Committee of the BMA) Comments: This has been completed, and the updated policy is in use. It is due for renewal in January 2026 Action for next year: Not applicable

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To recruit five new appraisers Comments: Whilst the Trust has recruited 6 new appraisers, 3 of them are retired consultants, 2 of whom are on honorary contracts, and do limited numbers of appraisals, so this will not lead to a sustained increase in appraiser numbers. Despite this recruitment, the Trust has found it difficult to appraise all its connected doctors within the required time frame. There are two main reasons: Firstly, the decline in the number of appraisers, and appraisals offered, has exceeded the rate at which appraisers have been recruited. This has been coupled with an increase in the number of doctors who require appraisal. There has been a steady increase in the number of doctors who have retired or reduced their workload in the years since the pandemic. Many of these doctors were appraisers, and their loss has not been matched by the recruitment of new appraisers, able to do the same number of appraisals, despite the Trust having the appropriate benchmarked job plan tariff for appraising. Some of our appraisers have also been unable to appraise because of long-term sickness. Others have limited the number of appraisals that they complete. In addition, there has been an increase in the number of doctors who require appraisal (consultants and locally employed doctors) of 13%. This increase has been prompted by firstly, the reviews and expansion of services such as the Ockenden report and the

opening of the Community Diagnostic Centre, and secondly, the changing working and career patterns of doctors. Many more are choosing not to enter a recognised training programme and are 'locally employed'. Many are also working in a less than full time manner, so the Trust has recruited more doctors to avoid gaps in the rota.

The Industrial action undertaken by the medical workforce has also influenced the number of appraisals that have been completed. There have been 8 periods of industrial action undertaken by 'Junior' doctors resulting in 41 days, and a similar number of nights where the senior doctors have had to cover their workload. It is well recognised that it is more difficult to recover from disruption to sleep caused by working nights with increasing age. The senior workforce has also undertaken industrial action. Fewer doctors completed appraisals during or shortly after the days of industrial action.

Action for next year: The Trust is committed to increasing the number of appraisers in a sustainable way. The current position has been raised with the Clinical Directors and is being included in the discussions related to team job planning. The Clinical Directors have been given targets for the number of appraisers required for each area (ICSU, Integrated Clinical Service Unit), and this will be monitored at their performance review.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: The results of the Peer review were to be shared with the appraisers at an appraiser Network event.

Comments: Whilst appraiser network events have been organised, they have had very poor attendance (single figures) and in addition the dates have been disrupted by the medical workforce industrial action. The results of the peer review have therefore not been shared.

Action for next year: The Trust will engage the appraisers and consider ways in which the appraiser network can be revived, including offering differing formats of meeting and changing the meeting times. This action is underway, with two lunchtime meetings scheduled for October, in a hybrid format to encourage attendance

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: The results of the external review process were to be discussed at an appraiser network meeting

Comments: Whilst the results of the external review were not discussed at an appraiser network meeting they were presented in several other forums and presented at Trust Board. As the external review was completed using our previous appraisal system, and the results are over a year old, the results may not be as relevant now. The new appraisal and revalidation system is in the process of being updated further to reflect the updated 2024 Good Medical Practice domains, as set out by the General Medical Council.

Action for next year: A further external review should be carried out when the updated software has been embedded.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as of 31 March 2024	328
Total number of appraisals undertaken between 1 April 2023 and 31 March 2024	169
Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	161
Total number of agreed exceptions	105*

*This number includes the following:

- 14 Doctors who were on parental leave, sick leave, or a career break, including 1 doctor who voluntarily suspended his licence.
- 37 Doctors whose commencement date at the Trust was so close to their appraisal date it was inappropriate for them to have an appraisal.
- 54 Doctors whose had an agreed exception to their appraisal for several reasons (e.g., retirement of their appraiser, change of appraiser due to appraiser illness, cancellation of a planned appraisal due to industrial action. This group also included doctors who had an agreed extension because of the Trusts lack of appraisers)

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: To continually review internal processes to ensure that GMC submissions are not missed.

Comments: There were two missed GMC submissions in the year 2023/24. These prompted an internal review of the processes within the Medical Directorate and a change in the way GMC submissions are made. These processes are still being embedded.

Action for next year: We plan to continually review processes to ensure that GMC submissions are not missed.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Not applicable.

Comments: Following discussion at the Medical Appraisal and Revalidation Decision Making Group, recommendations are submitted through the GMC portal during or immediately after the meeting, and confirmations of the recommendations are sent to the doctor by email.

If the decision has been one of deferral, there doctor will have been contacted by the Revalidation team prior to the submission date to see if, with support, a recommendation to revalidate can be made. If this has not been possible, the doctor will have been aware that their revalidation submission will be deferred, and the reason why. They are then supported to enable them to provide the evidence required prior to their new submission date.

A recommendation of non-engagement will only be made after strenuous and prolonged efforts have been made to support the doctor to meet the requirements for a recommendation to revalidate have been made.

Action for next year: Not applicable.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Not applicable.

Comments: The Trust has an appropriate system for clinical governance including review processes, executive oversight for complaints, incident management and infection control. Aspects of these arrangements are subject to internal audit at agreed intervals.

The Trust maintains certain corporate data which is issued to doctors prior to their annual appraisals. This data includes:

- Complaints and compliments.
- Incidents, including but not limited to Serious Incidents and high-risk incidents, and including incidents that the doctors reported even if they were not themselves responsible.
- Information on legal claims.

The Trust has a Quality Improvement Lead in post, and 2 Associate Medical Directors for Clinical Effectiveness who share a post. Doctors and teams are supported to undertake quality improvement projects and share the learning from these projects.

Action for next year: Not applicable.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Not applicable.

Comments: Conduct and / or performance issues related to doctors can be raised via several routes, including the clinical management structures and / or internal or national audits. All such issues are investigated, formally if appropriate, via the relevant policies, including 'Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff'. The details of any formal discussions with Executive Medical Director (previously) or Acting Medical Director (currently) are confirmed in writing, and the doctor is required to reflect on it during the next appraisal. The Trust has reviewed the last 5 years of formal conduct and capability concerns and presented this data to the Workforce Assurance committee.

Action for next year: Not applicable

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Not applicable.

Comments: The Trust is currently updating its local policy for 'Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff to incorporate the Just Culture Guidance, which is being used, but is currently a separate document.

The Acting Medical Director and the Responsible Officer have regular meetings with the Trusts GMC Employer Liaison advisor and discuss any concerns that may have arisen regarding a doctor's conduct, performance, or health. In addition, the Trust may initially discuss this with the Practitioner Performance Advice Service at NHS Resolution.

The Acting Medical Director and the Responsible Officer work together to ensure that both have full oversight of governance issues that relate to the medical staff.

Action for next year: The Trust will agree and implement the updated policy for 'Conduct, Performance and Ill-Health Procedures for Medical and Dental staff'.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Not applicable.

Comments: The Trust Board receive monthly reports if there are any doctors who are subject to an investigation using the Trust's Conduct, Performance & Ill-Health Procedures for Medical & Dental Staff. The Trust uses the Just Culture Guide when considering disciplinary cases. Active cases are reviewed monthly with the HR teams and an extract report is compiled each month. This information includes a breakdown by protected characteristics.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

The Trust have a Medical Appraisal and Revalidation Decision Making Group to make decisions around revalidation recommendations.

Action for next year: Not applicable.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: Not applicable.

Comments: The Trust uses the MPIT form where appropriate.

Action for next year: Not applicable.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Not applicable

Comments: The Trust has a Fair Treatment Panel that reviews processes conducted under HR policies; this includes any action under the Trust's Conduct, Performance & Ill-Health Procedures for Medical & Dental Staff. The Trust uses the Just Culture Guide when considering disciplinary cases.

The Trust have a Medical Appraisal and Revalidation Decision Making Group to make decisions around revalidation recommendations.

Action for next year: Not applicable.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Not applicable.

Comments: Pre-employment checks for doctors on permanent or fixed term contracts are performed by the Recruitment Team and Occupational Health. These include:

- Verification of identity
- Health clearance checks
- Criminal records checks and the signing of a Criminal Convictions Declaration form
- Verification of right to work in the UK, where this is necessary
- Verification of license to practice and other relevant qualifications
- Filing of references and CVs

Honorary contracts are issued by the recruitment team with sign off via the Medical Directors office. Where a doctor applies for an honorary contract with Whittington Health, but also holds a substantive role at another organisation, verification of employment checks from their substantive employer is sought from the other NHS employing body.

Doctors who are working on a short-term or locum basis are preferentially employed via our Bank Partners who also perform the checks outlined above, before agreeing to employ the doctor.

The Trust has committed to employ minimal numbers of doctors who are from external agencies, and none who are working for an agency which is 'off framework' and does not complete the required checks.

Action for next year: Not applicable

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of actions since last Board report

- There has been substantial change within the Revalidation Team. Dr Clare Dollery, the previous Executive Medical Director became Acting Deputy CEO in addition to her role as Executive Medical Director in December 2024 and then took up the role of Acting CEO on the 1st of April 2024. Dr Sola Makinde became the Responsible Officer (RO) on the 1st of May 2024. Dr Charlotte Hopkins joined the Trust in the role of Acting Medical Director in June 2024. Dr Hopkins has undertaken RO training in their previous Trust, has worked as a deputy RO, and has extensive experience in all aspects of the Maintaining High Professional Standards policy (the policy which governs the conduct and behaviour of medical staff).

- The Trust has appointed a new Business manager to the Medical Director, who took up her post on the 13th of June 2024. The business manager is an integral part of the revalidation team.
- The Trust has updated and implemented the Revalidation and Appraisal Policy.
- The Trust has embedded the new appraisal and revalidation software – this has involved some support and education of both appraisees and appraisers, in common with the adoption of other new pieces of software, and the cleansing of data within the software to ensure that the records were an accurate representation of a doctors' appraisal history.
- The Trust has continued to run appraiser Network meetings, but they have had poor attendance, despite changing (as requested by appraisers) to a face-to-face format.

Actions still outstanding

- The number of appraisers who are attending the network meetings is small (single figures). Therefore, the results of the peer review have not been shared. There is a renewed focus on improving the engagement of our appraisers, and a new date has been set for the next meeting
  .
- The number of doctors who have missed an appraisal, although decreasing, remains higher than we would like. This is monitored monthly by the Revalidation Group and actions agreed.
-

Current Issues

The Trust does not have sufficient appraisers to appraise its connected doctors in a timely way

- As doctors have retired or reduced their workload, the appraisal portion of their workload has often not been replaced. This has been coupled with an increase in the number of doctors who require an appraisal, due to service reviews and expansions, and the increase in the number of locally employed doctors. In addition, there has been continued medical workforce industrial action, the medical workforce shortages have continued, and there has been the need to address the elective surgical backlog. This has resulted in the need for doctors to work additional shifts, and to 'act down' by completing the work that trainees would usually perform. Consequently, the workforce is tired and demoralised. This has had several effects; it has had a marked impact on our ability to recruit

appraisers in a sustainable way, we have had to ask the appraisers that we do have to complete more appraisals, and it has also impacted on the number of doctors who have completed their own appraisal within a 12-month time frame. This is a key objective for the Trust for 24-25.

New Actions:

- The Trust will make a concerted effort to recruit new appraisers by firstly approaching appropriate doctors, and then by ensuring that, if appropriate, the doctors request to be an appraiser is approved by their clinical line managers. Previously the Clinical Directors have not had oversight of the number of appraisers that are required (in each of their ICSUs). The Clinical Directors have now been given targets for the number of appraisers required for each area and this will be monitored at their performance review.
- The Trust will re-invigorate the appraisers' network, by identifying times and formats for Network meetings which will have greater attendance.
- The Trust will introduce active scrutiny of the small number of doctors who are employed via an agency by reviewing their number and the duration of their employment monthly.
- The Trust recognises that doctors who are new to the appraisal process may have difficulty understanding its requirements and plans to introduce targeted support for this group.
- The appraisal software is being updated to reflect the new domains within Good Medical Practice A further external review should be carried out once the updated software has been embedded

Overall conclusion:

The Trust is compliant with the appraisal guidance for 2023/24, but recognises the acute need to recruit additional appraisers, and is taking steps to address this.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: _ Whittington Health NHS Trust _ _ _ _ _ _ _ _ _ _ _

Name: _ Dr Clare Dollery _ _ Signed:

Role: Acting CEO

Date: 5/9/24

NHS England
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Meeting title	**Trust Board – public meeting**	**Date: 27 September 2024**
Report title	**Workforce Assurance Committee Chair's report**	**Agenda item: 11**
Committee Chair	Rob Vincent, Non-Executive Director	
Executive lead	Liz O'Hara, Chief People Officer	
Report authors	Marcia Marrast-Lewis, Assistant Trust Secretary, and Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary, Liz O'Hara and Rob Vincent	
Executive summary	Trust Board members are presented with the Workforce Assurance Committee Chair's report for the meeting held on 22 July 2024 **Areas of assurance:** • Chief People Officer verbal report • Board Assurance Framework – People entries • Risk Register • Quarter 1 corporate workforce information report • Quarter 1 People Pulse report • Religion and belief guide • Pay gap report (gender, race and disability) • Staff Story: Staff development through apprenticeship The Committee agreed to bring the following areas to the attention of the Board: • The two risk register entries in relation to the Barnet 0-19 service and staffing in the children's safeguarding team • The good work to develop a Religion and belief guide to help increase awareness of cultural competency for our diverse patient communities • The outcomes from the annual pay gap reporting for disability, race and sex • The outcomes from the Q1 People Pulse report	
Purpose	Noting	
Recommendation(s)	Board members are invited to note the Committee Chair's report, particularly areas of significant assurance.	
BAF	People 1 and 2 entries	
Appendices	1. Annual pay gap report 2. Religion and belief guide 3. Q1 Pulse report	

Committee Chair's assurance report

Committee name	Workforce Assurance Committee
Date of meeting	22 July 2024
Summary of assurance:	

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

Chief People Officer's report

- The Committee received a verbal report from the Chief People Officer in which she highlighted key events and developments since the last meeting: A new government was elected at the beginning of July and was expected to implement changes that would have a direct impact on the workforce and the rights of employees. The changes which would impact on Trust policies and procedures, included:
  - The right for employees to bring unfair dismissal claims from day one of their employment; currently, employees need two years' service to claim unfair dismissal.
  - Other day one rights to be considered related to parental leave, flexible working and statutory sick pay.
- A review of the NHS long-term workforce plan.
- There was a significant focus in North Central London and in Whittington Health on finances and this would encompass a review of off-framework agencies and non-clinical agency staffing expenditure.
- There continued to be a focus on recruitment to substantive vacancies, especially in hard to recruit areas.
- A decision was awaited on the recommendation from the Pay Review Body for a pay award which was above the level budgeted for in 2024/25

The Committee welcomed and noted the verbal update and agreed that reports on apprenticeships, the NHS long-term workforce plan and employee rights would be discussed at future meetings.

Quarter 2 Board Assurance Framework (BAF)

The Committee received the report which considered the risks to the delivery of the Trust's People strategic objectives. The Committee was informed that the Trust's external auditors, KPMG LLP, had highlighted that most BAF entries were far from their respective target scores as outlined in the risk appetite statement.

Committee members discussed the scores for the two People entries and agreed that they were treated as live issues which were considered carefully at each meeting, and that the risks were appropriately scored. The Committee acknowledged the challenge in meeting target scores as set out in the risk appetite statement and agreed that the test to apply at each meeting was whether the Committee paid sufficient attention to the details of the areas highlighted in the BAF entries. It was agreed that as recruitment, staff health and wellbeing, inclusion and organisational development featured as standing items at each meeting, there was good evidence to demonstrate that the

Committee routinely reviewed the key issues The Committee Chair also outlined that when staff retention and wellbeing were next considered, the Committee would review the BAF risks scores.

The Committee approved the quarter two 2024/25 BAF entries for the risks to the delivery of People strategic objectives and agreed the scores for both entries.

Risk register

The Committee considered a report on the key changes to the risk register. Committee members noted that there were:

- 37 risks scored at 15 or above on the risk register.
- There were four new risks, two of which were solely workforce issues:
  - Risk no. 1549 – staffing and workload of children's safeguarding team
  - Risk no. 1537 – Barnet Healthy Child program long waits for mandated contacts and contacts for children moving into the Borough.
- There were three closed risks two of which were workforce risks:
  - Risk no. 165 -Simmons House environment and estate
  - Risk no. 1523 – Delivery of Barnet 0-19 health visiting and school nursing service. This risk had been spread across all the risks related to the service.

The Committee was informed that staffing vacancies in the Children's safeguarding team meant that it was challenging to meet all statutory obligations. Committee members were informed that the risks came with the service when it was taken over by the Trust in April 2024. Work was ongoing to understand which mitigations would have the greatest impact, but in the meantime, there was a heavy reliance on bank and agency staff to fill staffing gaps across the service.

The Committee agreed that the Barnet 0-19 Service risk and the Children's safeguarding team risk would be reported to the Board and would be included on the Committee's forward plan to review the trajectory for the total risk scores for both entries, as part of deep dives in Q2 and Q3.

The Committee noted the Risk Register report.

Quarter one, Workforce Information report

The Committee was informed that:

- The vacancy rated decreased from 9.1% to 8.3% in March 2024
- Mandatory training compliance was 87%
- Appraisal compliance was 77% against a target of 85%
- Expenditure on temporary bank and agency staffing had decreased by £1.4m between Q4 and Q1.
- Time to hire had dropped below 62 days for each month in Q1.
  The number of employee relations cases had increased by 24

The Committee discussed the 77% appraisal rate compliance in Q1 against a target of 80%. The Committee was informed that a recruitment exercise had begun to secure an organisational development facilitator who would deliver

training on appraisals as well as bespoke training for specific departments. In addition, the Committee fed back that it would be helpful to see rostering information as part of reviews of bank and agency staffing brought in to cover shifts at future meetings.

The Committee noted the Q1 Workforce information report.

Q1 People Pulse report
The Committee reviewed the outcome of the national quarterly Pulse survey held in April 2024, for which there were 324 (less than 10%) responses received from staff working within the Trust (substantive and temporary). The Committee learned that the engagement score was 6.61 out of ten, above the national average of 6.36. Advocacy had increased and the mood in the organisation remained unchanged. Feedback to the organisation was around staffing and resources.

Committee members discussed the themes emerging from the findings which included: communication, team working, the environment/facilities and workloads. Despite the low response rate, it was observed that only 51.7% of respondents said they looked forward to going to work. The Committee was informed that drinking water was an issue in some areas of the Trust.

The Committee agreed that the outcome from the next quarterly Pulse survey in January 2025 would be reviewed alongside the priority action areas identified from the two year action plan put in place following the 2023 NHS staff survey. The Committee also agreed that a deep dive into working conditions would be included in its forward plan.

The Committee noted the Q1 People Pulse report

Religion & Belief Guide
Committee members welcomed the draft Religion and Belief Guide which was designed to promote cultural competency across the organisation, raise awareness of the diverse patient communities served, particularly in relation to their preferences for end-of-life care, diet and dress. The Committee was informed that the guide would be made available on the Trust intranet to facilitate easy access for staff. The Committee agreed that the document would provide helpful guidance for staff and noted that it would remain a live document, which would be updated through further engagement with staff and staff networks, especially for entries covering countries from eastern and southern Europe, south-east Asia and south America, and by cross-referencing with data held by local authorities in Islington and Haringey. The Committee asked that the Religion and Belief Guide was included as an agenda item for the Quality Assurance Committee meeting in September 2024.

The Committee noted the Religion and Belief Guide.

Pay Gap Report

The Committee considered the report which highlighted the annual outcomes for gender, race and disability pay gaps and noted the following outcomes:

- There had been a slightly increase in the median average gender pay gap in favour of male staff by 2%
- Following the decision to equally distribute clinical excellence awards to eligible staff, there was an improvement in the median average bonus pay gap from 35.7% in favour of men to 0%.
- There had been a 1.5% increase in the female staff represented in clinical excellence awards.
- There was an improvement in the median average ethnicity pay gap which decreased for most minority groups, except for the 'Other category'. The disparity in median average pay between white and black staff decreased to 27.6%.
- For the first time, the Trust had reported on the disability pay gap. The data showed that there was a median average pay gap of 8.1% in favour of staff without a disability or long term health condition. The Committee was informed that the low declaration rate for disability at the Trust did compromise the quality and analysis of the data.

The Committee welcomed the benchmarking data provided within the report against other North Central London providers and supported the actions highlighted to help achieve further improvements in pay gaps. In addition, the Committee agreed the focused work to tale place to help increase the level of ethnicity and disability declarations from staff. The Committee noted that the Trust was 'ahead of the game' in reporting on the disability pay gap, which was a requirement from 2025 from NHS England's six high impact actions for inclusion.

The Committee noted the annual pay gap report and agreed the actions outlined.

Staff Story: staff development through apprenticeship

The Committee heard from a staff nurse who joined the meeting to talk about her nursing journey from 1999 to 2024. Committee members were informed that:

- The staff nurse began her career as a care assistant in a nursing home which was fulfilling and rewarding. The role prompted a return to education where she began an access into nursing course in 2000.
- In 2004, she started work at Whittington Health as an Health Care Assistant (HCA) bank staff member where she gained experience on a wide variety of wards and felt a deep sense of satisfaction, knowing that she had contributed to the welfare of patients during their hospitalisation.
- Her ambition to become a nurse grew after she received several excellence awards in recognition for her hard work and dedication to patients and colleagues. At that time, the Trust offered a range of study options that were available to all employees, and after some consideration it was felt that an apprenticeship pathway was the best option. In addition, she felt that working as an HCA and a nursing

	associate, gave her the confidence and drive to commit to a degree in nursing. • The staff nurse felt that the traits needed to become a good nurse included ambition, perseverance and resilience and as a healthcare professional she strived to become the best nurse that she could be. To that end, she had achieved her goal of passing a degree in nursing. • She was grateful to have been offered the opportunity to undertake an apprenticeship sponsored by the Trust. She stated that apprenticeships offered anyone the opportunity to develop new skills and knowledge, in a work placed environment. • She now planned to excel in her chosen field of expertise. In April 2024,she was invited to join an event to celebrate her apprenticeship achievements and receive an award of recognition. She felt extremely honoured and humbled to receive the award which has boosted her confidence as a registered nurse. She advised that anyone that has considered an apprenticeship course should take the opportunity, she felt that if she could do it anyone could. Committee members acknowledged that the staff nurse was well known for the exceptional care given to all patients on Thorogood ward. They stated that she was a phenomenal nurse with a great dedication to her role and patients. Committee members also queried how the Trust benchmarked against other Trusts that offered apprenticeships and agreed that this would be explored in more detail at a future meeting. **The Committee thanked the staff nurse for her inspirational story.**
2.	**Present:** Rob Vincent, Non-Executive Director (Committee Chair) Clarissa Murdoch, Deputy Medical Director Liz O'Hara, Chief People Officer Chinyama Okunuga, Chief Operating Officer Glenys Thornton, Non-Executive Director **In attendance:** Simon Anjoyeb, Inclusion lead (items 9 and 10) Deborah Choudhury, Executive Assistant to the Chief People Officer Deborah Clatworthy, Deputy Chief Nurse Eliana Chrysostomou, Acting Assistant Director of Learning and Organisational Development Tina Jegede, Joint Director of Inclusion and Lead Nurse, Islington Care Homes Marcia Marrast-Lewis, Assistant Trust Secretary Charlotte Pawsey, Deputy Director of Workforce Nelida Pedro-Moati, Staff Nurse Swarnjit Singh, Joint Director of Inclusion & Trust Company Secretary Eva Tinka, Head of Staff Wellbeing and Staff Engagement Terry Whittle, Chief Finance Officer & Deputy Chief Executive

	Apologies: Junaid Bajwa, Non-Executive Director Clare Dollery, Acting Chief Executive Charlotte Hopkins, Deputy Medical Director Astrid von Volckamer, Head of Talent Development Sarah Wilding, Chief Nurse and Director of Allied Health Professionals

Meeting title	**Workforce Assurance Committee**	**Dates: 22 July 2024**
Report title	**Annual Pay Gap reporting – gender, race, disability**	**Agenda item: 10**
Executive lead	Liz O'Hara, Chief People Officer	
Report authors	Amelia Barajas-Villaluenga, Head of Workforce Systems & Analytics, Simon Anjoyeb, Equality Lead, Tina Jegede and Swarnjit Singh, Joint Directors of Inclusion.	
Executive summary	Committee members are presented with the outcome of the annual snapshot reporting of the gender, race and disability pay gaps. While gender pay gap reporting has been in place for some time for public sector organisations, NHS England included reporting on race and disability pay gaps as part of its guidance on the six high impact actions needed to advance equality and inclusion (see appendix 4). **Headlines:** ***Gender Pay Gap:*** • Ordinary Pay (Decline): The median average gender pay gap increased from 1.7% (2022) to 3.7% (2023) in favour of male staff. • Bonus Pay (Improvement): The median average bonus pay gap decreased from 35.7% (2022, in favour of men) to 0% (2023, equity of pay). • Representation in Bonus Pay (Improvement): There has been a 1.5% increase in female staff represented in Clinical Excellence Awards. ***Ethnicity Pay Gap:*** • Ordinary Pay (Broad Improvement): the median average pay gap decreased for most minority groups, except for staff from 'other' ethnic origins which slightly increased. • Bonus Pay (Improvement): The median average bonus payment for most groups is 0% (meaning equity with white staff), except Black staff which further increased from -38.8% (2022) to -176.5% (2023, in favour of Black staff). • Representation in Bonus Pay (Improvement): All groups representation increased from 2022, but Black staff remain underrepresented in Clinical Excellence Awards.	

	Disability Pay Gap: • This is the first year this standard has been reported, as such there is no comparative data. • The median average pay gap is 8.1% in favour staff without disabilities or long-term health conditions. • The median bonus pay gap is 0.0%, there is no difference in bonus pay between staff with/without disabilities and long-term health conditions. • Disabled staff are underrepresented in Clinical Excellence Awards. There are a range of recommended actions that will help to improve findings in all the gender, ethnicity, and disability pay gaps, a summary include: • Undertaking a further deep dive into pay gaps by ICSUs and staff groups. • Targeting existing and new learning and career development opportunities to underrepresented groups. • Creating 'shadow board' opportunities to increase exposure to the Board. • Promoting existing coaching and mentoring schemes to underrepresented groups. • Review the policy in line with national flexible working policy to promote and increase fairness around flexible working, parental leave and menopause support • Implement the Mend the Gap recommendations and seek opportunities for the Trust to support staff with Clinical Excellence Awards applications.
Purpose	Approval
Recommendation(s)	Workforce Assurance Committee members asked to: i. note the results for annual pay gap reporting in relation to gender, race and disability; ii. support and approve the actions highlighted to improve the pay gap outcomes; and iii. approve publication of these outcomes on our intranet.
BAF	People1 and People 2
Appendices	1. Gender pay gap report 2. Race pay gap report 3. Disability pay gap report 4. NHS England » NHS equality, diversity, and inclusion improvement plan

Annual Pay Gap Reporting – gender, race, disability

1.0 Introduction

Pay gap reporting provides an overview of equity in pay within a workforce by providing a comparative of average pay for different groups. Pay gap reporting is different from 'equal pay' which looks at the pay rates of different groups for doing work of equal value, pay gap reporting requires a broad comparison of majority and minority groups average pay across the whole workforce.

Pay gap reporting, adds a further vital dimension in understanding equity within the Trust's workforce, and complements other forms of equality reporting (NHS Race and Disability Equality Standards); helping the Trust to demonstrate compliance with the Public Sector Equality Duty contained within the Equality Act 2010.

This report provides an overview of:

- Gender Pay Gap Reporting
- Ethnicity Pay Gap Reporting
- Disability Pay Gap Reporting

Gender pay gap reporting has been a statutory requirement for public, private and voluntary sector organisations, with 250 or more employees since 2017, data within this report considers the workforce as it was on 31 March 2023.

Pay gap reporting for other protected characteristics is a voluntary measure an encouraged by the UK Government and CIPD; however, race and disability pay gap reporting is a requirement under the NHS Equality, Diversity and Inclusion Improvement Plan's High Impact Actions. As this is a new and voluntary measure, there is no centralised national data that provides a reliable and contemporary point of comparison, however, it does provide insight into the experiences of pay within the Trust from minority and majority groups. This report considers the workforce as it was on 31 March 2023.

1.2 Implications of Pay Gap Reporting for the Trust

The findings from pay gap report impacts the work of several Trust services charged with delivering/supporting fair and equitable outcome for staff. For example:

- HR – in workforce planning, strategic implementation of workforce recruitment and retention plans and implementation of systems that can monitor flexible working arrangements.
- Learning & Organisational Development – in promoting, developing or commissioning of existing and new programmes and opportunities to increase the skills base/career development of the Trust's staff
- Recruitment – in the implementation and monitoring of fair recruitment and selection processes, and continued delivery of the Diverse and Inclusive Panel Programme
- Inclusion – in the delivery of programmes/initiatives that support a more inclusive workforce delivered through the Inclusion Strategy.
- Leads for ICSUs/staff groups e.g. nursing, Allied Health Professionals, clinical and medical staff– to consider how to further promote existing opportunities to further advancement of staff and develop their own opportunities.

1.3 Metrics used within Pay Gap Reporting

The minimum dataset to conduct pay gap reporting, includes:

- Breaking the overall pay structures into equal quartiles and measuring the representation of different groups (e.g. male/female, non-disabled/disabled, etc.)
- Mean average hourly pay for different groups
- Median average hourly pay for different groups
- Percentage of different groups receiving a bonus payment
- Mean bonus payments for different groups
- Median bonus payments for different groups

The breakdown of the workforce into four broadly equal quarters helps organisation see how groups are represented at differing levels of seniority. The four quarters should contain broadly equal numbers of staff and relate to hourly pay. The quartiles are named: lower quartile, lower-middle quartile, upper-middle quartile and upper quartile.

The mean average shows the average hourly pay which considers all employees in an organisation or specified group. This type of average is useful as it places the same value on every number they use, giving a good overall indication of the ethnicity pay gap. But very high or very low hourly pay/bonuses can distort the overall average.

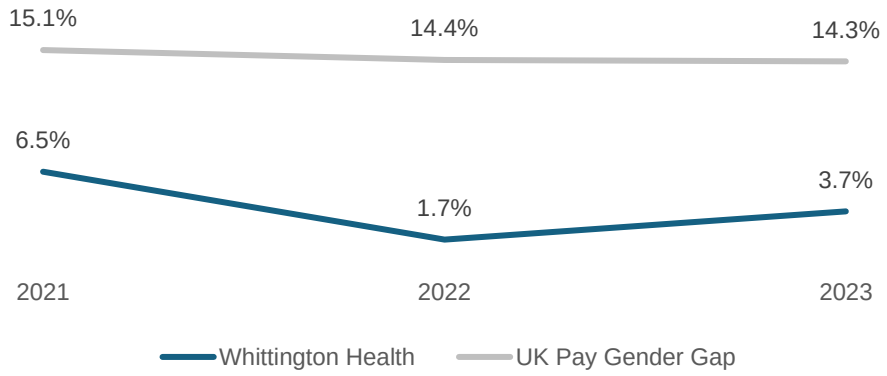
The median average (is the middle figure of a group), typically indicating what the ‘typical’ situation is; they are not distorted by very high or low hourly pay/bonuses. As such, is typically the headline data when discussing pay gaps between different groups.

Bonus payments - at Whittington Health, the only bonuses that are paid are Clinical Excellence Awards (CEAs) to consultants. The guidance from NHS Employers and the ESR (Electronic Staff Records) Central Team is that CEAs meet the definition of a “bonus payment” in accordance with the Advice and Conciliation Service (ACAS) guidance relating to the scheme. Local awards are determined and funded locally. National awards are determined nationally and funded by the Department of Health.

2.0 Analysis of pay gap outcomes

2.1.0 Gender pay gap

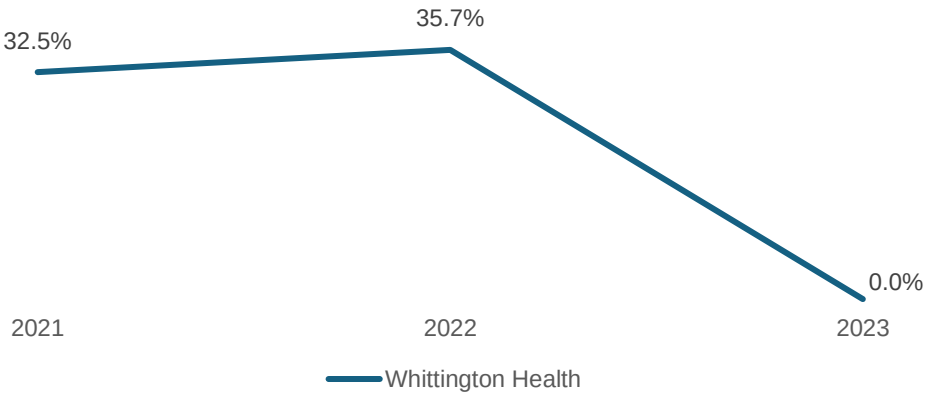
Chart 1: The Gender Pay Gap of ordinary pay (median average) since 2021



A positive pay gap is in favour of men, a negative pay gap is in favour of women.

Chart 1 shows that the Trust's gender pay gap data is much lower than the pay gap for the UK. The UK's pay gap is on a downward trend though incremental in nature. However, the Trust's median pay gap saw a sharp decrease from 6.5% (2021) to 1.7% in 2022 but rose by 2% in 2023 to 3.7%.

Chart 2: Whittington Health Bonus Pay Gap (Median Average)



A positive bonus pay gap is in favour of men, a negative pay gap is in favour of women.

Bonus pay gap data is not as available for the UK, as such has been excluded from this chart.

Chart 2 shows the median bonus pay gap for female staff was circa 33% in 2021 and 2022 in favour of male staff, however, in 2023 it fell dramatically to 0.0%, highlighting that there is no difference between male and female staff.

Chart 3: Percentage of Male and Female Whittington Health Staff Receiving Bonuses

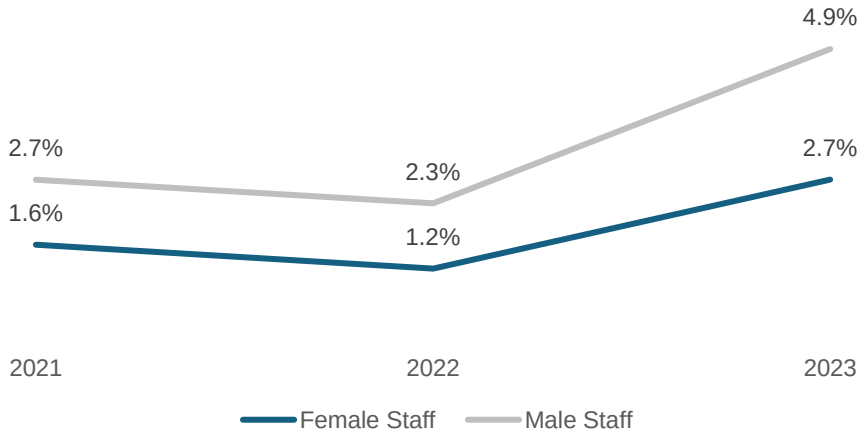


Chart 3 shows that proportionally more male staff receive bonus payments compared to female staff. However, both groups experienced a slight decrease from 2021 to 2022, and an increase in 2023. The difference in female and male staff remained at 1.1% in 2021 and 2022 and doubled in 2023 to 2.2%.

Table 1: Comparison of Trust outcomes to local NCL Trust.

	Ordinary Pay Gap % (Mean Average)	**Ordinary Pay Gap % (Median Average)**	% Women Received Bonus	% Men Received Bonus	Bonus Pay Gap % (Mean Average)	Bonus Pay Gap % (Median Average)
Whittington Health NHS Trust	**6.3**	**3.7**	**2.7**	**4.9**	**-22.2**	**0.0**
Central London Community Healthcare NHS Trust	**5.0**	**0.0**	**4.3**	**2.0**	**-121.0**	**0.0**
University College Hospital NHS Trust	**13.2**	**7.9**	**1.2**	**4.6**	**26.2**	**31.2**
Royal Free London NHS Foundation	**14.2**	**12.1**	**33.8**	**66.2**	**32.1**	**52.0**
North Middlesex University Hospital NHS Trust	**22.7**	**17.2**	**2.3**	**8.9**	**21.7**	**0.0**

Data from Gender Pay Gap Reporting Service (2023/24 data)

Table 1 shows a comparison of factors relating to ordinary pay and bonus payments, comparing to local Trusts within the North Central London health economy. The data has been sorted in order of ordinary pay % (median average). Items in red box indicate worse performance than Whittington Health and green is better performance.

Overall, it shows that Whittington Health is performing well compared to organisations in the local health economy.

2.1.1 Improving staff gender pay experiences

Improving the pay gap:

- Undertake further analysis on an ICSU and staff groups basis to identify specific barriers affecting women being represented in senior roles, appropriate actions to be developed by ICSUs and leads for professions.
- Seek targeted career development opportunities and programmes both corporately (e.g. apprenticeships) and via ICSUs to encourage career development of career development into senior management roles.
- Promote existing mentoring and coaching opportunities for staff as part of 1:2:1s and appraisals.
- Continue with the programme of Diverse and Inclusive Panels
- Actively promote flexible working for roles where applicable and monitor applications for flexible working requests.
- Develop a menopause policy once the national policy is released and deliver associated supportive training
- Create a robust exit/stay interview process to understand if pay/progression are factors impacting staff retention.
- Sign up and promote the NHS sexual safety in healthcare organisational charter to commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this.
- Review the policy in line with national flexible working policy to promote and increase fairness around flexible working, parental leave and menopause support.
- Research and implement innovative flexible working practices that will support women in the workplace
- Creating ‘shadow board’ opportunities to increase exposure to the Board.

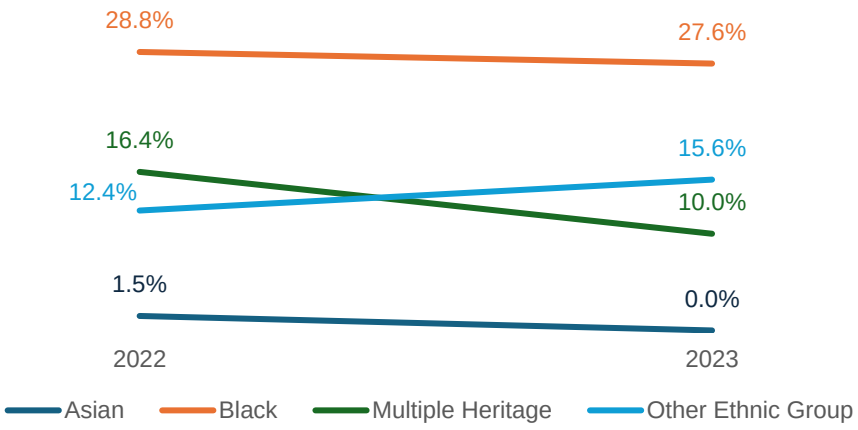
2.1.2 Improve the bonus pay gap:

- Continue to support women in medical roles to return to work following maternity and adoption leave – measure the impact of the policy for equity.
- Offer/monitor requests for shared parental leave.
- Promote the Clinical Excellence Award Scheme with female staff, providing coaching and advice for the process.
- Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce outlined in the NHS equality, diversity, and inclusion improvement plan (Jun 2023)

2.2.0 Race pay gap

Ethnicity pay gap is currently voluntary and no regular centralised reporting process exists, therefore, there is no national/regional comparative data to compare the Trust's outcomes.

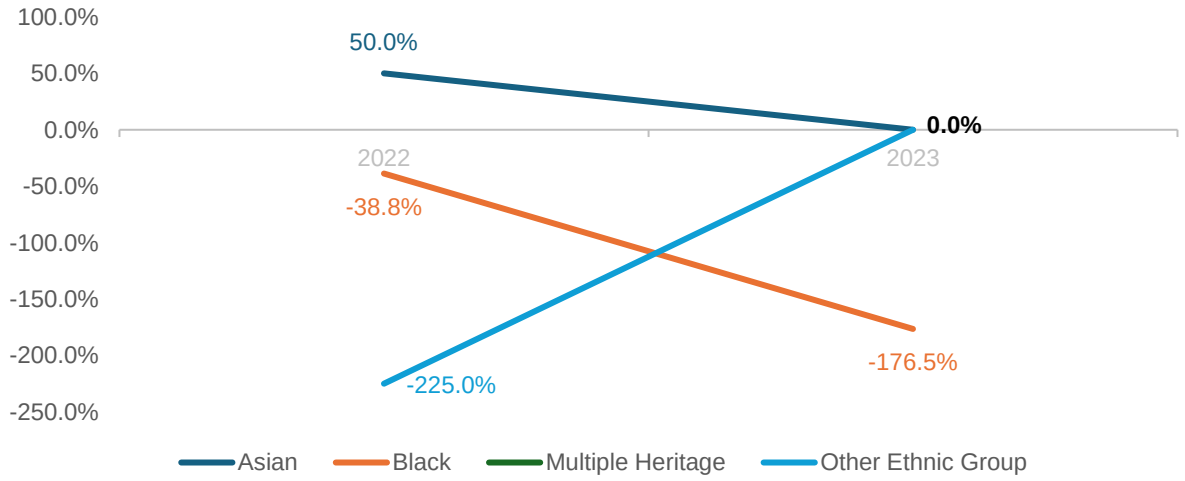
Chart 4: Disparity in Ordinary Pay (Median Average) BME Staff's Pay Experiences to White Staff's



A positive median pay gap is in favour of white staff, a negative is in favour of staff from minority groups; a 0.0% pay gap would mean that there is no difference between both groups.

Chart 4 highlights that most groups (Asian, multiple heritage and Black) have a closing in the gap for the two years the pay gap has been measured. However, for staff from an 'other' ethnic origin has increased from 2022 to 2023. Asian staff have the lowest disparity in pay compared to white staff, and Black staff have the greatest.

Chart 5: Disparity in Bonus Pay (Median Average) BME Staff's Pay Experiences to White Staff's

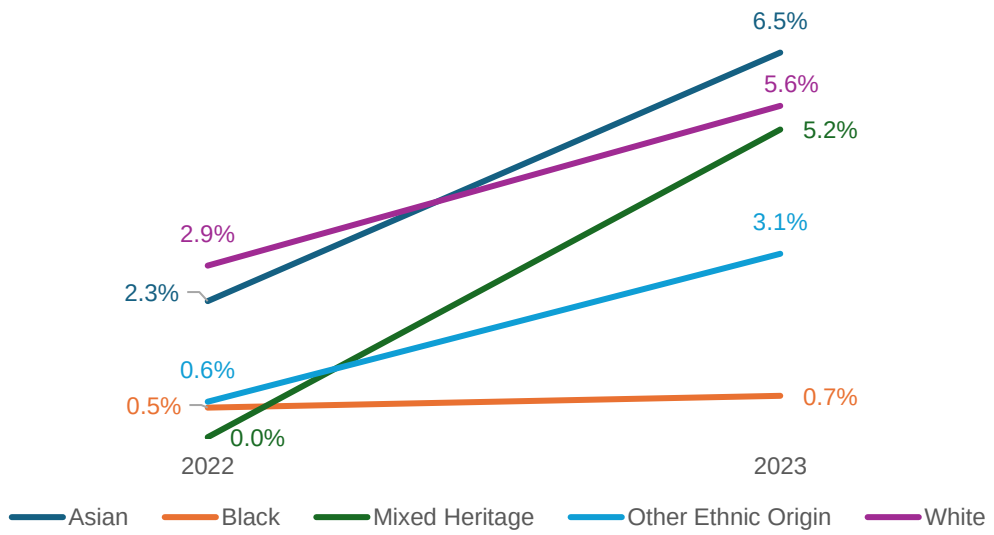


A positive median bonus pay gap is in favour of white staff, a negative is in favour of staff from minority groups; a 0.0% pay gap would mean that there is no difference between both groups.

In 2022, there was a 50% bonus pay gap for Asian and white staff (in favour of white staff), and large bonus pay gaps from staff that are Black or from 'other' ethnic groups (which were in favour of the BME ethnic groups).

In 2023, most groups had the same level of bonus pay to white staff, except for Black staff where this increased (further in favour of Black Staff).

Chart 6: Percentage of Ethnicity Groups Receiving a Bonus Payment as a Proportion of the Workforce



From 2022 to 2023, every ethnicity group has increased the proportion of staff receiving a bonus payment, however Black staff are still vastly unrepresented in the Clinical Excellence Awards but have the highest average bonus payments as a group.

2.2.1 Improving staff race pay experiences

Improving the pay gap:

- Continue to improve the quality and coverage of ethnicity declaration to actively reduce the number of staff where their ethnicity is not known, improve the data quality and coverage for future reporting.
- Undertake further analysis on an ICSU and staff group (profession) basis to identify specific barriers affecting BME staff being represented in senior roles, appropriate actions to be developed by ICSUs and leads for professions.
- Continue and promote the Band 2-7 development programme and the 'Working Uphill' Programme for Band 8A and above and encourage ICSUs to undertake positive action measures to improve opportunities to increase BME representation in senior roles.
- Promote existing mentoring and coaching opportunities for staff as part of 1:2:1s and appraisals.
- Continue with the programme of Diverse and Inclusive Panels
- Continue to promote learning and development opportunities to all staff including Core Managers: Inclusive Leadership in Health and Care offered by NHSE.
- Create a robust exit/stay interview process to understand if pay/progression are factors impacting staff retention.
- Creating opportunities for shadow boards to increase access to underrepresented groups who may lack board exposure leading to career stagnation.
- Embed fair and inclusive recruitment processes including the evaluation of the Trust diverse panel process.
- Review talent management strategies that target under-representation and lack of diversity

2.2.2 Improve the bonus pay gap:

- Promote the Clinical Excellence Award Scheme with BME staff, providing coaching and advice for the process.

2.3.0 Disability pay gap

As this is the first year of reporting on the disability pay gap there is no historical data to show trends.

2.3.1 Improving staff disability pay experiences

Improving the pay gap:

- Continue to improve quality/coverage of disability status staff data to improve accuracy/coverage of future reporting
- Undertake further analysis on an ICSU and staff group (profession) basis to identify specific barriers affecting disabled staff being represented in senior roles, appropriate actions to be developed by ICSUs and leads for professions.
- Seek targeted career development opportunities and programmes both corporately (e.g. apprenticeships) and via ICSUs to encourage career development into senior management roles.
- Promote mentoring and coaching opportunities for staff as part of 1:2:1s and appraisals.
- Embed fair and inclusive recruitment processes including the evaluation of the Trust diverse panel process.
- Actively promote flexible working for roles where applicable and monitor applications for flexible working requests.
- Continue to promote learning and development opportunities to all staff including Core Managers: Inclusive Leadership in Health and Care offered by NHSE to support manager understanding of disability and reasonable adjustment.
- Create a robust stay/exit interview process to understand if pay/progression are factors impacting staff retention.
- Research and implement new and innovative flexible working practices that will support disabled staff in the workplace
- Creating opportunities for ‘shadow board’ to increase access and exposure of disabled staff leading to board level career progression.

2.3.2 Improve the bonus pay gap:

- Promote the Clinical Excellence Award Scheme with disabled staff, providing coaching and advice for the process.

Appendix 1: Gender Pay Gap Reporting

Workforce Snapshot Date:	31 March 2023
Gender workforce breakdown as of 31 March 2023:	• 76.6% Female • 23.4% Male

Gender pay analysis for 2023 shows that at Whittington Health, women employed by our Trust earn an average of 3.7% less than men, per hour.

Hourly Pay:

Table 2: Mean and Median hourly rates of pay

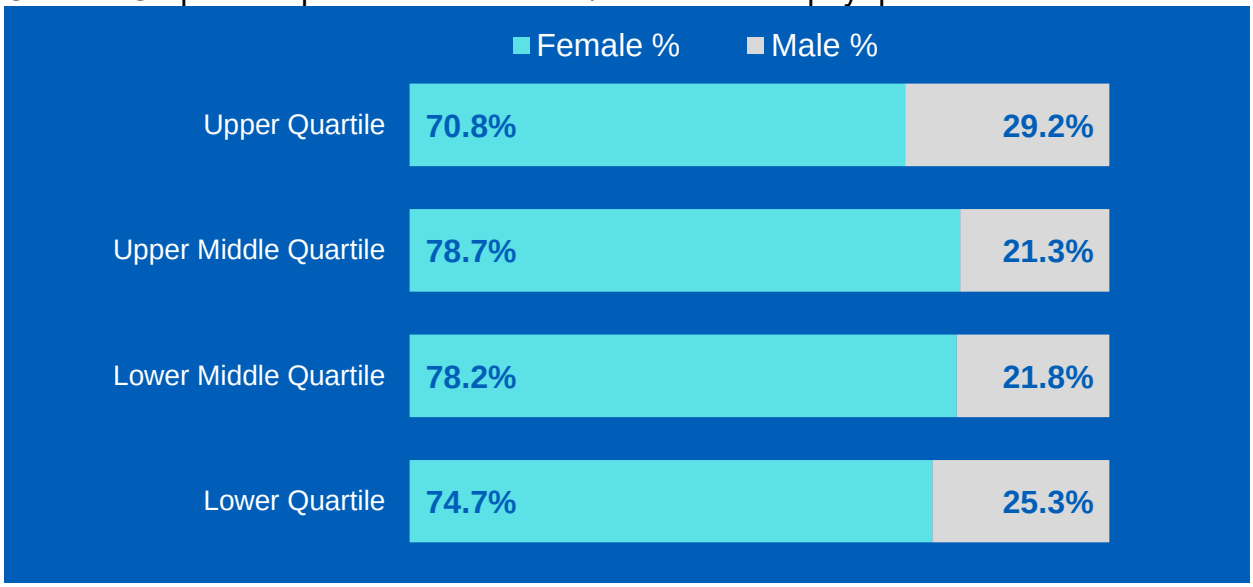
Gender	Hourly Pay (Mean Average)	Hourly Pay (Median Average)
Male	£24.67	£21.83
Female	£23.12	£21.03
Difference	£1.56	£0.80
Pay Gap %	6.3%	3.7%

A positive pay gap figure would suggest that the gap is in favour of male staff, a negative figure indicates it is in favour of female staff.

Table 2 shows that there is a pay gap of 3.7% (median average) in favour of male staff. This means women earn £0.96 for every £1.00 male staff earn. There is also a mean average pay gap of 6.3% in favour of male staff.

Representation in Pay Quarters:

Chart 7: Graphical representation of male/female staff in pay quartiles:



If there are equity within the quartiles the representation should correspond to the overall workforce representation at the time of the data snapshot (76.6% Female and 23.4% Male).

Chart 7 highlights that female staff are underrepresented in the upper (highest pay) and lower (lowest pay) quartiles, and overrepresented in the two middle quartiles. Male staff are overrepresented in the upper and lower quartiles and underrepresented in the two

middle quartiles. Within the upper quartile male staff are overrepresented by 5.8%, compared to the overall workforce representation.

Average Bonus Pay

Table 3: Mean and Median for Bonus Payments

Gender	Bonus Pay (Mean Average)	Bonus Pay (Median Average)
Male	£6,346.77	£3,416.69
Female	£7,756.04	£3,416.69
Difference	-£1,409.27	£0.00
Pay Gap %	-22.2%	0.0%

A positive pay gap figure would suggest that the gap is in favour of male staff, a negative figure indicates it is in favour of female staff.

Table 2 shows that there is a pay gap of 0.0% (median average); meaning there is no difference in bonus pay for male and female staff. There is also a mean average pay gap of -22.0% in favour of female staff.

Percentage of Staff Receiving a bonus

Table 3: Number of male and female staff receiving bonuses

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	100.00	3,674.00	2.7%
Male	56.00	1,136.00	4.9%

The comparison of male and female staff that have been paid a bonus compared to the overall workforce, suggests that women are underrepresented in the Clinical Excellence Awards programme, and as such are nearly half as likely than men to be paid a bonus.

Appendix 2: Ethnicity Pay Gap Reporting

Workforce Snapshot Date:	31 March 2023
Ethnicity workforce breakdown as of 31 March 2023:	• 13.7% Asian • 20.1% Black • 3.5% Multiple Heritage • 4.3% Other (ethnic origin) • 37.4% White • 21.1% Unknown ethnicity)

Hourly Pay:

Table 4: Mean and Median hourly rates of pay

Ethnicity	Mean Average	Mean Difference from White Staff	% Mean Difference from White Staff	Median Average	Median Difference from White Staff	% Median Difference from White Staff
Asian	£26.20	-£0.36	-1.4%	£24.53	£0.00	0.0%
Black	£20.12	£5.72	22.2%	£17.75	£6.78	27.6%
Multiple Heritage	£23.87	£1.97	7.6%	£22.07	£2.46	10.0%
Other	£23.14	£2.71	11.7%	£20.71	£3.82	15.6%
White	£25.84			£24.53		
Unknown	£21.07	£4.77	18.5%		£5.16	21.0%

Table 4 compares the average (mean/median) pay of BME (groups) to white staff. A positive pay gap figure would suggest that the gap is in favour of white staff, a negative figure indicates it is in favour of BME ethnic group.

Table 4 shows median (average) pay gaps:

- 0.0% for Asian staff – meaning Asian staff on average earn the same as white staff.
- 27.6% for Black staff – meaning on average for every £0.72 a Black member of staff earns, white staff earn £1.00.
- 10.0% for staff from multiple heritage, meaning for every £0.90 a member of staff from this group earns a white member of staff earns £1.00.
- 15.6% for staff from other ethnic groups, meaning for every £0.84 a member of staff from this ethnic minority earns a white member of staff will earn £1.00.

It also shows mean (average) pay gaps:

- -1.4% for Asian staff, in favour of Asian staff
- 22.2% for Black staff, in favour of white staff
- 7.6% for multiple heritage staff, in favour of white staff
- 11.7% for staff from other ethnic groups, in favour of white staff.

Representation in Pay Quarters:
Table 5: Representation of the ethnicities of staff in pay quartiles:

	ASIAN	BLACK	MULTIPLE HERITAGE	OTHER ETHNICITY	WHITE	UNKNOWN
LOWER QUARTILE	11.9%	27.7%	3.5%	3.9%	27.0%	26.0%
LOWER-MIDDLE QUARTILE	10.9%	24.8%	2.9%	4.9%	27.7%	28.8%
UPPER-MIDDLE QUARTILE	13.1%	16.7%	3.1%	4.3%	41.2%	21.6%
UPPER QUARTILE	18.3%	11.1%	4.1%	3.7%	49.9%	13.0%

If there is equity within the quartiles the representation should correspond to the overall workforce representation at the time of the data snapshot (13.7% Asian, 20.1% Black, 3.5% Multiple Heritage, 4.3% Other, 37.4% White and 21.1% Unknown);

Table 5 shows the representation of ethnicity in the quarters, where the representation is lower compared to the overall workforce representation will be in red text, broadly equal in orange text and a higher representation will be in green text.

- Asian staff are underrepresented in the lower/lower-middle quartiles, have a broadly equal representation in the upper-middle and a greater representation in the upper quartile.
- Black staff are overrepresented in the lower/lower-middle quartiles and underrepresented in upper-middle/upper quartiles.
- Staff from multiple heritage backgrounds are underrepresented in the lower-middle quartile, have a broadly equal representation in the lower/upper-middle quartiles and have a greater representation in the upper quartile.
- Staff from other ethnic groups are underrepresented in upper quartiles, have a broadly equal representation in the lower/upper-middle quartiles and a greater representation in the lower-middle quartile.
- White staff are underrepresented in lower/lower-middle quartiles and have a greater representation in upper-middle/upper quartiles.
- There remains a high level of non-declaration within the workforce particularly in the first three quartiles, this will impact the quality of this data.

Average Bonus Pay

Table 6: Mean and Median for Bonus Payments (see overleaf)

Ethnicity	Mean Bonus Pay	Mean Difference from White Staff	% Mean Difference from White Staff	Median Bonus Pay	Median Difference from White Staff	% Median Difference from White Staff
Asian	£5,497.28	**£2,472.00**	31.0%	£3,416.69	£0.00	0.0%
Black	£10,859.67	**-£2,890.40**	-36.3%	£9,448.67	-£6,031.98	-176.5%
Multiple Heritage	£6,055.69	**£1,913.59**	24.0%	£3,416.69	£0.00	0.0%
Other Ethnicity	£6,684.03	**£1,285.24**	16.1%	£3,416.69	£0.00	0.0%
White	£7,969.27			£3,416.69		
Unknown	£5,427.37	**£2,541.91**	31.9%	£3,416.69	£0.00	0.0%

Table 6 represents a comparison of bonus pay of staff from BME ethnic groups compared to white staff. A positive pay gap figure would suggest that the gap is in favour of white staff, a negative figure indicates it is in favour of staff from BME ethnic groups.

Table 6 shows that there is a pay gap of 0.0% (median average) for Asian, multiple heritage and other ethnicities; meaning there is no difference in bonus pay for staff from those groups and white staff. However, there is a -176.5% pay gap in favour of black staff.

When comparing the mean average in bonus pay there is a pay gap of:

- 31.0% for Asian staff (in favour of white staff)
- -36.3% for Black staff (in favour of Black staff)
- 24.0% for multiple heritage staff (in favour of white staff)
- 16.1% for other ethnicity staff (in favour of white staff).

Percentage of Staff Receiving a bonus

Table 7: Breakdown of staff receiving bonuses by ethnicity

Ethnicity	Employees Paid Bonus	Total Relevant Employees	%
Asian	**40**	**613**	**6.5%**
Black	**6**	**907**	**0.7%**
Multiple Heritage	**8**	**153**	**5.2%**
Other Ethnicity	**6**	**191**	**3.1%**
White	**93**	**1650**	**5.6%**
Unknown	**3**	**1011**	**0.3%**

The comparison shows that Black staff are underrepresented in Clinical Excellence Awards programme, whilst table 6 highlights they have the highest average bonus payment; there is a low number of staff within this process.

Appendix 3: Disability Pay Gap Reporting

Workforce Snapshot Date:	31 March 2023
Ethnicity workforce breakdown as of 31 March 2023:	• 3.0% Disabled • 47.6% Not Disabled • 49.5% Unknown

Hourly Pay:

Table 8: Mean and Median hourly rates of pay

Disability Status	Hourly Pay (Mean Average)	Hourly Pay (Median Average)
Disabled	£22.63	£21.83
Not Disabled	£24.83	£23.76
Difference	£2.20	£1.93
Pay Gap %	8.8%	8.1%

A positive pay gap figure would suggest that the gap is in favour of non-disabled staff, a negative figure indicates it is in favour of disabled staff.
Table 8 shows that there is a pay gap of 8.1% (median average) in favour of non-disabled staff. This means disabled staff earn £0.92 for every £1.00 non-disabled staff earn. There is also a mean average pay gap of 8.8% in favour of non-disabled staff.

Representation in Pay Quarters:

Table 9: representation of disabled and non-disabled staff in pay quartiles:

Quartile	Disabled %	Not Disabled %	Unknown %
Lower	2.4%	35.7%	61.9%
Lower-middle	2.5%	37.9%	59.6%
Upper-middle	2.8%	51.3%	45.9%
Upper	2.6%	52.3%	45.1%

If there are equity within the quartiles the representation should correspond to the overall workforce representation at the time of the data snapshot (3.0% Disabled, 47.6% Not Disabled and 49.5% Unknown).

Table 9 shows that disabled staff are underrepresented in most quartiles (lower, lower-middle and upper) and has a broadly equal representation in the upper-middle quartile. Non-disabled staff are underrepresented in the lower/lower-middle quartiles and have a greater representation in upper-middle/upper quartiles. However, there is a great number of staff who have not shared their disability status which is masking the true level of representation within the Trust's workforce.

Average Bonus Pay

Table 10: Mean and Median for Bonus Payments

Disability Status	Bonus Pay (Mean Average)	Bonus Pay (Median Average)
Disabled	£3,416.69	£3,416.69
Not Disabled	£6,147.66	£3,416.69
Difference	£2,730.97	£0.00
Pay Gap %	44.4%	0.0%

A positive pay gap figure would suggest that the gap is in favour of non-disabled staff, a negative figure indicates it is in favour of disabled staff.

Table 10 shows that there is a pay gap of 0.0% (median average); meaning there is no difference in bonus pay for disabled and non-disabled staff. There is also a mean average pay gap of -44.0% in favour of non-disabled staff. However, 66 (42%) staff that received bonus payment have not shared their disability status, impacting the overall reliability of this data.

Percentage of Staff Receiving a bonus

Table 11: Number of disabled and non-disabled staff receiving bonuses

Disability Status	Employees Paid Bonus	Total Relevant Employees	%
Disabled	2.00	118.00	1.7%
Not Disabled	88.00	2005.00	4.4%
Unknown	66.00	2402.00	2.7%

Table 11 highlights a large portion of staff have not shared their disability status, which will impact the quality and accuracy of this data; however, more work could be undertaken to encourage staff with disabilities to apply for Clinical Excellence Awards.

NHS
Whittington Health
NHS Trust

Our Staff at Whittington Health

We value our workforce that are from across the world and help us provide the best possible care for our patients. We are proud of, and respect, the rich diversity of our staff – below are some of the countries that our people can trace their heritage to:

Our staff have helped develop our vision for Inclusion, and together we are working to acheive it:

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

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

Whittington Health Draft Diversity Guide – Religion and culture

Introduction

Britain is a fast-changing and diverse mix of many different communities. We know from our history that Britain has always attracted new communities. Romans, Angles, Saxons and Vikings arrived in ancient times, followed by Irish, Huguenot, Jewish, Polish, Italian, Greek and Turkish Cypriots, Asian, African, Caribbean and, more recently, Eastern European people. Different people from around the world have brought their religions, cultures and energy, helping to create the wealthy and dynamic United Kingdom of today.

It is helpful for public and private organisations to know about the different cultures, customs and religions of their current and potential customers and employees. Whether you operate in the private, public or voluntary sector, this book provides key information for your business, helping you to deliver the best quality products and services to everyone. Similarly, understanding the cultures, customs and religions of employees from different ethnic groups helps everyone to eliminate unlawful discrimination from their workplace.

Differences in cultural, spiritual and religious beliefs are not the only factors affecting whether patients accept and follow healthcare recommendations. Other factors can also limit the success of healthcare provision, such as language barriers, insecure immigration status and housing, discrimination, lack of Trust between patients/service users and healthcare professionals and time and financial cost of attending appointments.

Cross-cultural dynamics can also affect how people communicate in healthcare settings. Working with well-trained intercultural mediators (for example, bilingual advocacy programmes) can support effective cross-cultural communication between healthcare professionals and patients. Intercultural mediators can also help to explore relevant religious beliefs and practices.

Diversity Guide – religion and culture

What does valuing diversity mean to us at Whittington Health NHS Trust? Everyone would agree that we should strive to treat every patient with respect, privacy and dignity, but what does this mean to different people?

Getting it right involves respecting different points of view and acting to meet individual needs.

Sometimes, it will be about asking the right question; after all, no two people are the same. Individuals will have their own sense of what's important in their life, and this perspective can differ significantly from that of their loved ones.

What the guide covers

This guide brings together information to help us to provide a sensitive, tailored personal service to patients, their families and visitors. It aims to raise awareness amongst front line and other staff and covers:

- Religion and belief – including alternative spiritualities and non-religious beliefs.
- Culture

No one person can be expected to know all there is to know about every faith or culture of the patients we serve and this guide does not seek to provide this. It is designed to help us all look more closely at the service we provide and to examine how our own knowledge and attitudes affect whether or not we meet someone's needs.

- The guide also signals how to make best use of our dedicated in-house teams such as language support, spiritual health care, voluntary services and bereavement staff.
- So take a step back and think about things from a different point of view. Use this guide to talk in your teams about how to do things better. And don't worry about what you don't know – the most important thing is to ask.

Religion and belief – introduction

Why is religion or belief important?

Religion or belief can play a large part in how a person lives their life, guiding choices, shaping attitudes and determining behaviours. It can also play a lesser role, depending on an individual's view of what it means to practise their religion.

Visiting hospitals, whether as a patient, family member or friend, can be a stressful, difficult experience for many people. At such times, religion and belief can be a cornerstone in people's lives, helping them to cope with what is happening to them and to maintain a sense of normality.

Recognising and understanding the many ways that people choose to express themselves through their religion or belief is an important step towards meeting their needs. If you are not religious, or you practise a different religion, it can be hard to appreciate the importance that certain decisions, rituals or practices may have to an individual.

It is important to remember that although formal religion may not play a part in someone's life at all, people are still likely to have spiritual needs. They may find it difficult to identify these needs themselves, but it doesn't mean they don't have them.

The religions and belief systems featured in this section of the guide have been included for the following reasons:

- Nine main religions are recognised by the Multi-faith Group for Health Care Chaplaincy, which is accountable to the Department of Health.
- Other sizeable religions and non-religious belief systems based on Census data.
- Religions with very specific health care requirements, even if the number of followers is small.

Spiritual health care at Whittington Health

The Trust's spiritual health care team, also known as Chaplaincy, offers advice and guidance on the following faiths:

- **Bahá'í**
- **Buddhism**
- **Christianity**
- **Hinduism**
- **Islam**
- **Jainism**
- **Judaism**
- **Sikhism**
- **Zoroastrianism**

It is just as important to recognise the needs of people who do not practise these religions. This is why the chaplaincy service team also provides or arranges support for people who practise other faiths and spiritualities, and for those who have beliefs or philosophies that are not based on a religion.

By far the largest part of the team's work is with people who are not associated with a religious group, but who need to talk through spiritual issues such as life events, illness, ethics, morals and end-of-life care.

What information will I find?

For each of the nine main religions, the following sections are included:

- **Introduction** - an overview of the faith.
- **Core beliefs** - summarises the religion's key beliefs.
- **Festivals and holy days -** examples of commonly celebrated festivals, although there are many more that individuals may mark. Timings can vary from year to year in some cases. Be aware that Trust staff may request time off in order to observe a religious festival.
- **Prayer, worship and holy texts -** outlines key religious texts, how prayer takes place, sacred items and important days for worship.
- **Names and titles -** how religious names are formed.
- **Dress code -** outward signs of religious dress, which you may or may not see in a hospital setting, plus attitudes towards modesty and specific actions that should be taken to preserve it.
- **Diet and fasting -** a guide to food, drink and fasting customs, and dietary restrictions.
- **Death and dying -** explains attitudes towards death and life after death, the acceptance of burial and cremation, the importance of spiritual contact with religious leaders, rituals and mourning preferences.
- **Organ transplants, blood transfusions and post-mortems** - explains attitudes relating to any religious objection.
- **Other health care issues -** any issues not covered elsewhere that could impact on care.
- **Family planning and fertility treatment -** the acceptability of contraception and abortion, and views on when human life begins.
- **Women and children -** details any specific needs, rituals and celebrations, particularly around the time of birth.
- **Useful contacts -** sources of help, advice and support for staff, patients, families and visitors.

How will this information help me?

This part of the guide will help you to:

- Be more proactive in identifying spiritual care needs for patients, visitors and families with and without a faith.
- Provide access to a suitable member of the spiritual health care team, to prayer facilities and to any special services being held at the Trust.
- Help patients achieve a goal to leave hospital – either temporarily or permanently to celebrate an important festival.
- Ensure standards of modesty are upheld, for example, during physical examinations, using a hoist or carrying out tests.
- Operate with sensitivity where your gender could be an issue for the person being treated.

- Empathise with the bereaved and understand what considerations may be important to them at a time of loss.
- Provide appropriate sources of advice, support and information to meet needs you are not able to satisfy or issues you cannot resolve in your role. Consider alternative ways of carrying out routine tasks to meet religious needs as closely as possible.

Getting the basics right

- Ask every patient about their beliefs and record their answer correctly.
- People will practise their religion in different ways – do not make assumptions and ask questions instead.
- When a patient dies, always check the wishes of the carer / family before beginning any last offices procedures. Prompt involvement of the bereavement and mortuary service is essential.
- Some people will be strict, observing all aspects of their religious code, while others will be more liberal.
- Always check before opening any closed bedside curtain.
- Make all people aware of the prayer rooms.
- Ensure you explain how single-sex facilities operate.
- Do not blaspheme, for example, by saying, “Oh, God!”
- Never interrupt prayer.
- Contact the spiritual health care team on 020 7188 5588 or via Switchboard 24-hours a day.
- Detailed religious calendars are available from the spiritual health care team.

Here is a checklist of getting the basic right

		Yes	No	N/A
1	Have you ask the patient or service user about their beliefs and record their answer correctly?	Yes	No	N/A
2	Have you ask the patients about their own understanding of their condition, and about what is important to them regarding their health issues and why. Have you recorded their answer correctly?	Yes	No	N/A
3	Have you asked how the patient service user practice their religion and record the information and what support they need?	Yes	No	N/A
4	Have you asked if there are any cultural, spiritual and religious considerations that the patient would like to take into account during treatment planning?	Yes	No	N/A
5	Have you asked and record whether the patient is already engaged in another complementary and alternative medical treatments, including any traditional healing practices, and consider how this will affect treatment planning?	Yes	No	N/A
6	Have established what is acceptable to the patient/service user in terms of diagnostic investigations, proposed treatments and medications?	Yes	No	N/A

7	Have you provided information on the chaplaincy/spiritual support available and where the prayer room is situated?	Yes	No	N/A
8	Have you checked if there is a healthcare professional gender preference and is this documented?	Yes	No	N/A
9	Is there a request for the chaplaincy service?	Yes	No	N/A
10	If the answer is yes, has the chaplaincy service been contacted?	Yes	No	N/A

Culture

Introduction

Britain today is a multi-cultural country, particularly in the major cities and increasingly in smaller cities and large towns. London is said to be the capital in which the largest number of languages are spoken, and our successful 2012 Olympic bid makes reference to 'the world in one city'.

Historically, many of our communities come from countries that were colonised by Britain and other European nations. This legacy of imperialism can be a sensitive issue for some. Now that these countries and states have achieved independence, Britain has a relationship with many through the Commonwealth.

The Commonwealth acts as an umbrella for around a third of the world's population drawn from the broadest range of faiths, races, cultures and traditions. It also acknowledges the many soldiers from Commonwealth countries who lost their lives fighting in Britain's name in both World Wars.

British communities have also developed as a result of global conflict, with Britain acting as a safe place for refugees and asylum seekers.

The enlargement of the European Union (EU) from 15 to 25 member states also brought new arrivals from across Europe who were able to live and work in the UK.

The cultures listed below have been chosen for one or more of the following reasons:

- The ethnicity of our local population based on 2021 Census data.
- Highest demand for Trust language support services.
- The very specific nature of cultural needs or values, even if numbers are small.
- The guide is a living document and will be updated to reflect changes to our cultural communities.

- African
- Arabian (Arabs)
- Bangladeshi
- British
- Caribbean
- Chinese
- Eastern European
- Eritrean
- Ethiopian
- Ghanaian
- Gypsies (Roma) and Irish Travellers
- Indian
- Iranian

- Irish
- Japanese
- Kurdish
- Latin & South American
- Nigerian
- Pakistani
- Somali
- Tamil
- Turkish
- Vietnamese

Why is culture and ethnicity important?

A person's culture is bound up in many things, including:

- Arts (dance; music; oral traditions).
- Food.
- How people live day-to-day.
- How they come together.
- Language.
- Religion
- How they celebrate birth and how they come to terms with death and grief.

Culture provides a sense of shared history, social norms and identity within families, local communities and the world at large. Ethnicity is an important aspect of cultural life. It tells us how the person views themselves and the importance of current or past roots. This perception may or may not change over time, and often differs within generations of the same family.

Being in hospital means that a person's everyday life is temporarily suspended. Staff who understand cultural needs and who balance this with the need to work within certain policies and procedures will make the person's visit to the hospital a much more comfortable and positive experience.

What information will I find?

- Introduction - summary background including references to key historical events.
- Language - which languages may be spoken, literacy levels,
- language support requirements.
- Religion - links between culture and religion, referencing chapters in Religion and belief where needed.
- Diet - preferences, needs and traditions relating to food and drink.
- Names and titles - how names may be formed.
- Main health care issues - requirements around death, transplants, transfusions and examples of particular health issues that affect a cultural group disproportionately*.

How will this information help me?

It provides staff with information about some of the key cultural issues which could affect a person's needs and responses in hospital. This part of the guide will help you to:

- Be more proactive in identifying patients' cultural needs.
- Understand more about the relationship between culture and religion.
- Offer choices that could be more acceptable or familiar.
- Think about how to be more flexible in what you do.
- Ensure standards of modesty are upheld, for example, during physical examinations, using a hoist or carrying out a test.
- Operate with sensitivity where your gender could be an issue for the person being treated.
- Empathise with the bereaved and understand what considerations may be important to them at a time of loss.
- Think about how you use language and the impact this may have.

Here is a checklist of getting the basic right

		Yes	No	N/A
1	Is the Trust's Patient Diversity form completed and correctly records the person's ethnicity.	Yes	No	N/A
2	Is the patient ethnicity recorded on PIMS if this has not already been done? **This will also allow us to plan our services more effectively.**	Yes	No	N/A
3	Does the patient want an interpreter even though they speaks some English?	Yes	No	N/A
4	Has the appointment changed and a language support request **NB - Do not carry a booking reference over to the new appointment.**	Yes	No	N/A

Alternative spiritualities, other religions and non-religious beliefs

The spiritual health care team provides or arranges support for people who practise any faith and spirituality, and for those who have beliefs or philosophies that are not based on a religion. Find out more about:

- Atheism, agnosticism and secularism
- Christian Science
- Church of Jesus Christ of Latter-Day Saints (Mormons)
- Humanism
- Jehovah's Witnesses
- Paganism
- Rastafarianism
- Scientology (The Church of Scientology)
- Spiritualism

By far the largest part of the team's work is with people who are not associated with a religious group, but who do need to talk through spiritual issues such as life events, illness, ethics, morals and end-of-life care.

Atheism, agnosticism and secularism

Atheism can be described as a lack of belief that there is a God or a belief that there is no God. Life is lived according to personal moral codes based on secular values, not religious texts.

Some atheists are also secularists. Secularists support a person's freedom to practise any religion or none at all, but actively oppose any religion or belief being given a political status that might create advantage or disadvantage. People who are agnostic feel that the existence or non-existence of God cannot be proven. Because agnostics believe there is not enough evidence to prove God's existence or otherwise, they consider this an unsolvable issue.

Main health care issues

- Inform the chaplaincy team via pager if patient does not want a visit on the ward.
- In general, the standard health care practice of clear advice and informed choice is all that is needed.
- May not wish to see others praying or worshipping.

Bahá'í

Introduction
The Bahá'í faith was founded in Iran in 1844 by Baha'u'llah. There are six million Bahá'ís across 235 countries, with around 6,000 followers in England and Wales. It is a growing faith with its world centre in Israel. The Bahá'í faith accepts all religions as having true and valid origins.

"To be a Bahá'í simply means to love all the world; to love humanity and try to serve it; to work for universal peace and universal brotherhood." Abdu'l-Baha

Core beliefs	• Belief in one God. • The unity of humanity. • Independent investigation of truth. • Harmony of science and religion. • Universal belief in peace

Festivals and holy days
There are a number of holy days on which Bahá'ís should not work. Bahá'ís are generally discouraged from celebrating the holy days of any other religion. Festival activities usually include prayers and food.

Three major festivals are:
- The Ridvan Festival – sunset on April 21 to sunset on May 2.
- Naw-Rúz (New Year) – March 21. First day of the Spring Equinox, which runs paprallel to Iranian (Persian) New Year.
- Birth of Baha'u'llah – November 12.

Prayer, worship and holy texts
- There are Bahá'í scriptures.
- There are different kinds of prayer of differing lengths, so check what facilities the person needs.
- The person's culture may mean they wish to wash before prayer – a jug/cup and bowl will be needed if the patient is unable to leave their bed.
- Bahá'í rituals and prayer are never photographed.

Names and titles
- Names are linked to the person's ethnic origin.

Dress code
- No religious obligations.
- May be linked to culture – modest dress similar to that worn by Muslims is common.

Diet and fasting	• No religious dietary laws. • Many Bahá'ís are vegetarian, but it is not a religious requirement. • No alcohol, including in cooking.

	• Fasting is seen as a time for spiritual regeneration. The main fast is between sunrise and sunset from March 2-20, with meals eaten after sunset. • Do not have to fast if ill, pregnant or menstruating, or if the person is under 15 or over 70 years of age.
Death and dying	• Very likely to accept palliative treatment. • Prayers for the deceased patient may be carried out by friends or family. • No specific rituals concerning the deceased. • Bahá'ís must be buried, not cremated. • Burials take place within an hour's travelling time of the place of death.
Organ transplants, blood transfusions and post-mortems	• No religious objections, but some may have cultural objections.
Other health care issues	• Bahá'ís are likely to want to have a serious, detailed discussion about any investigations and reasons for treatment. • Clinical opinions are usually valued and respected when they are discussed properly. Bahá'ís are encouraged to consult professional health care advice. • The power of prayer in healing is also important. • Habit forming drugs are forbidden, which impacts on the use of pain relief such as morphine. • Smoking is discouraged.
Family planning and fertility treatment	• Sterilisation is strongly discouraged unless there is a medical reason. Clear advice and information would be needed. • Contraception choices should be clearly explained. • Fertility treatment is a matter of personal choice.
Women and children	• Gender equality is important. • Birth is a joyous occasion, although there are no rituals. • Children are placed in high regard
Useful contacts:	The National Spiritual Assembly of the Bahá'ís of the UK 27 Rutland Gate, London SW17 1PD T 020 7584 2566 www.bahai.org.uk

Buddhism

Introduction

Buddhism is considered a way of life and Buddhists do not believe in, or worship, a God. Buddha is a title meaning 'Enlightened One', reflecting how Buddhism encourages the person to discover their way for themselves. Different branches of Buddhism are practised across the world. There are around 150,000 Buddhists in the UK and we have a higher than average number of Buddhists in our local area, many of whom follow the Thai branch.

Like a number of religions, Buddhists believe in reincarnation and the law of karma. Karma is an individual's reaction to the good or bad things that they do in this, or in a previous, life.

Core beliefs	Buddhists believe in four noble truths: • Existence of suffering. • Origin of suffering. • Elimination of suffering. • The path that leads to the elimination of suffering.

Buddhists believe that the origin of suffering is an attachment to desires like money and pleasure. Wisdom, morality and meditation are important qualities for Buddhists travelling on the path towards the elimination of suffering.

Festivals and holy days

Examples of Buddhist festivals are:

- Wesak (Buddha's Enlightenment) – falls during the full moon in May/June.
- Dhammachakra Day (Buddha's Teaching) – falls during the full moon in July.
- Anniversary of the Buddha's first sermon.
- Buddha's birthday – the timing depends on the branch of Buddhism practised.

Prayer, worship and holy texts

- Different branches have different texts. Thai Buddhism has a number of protective verses called 'sutta' which are chanted when a person is unwell. These are also used by Western Buddhists.
- Space for quiet thought and mediation is important, especially before an operation or after receiving bad news.
- Some may wash before chanting.

Names and titles

- Names are linked to the person's ethnic origin.

Dress code

- No religious obligations. May be linked to the person's culture or personal choice.

- Ordained monks and nuns have distinctive, modest dress such as long orange robes.

Diet and fasting	• Mostly vegetarian – many Buddhists do not wish to harm living creatures. • Salt-free foods. • Some may be strict vegans. • Fasting is not required except for ordained Buddhists, who eat everyday meals during daylight hours before noon.
Death and dying	• Cremation is preferred. • Buddhists who die on the last day of the lunar month want to be cremated on the same day if at all possible. Ensure there is proper discussion if the funeral must take place in the next lunar month (a new moon). • The next-of-kin may wish to wash and drape the deceased patient in fresh clothes, except for the head and face. Hair may be combed. • The deceased patient should be kept on the bed and should not be disturbed unless there is a clear reason. • There are no special rituals, but some people may want their priest present for prayers before the deceased patient is moved. • The deceased patient can be washed by people of either gender, although this may vary across cultures. • Babies who die after birth would have a special Buddhist ceremony and would be buried if very young (up to about one month of age). • Offering mementos of a dead child such as locks of hair, foot and hand prints or photographs is not usually acceptable.
Organ transplants, blood transfusions and post-mortems	• No religious objections, but some may be linked to culture. • Donation is generally considered a positive act.
Other health care issues	• A clear mind and consciousness at the time of death is vital. This may impact on terminally ill patients and those undergoing surgery, even if they would be in pain. Many Buddhists refuse pain relief if there is the slightest chance it might dull their senses. • The person may wish to die chanting or hearing chanting. • Many will prefer to die at home if possible.

	• Strict Buddhists may wish to be treated by a person of the same gender.
Family planning and fertility treatment	• All contraception is acceptable except for emergency contraception such as the morning after pill. • Abortion is acceptable where the mother's life is in danger, but clear advice is needed. • Fertility treatment is a matter of personal choice.
Useful contacts	**Buddhist Society** The Buddhist Society **Network of Buddhist Organisations in the UK** www.nbo.org.uk Email: nboadmin@nbo.org.uk

Christian Science (The Church of Christ, Scientist)

Christian Science was established in the USA in 1879 by Mary Baker Eddy. It is a universal and practical system of spiritual prayer-based healing and is available to, and accessible by, people of all faiths. It is not part of mainstream Christianity.

Church services are combined with Bible reading and readings from the faith's book, *Science and Health*. Privacy for prayers may be required.

Main health care issues	• Christian Scientists believe that disease and illness only exist in the mind and can be overcome through prayer and training. • Do not accept pain relief or other medication. • Blood transfusion, blood products and organ donation or transplants are not normally acceptable for adults. • May accept medical care for their children if it is an absolute legal requirement. • May seek nursing care at home or in a Christian Science nursing home. • Belief in the power of healing. • No medical intervention when a person is dying and certain rituals are usually performed. • A female body should be handled by other females. • Unless there is a legal requirement, post-mortems are not permitted. • Cremation is preferred.

Christianity

Introduction
Christianity was founded by Jesus Christ and is the biggest religion in the world and in the UK. Followers call themselves Christians. Over 42 million people in the UK describe themselves as Christian, although many do not practise their faith regularly.

Christianity has a number of traditions and followers can have very different practices:

- Church of England (also known as Anglican or Episcopalian) – led by the
- Archbishop of Canterbury, who is appointed by the monarch.
- Roman Catholic – led by the Pope in Rome.
- Free Church – a loose body that looks after several hundred smaller
- denominations such as Pentecostal, Baptist, the Salvation Army and Methodist churches. It also includes Seventh Day-Adventist and Quaker, which have strong individual identities.
- Orthodox – Greek, Russian and Armenian traditions.
- Coptic – an independently-run very traditional church popular in North Eastern and Eastern Africa and parts of the Middle East.
- Christian Science, Jehovah's Witnesses, Church of Jesus Christ of Latter Day
- Saints (Mormonism) and Rastafarianism – although considered distinct from
- mainstream Christianity, these faiths retain some common links and followers may call themselves Christians.

Core beliefs	Christians believe in one God revealed in three 'persons': • God the Father. • God the Son (Jesus Christ). • The Holy Spirit. Christians believe that: • God sent his Son to earth to save mankind from the consequences of its sins. • Jesus was fully human and experienced the world in the same way as other human beings. • Jesus was crucified on the Cross. • Jesus rose from the dead on the third day after his Crucifixion. This is called the Resurrection and is remembered every Sunday. • Jesus was the Messiah promised in the Old Testament.

Names and titles

- First names are also known as Christian names.
- Christian names may be taken from the Bible, but not always

Festivals and holy days

- Easter and Christmas are among the most important holy times of year for
- Christians. Some dates vary each year and are celebrated at different times by some Christian traditions. Some of the UK's main public holidays fall at Christmas and Easter.
- Christians from across mainland Europe, especially France, Spain, Italy, Portugal and Eastern Europe, are likely to celebrate a Saint's Day.

Christmas

- Advent – the four Sundays leading up to Christmas Day.
- Christmas Eve – December 24.
- Christmas Day – December 25. Celebrates the birth of Jesus.
- Epiphany (the Twelfth Night) and Christmas Day for the Orthodox tradition – January 6.
- Ash Wednesday – February/March. The first day of Lent, a period of 40 days and a time for fast, prayer and preparation for Easter. Christians may wish their forehead to be marked with an ash cross.
- Holy Week starts on the last week of Lent and is the week before Easter. Palm Sunday celebrates Jesus' entry into Jerusalem and Maundy Thursday is an important day for receiving Holy Communion.
- Easter – March/April.
- Good Friday – a solemn day to remember the Crucifixation.
- Easter Day (Easter Sunday) – the holiest day in the Christian calendar that
- celebrates Jesus' resurrection.
- Easter Monday
- Pentecost (Whit Sunday) – 50 days after Easter Day.

Prayer, worship and holy texts

- Religious text: The Bible (the Old Testament and Psalms) plus the New Testament. The Old Testament (Hebrew Bible) is also the basis of Jewish scripture.
- Spiritual leaders have many titles including priest, minister, bishop and pastor.
- Christians worship in churches as part of a congregation.
- Sunday is the main day of worship.
- Christians are likely to welcome being able to pray or to receive Holy Communion while in hospital.
- Roman Catholics, Orthodox Christians and members of the high church may pray with rosary beads or prayer cards and may wish to confess to a priest.
- For Seventh Day Adventists, the Sabbath falls on Saturday (from sunset on Friday).

Dress code

- No particular everyday dress requirements.

- Many Christians wear a cross around their neck as a symbol of the Crucifixion.
- May dress modestly.
- Monks or nuns may have dark, full length clothes and head coverings.

Diet and fasting	• Generally, there are no specific dietary restrictions. • Some traditions may not allow stimulating food and drink like alcohol or caffeine. • Some Christians fast before certain festivals and at these times do not eat animal or dairy products. • Many avoid meat and eat only simple foods on Good Friday. • Seventh Day Adventists can have similar dietary requirements to Judaism, avoiding pork and pork products, and may not drink tea or coffee. • Some Christians may give up a particular food or drink for Lent and may fast before • receiving Holy Communion.
Death and dying	• Terminally ill patients may wish to prepare themselves for death through prayers with a hospital chaplain or their priest. • Christian patients should be offered final prayers before death - last rites. • Anointing with holy oils and the laying on of hands for healing may be important at times of crisis. Bedside privacy is very important. • Emergency baptisms can be carried out for dying babies and blessings for babies who are stillborn. • Christians can be buried or cremated, although cultural background may affect the person's preference. • Timescales for funerals vary across Christian traditions.
Organ transplants, blood transfusions and post-mortems	• Objections may be cultural rather than religious. • Christians are encouraged to help others in need, and organ donation can generally be discussed without offence although there are exceptions: • Orthodox Christians may not wish to donate organs or tissue. • Seventh Day Adventists may object to post-mortems and to organ and tissue donation. • Plymouth Brethren do not support post-mortems and oppose all transplants except for kidneys.
Other health care issues	• Christian teaching encourages followers to respond positively to illness and to entrust themselves to the healing and care of God in Jesus.

	• Respect for clinical opinion is usually combined with religious ritual and prayer.
Family planning and fertility treatment	• Contraception is usually a matter of personal choice. • Officially, the Roman Catholic and Orthodox Christian churches do not permit the use of contraception but, in practice, followers often make their own choice. • Fertility treatment is usually a matter of personal choice, but there may be exceptions. • Abortions can be carried out where there is a clear medical need.
Women and children	• A blessing, christening or baptism of a baby may be carried out.
Useful contacts	**Spiritual and pastoral care team** The team has a number of Christian chaplains and other members of the team who are able to advise. Please contact them either in person in the Kenwood wing of Whittington Hospital or: • Tel: 020 7288 5337 • E: whh-tr.chaplaincy@nhs.net **Church of England** Home | The Church of England **Roman Catholic Church in England and Wales** Catholic Church in England and Wales - Catholic Bishops' Conference (cbcew.org.uk) **Churches Together in England** Churches Together in England (cte.org.uk)

Hinduism

Introduction
Hinduism is the world's third most popular religion, with around 900 million followers known as Hindus. About 80% of India's population regard themselves as Hindus. Hinduism is the fourth largest religion in the UK, with around 558,000 followers.

Hinduism originated near the river Indus in India. There is no founder, single teacher or prophet and it is not a single, unified religion.

Core beliefs	• Hindus believe in a universal soul or God called Brahman. • There are many other gods or deities such as Krishna, Shiva, Rama and Durga. • Hindus believe in reincarnation – that existence is a cycle of birth, death and rebirth governed by karma.

Festivals and holy days
There are many festivals and holy days that are celebrated to varying degrees in the UK and in India. Three examples are:

- Holi – March. Celebrates the coming of Spring.
- Janmasthami – August. The birth of Lord Krishna, an incarnation of Lord Vishnu.
- Diwali – November. A festival of lights to celebrate the New Year.

Prayer, worship and holy texts
- Religious text: Bhagavad Gita.
- Provide running water or a bowl of water and cup/jug to wash hands and feet at prayers.
- Most Hindu homes have a shrine where offerings are made and prayers are said.
- A shrine can be anything from a room, a small altar or simply pictures or statues of the deity and family members often worship together.
- Weekly shrine sessions are held on both hospital sites by the Hindu chaplain.

Names and titles
- Unlikely to want the term 'partner' used to describe a husband or wife.
- Traditionally Hindus have a personal name, complementary name and sub-caste name.
- The caste system is linked to a person's social class and profession. Because attitudes towards the caste system have now changed – it is an illegal term – Hindus may not use a sub-caste name.
- The complementary name is often used as a last name and therefore may not be common to all members of the family.

Dress code

- For female patients, modesty is very important. Women may wish to cover their arms and legs.

Diet and fasting	• Many Hindus do not eat meat. • Some Hindus do not eat eggs. • Cow's milk is usually acceptable. • Vegetarian Hindus may prefer disposable plates, cutlery and cups. • Check whether it is a time for fasting.
Death and dying	• Hindus have a strong preference to die at home. If they must be in hospital, the patient may prefer medication to be reduced so that they are conscious of God when they die. • If the patient cannot recite holy words, words can be held in front of the patient's eyes. • Contact the spiritual health care team before calling for a Hindu priest. • Last rites, known as puja, include reading from the Bhagavad Gita and the use of symbols such as ganga water and beads. If any of these symbols are found on the deceased patient, they must not be removed after death. • If a patient dies in a ward bay, move them to a cubicle or viewing room as soon as possible. • Expect relatives and friends to pay their respects. • The person handling the deceased should preferably be the same gender and, if possible, a Hindu. If not, there should be minimal touching of the deceased. • Use gloves and move the deceased patient feet first. • Straighten limbs, close the eyes and mouth firmly, and wrap the deceased patient in a clean white sheet. • Do not remove jewellery, religious objects or a man's sacred thread (worn over the shoulder and across the body). • Relatives will normally wash the deceased patient. • Hindus are cremated, not buried, preferably within 24 hours of death, so paperwork should be completed as soon as possible.
Organ transplants, blood transfusions and post-mortems	• Organ transplants may be unacceptable on cultural grounds. • If a Coroner's post-mortem is needed, inform the Coroner that the person is a Hindu. Inform relatives

	of the likely time for the deceased patient to be released.
Other health care issues	• Ensure that single-sex facilities are made clear and that the Trust's single-sex policy is in force for ward bays. • Both men and women would prefer clinical treatment from a person of the same sex if possible. • Check where the patient would like a cannula inserted – some may prefer the arm, rather than the hand. • Check who the patient would like present during news-giving or examinations. • Patients may request religious books and images before an operation. • Several family members may wish to visit, pray and wait until an operation is over. • Patients will want to carry out a ritual washing using a bowl of water or running tap before and after operation. • Provide a bowl of clean water after the person has used a bedpan or the toilet. • Patients may wish to lie on the floor at times. • Tend to put hands together to greet, rather than shake hands.
Family planning and fertility treatment	• Abortions on religious grounds are allowed if the mother's life is in danger. • Contraception is not acceptable to strict Hindus. • Fertility treatment is not common, and sensitive discussion is needed.
Women and children	• Female patients prefer female staff, particularly for washing and for gynaecological examinations. • Home births are preferred. • Prayers are said at the birth of a child, before cutting the umbilical cord and before a first breastfeed. • Spiritual care of the unborn child starts with conception. A special ceremony is held between the fourth and sixth month of pregnancy. • Mothers may expect to sleep with their baby or child.
Useful contacts	**Useful contacts - Spiritual health care team** • Tel: 020 7288 5337 • E: whh-tr.chaplaincy@nhs.net **Hindu Forum of Britian:** HFB - Hindu Forum of Britain

Humanism

Humanists are generally either atheists or agnostics, but tend to view these positions as simply a negative response to religion. Humanism sees itself as an active, positive and ethical philosophy.

Humanists believe that moral values are founded on human nature and experience alone. They make decisions based on the available evidence and assess the outcomes of their own actions rather than seeking answers from religious texts or teachings.

An individual's rights and freedoms are seen as equal to duties of responsibility, social cooperation and mutual respect. They believe that people can and will continue to find solutions to the world's problems so that quality of life can be improved for everyone.

Humanists believe that there is only one life and that it is their responsibility to make it a good life, and to live it to the full.

Main health care issues	• In general, the standard health care practice of clear advice and informed choice is all that is needed. • Want to understand the risks of, and make decisions about, treatment. • May be more likely to want a living will and/or to reject treatment in order to die with dignity. • Many believe in assisted dying (or voluntary euthanasia). • Inform the spiritual health care team via pager if patient does not want a visit on the ward. • May be vegetarian or oppose certain methods of slaughter. • No special ceremonies before or after death. • Most humanists will wish to have a humanist funeral, and many will also want humanist weddings and naming ceremonies. • Very likely to agree to donate their organs. • Do not want to be 'prayed for'. • May want the support of a counsellor, but not a chaplain who has religious beliefs, to talk through their feelings and share their concerns.
Useful contacts	**British Humanist Association** T 020 7324 3060 Humanists UK – Think for yourself, act for everyone

Islam

Introduction
Islam has over 1 billion followers worldwide, a fifth of the world's population. A person who believes in and consciously follows Islam is called a Muslim. There are about 1.6 million Muslims in the UK.

There are two main Muslim traditions, Sunni and Shi'a, with further traditions within each. Sunnis account for about 90% and Shi'as for about 10% of Muslims.
Many Muslims in the UK are British born with origins in India, Pakistan and Bangladesh. Other Muslims in the UK have origins in a wide range of countries including Turkey, Iran, Somalia and Bosnia.

Core beliefs	Islam teaches that a person can only find peace in their life by submitting to Almighty God (Allah) in heart, soul and deed. The original Arabic word for Islam also gives us 'Salaam alaykum' which means 'Peace be with you', the universal Muslim greeting. The key principles of Islam are: • Belief in the oneness of God. • Reciting five daily prayers and weekly group prayer on Friday lunch-times. • Fasting for Ramadan. • Giving to charity (alms-giving). • Pilgrimage to Mecca during one's lifetime.

Festivals and holy days

There are many Muslim holy days and festivals. Three major festivals are:

- Ramadan – October, but it moves round the year, as do all Muslim festivals, because the lunar calendar used by Muslims is not adjusted for the solar calendar. A month of fasting in the ninth month of the Muslim year.
- Eid-al-Fitr – November. Breaking the Ramadan fast and a big festival.
- Eid-al-Adha – February. The feast of sacrifice.

Names and titles

- Usually a religious name, personal name and clan/family/regional name. Names are also linked to the person's culture.
- Religious names are titles, commonly Mohammed and Allah.
- Personal names may come first or may be followed by other names or titles, so check how the person wishes to be addressed.
- Because of how naming works, families are unlikely to share a last name.

Prayer, worship and holy texts

- Religious text: The Qur'an (Koran).

- Prayer mats, compasses and Qur'ans are available from the spiritual health care team.
- Prayer takes place on clean ground or a prayer mat.
- Muslims pray five times a day in the direction of Mecca (south east).
- Washing (ablutions) are carried out before prayer with running water or a bowl of clean water and a cup/jug. Patients unable to leave their bed will still wish to splash water on themselves.
- Do not walk in front of, or disturb, a Muslim during prayer.
- Friday is the main religious day.
- Muslim patients are likely to want to pray before an operation, and members of their family may want a place to pray during the operation.

Dress code

- For women, modesty is very important. Women may wish to cover their arms and legs.
- Some women may wish to cover their head at all times.
- Men will want at least the area between their navel and their knees covered in public.

Diet and fasting	• No pork or alcohol. • Halal food, preferably meat and not necessarily curry. • Offer disposable plates, cups and cutlery. • Do not have to fast if ill but ask. • If fasting, food should be available before sunrise and after sunset. • Eid-al-Fitr is the day of breaking Ramadan (fast), so avoid booking appointments on this day.
Death and dying	• Patients who are dead or dying should face Mecca (south east) or at least have their head turned, towards the right shoulder, towards Mecca. • Prayers at the deathbed are usually said by male family members. An Imam is not usually present. • The person handling the deceased patient should preferably be the same gender and, if possible, a Muslim. If not, there should be minimal touching of the deceased. • Nails and hair should not be cut. • Limbs should be straightened, the mouth closed and the deceased patient wrapped in a clean white sheet, preferably with no writing on it. The deceased patient should at no time be left naked. • The family will probably wish to wash the deceased patient. • Muslims are buried, not cremated, preferably within 24 hours of death, so paperwork should be completed as soon as possible.

	• Toys should not be put near a deceased child unless the parents have asked for this and the child should be dressed in plain clothing. • Expect relatives to visit. Move the deceased patient to a room or mortuary as soon as possible to allow relatives and friends to visit. Expect loud expressions of grief. • Remove all religious symbols for viewings of the deceased patient.
Organ transplants, blood transfusions and post-mortems	• Organ transplants may not be acceptable and asking may cause offence. • Post-mortems may not be acceptable unless ordered by a coroner. • In these cases, inform the coroner that the deceased patient is Muslim. Inform relatives of the likely time for the deceased to be released.
Other health care issues	• Do not shake hands unless the person offers their hand first. • Check who the person would like to be present during any news-giving or examinations. • Ensure that single-sex facilities are made clear and that the Trust's single-sex policy is in force for ward bays. • Check where the patient would like a cannula inserted – some may prefer the arm rather than the hand for ritual washing and eating purposes. • Showers are preferred over baths, because of the flowing water. • Provide a bowl of clean water and a cup/jug after the person has used a bedpan. • If fasting, try to give drugs before sunrise and after sunset. • Do not cut hair unless asked to do so, even after death. • For Muslims who need an amputation, discuss arrangements as far as possible in advance of surgery. The limb may be buried in the same place the person will be buried when they die. In these cases, involve mortuary staff early so that any arrangements can be made.
Family planning and fertility treatment	• Abortions are allowed if the mother's life is in danger and before 120 days after conception, when 'life' is believed to begin. They are not permitted in cases of rape or incest.

	• It is not acceptable to use donor eggs or sperm, but it may be acceptable to use the husband's own sperm for fertility treatment. • There are varying cultural attitudes towards contraception. The IUD is one of the most popular choices for Muslim women.
Women and children	• Female patients prefer female staff, particularly for washing and for gynaecological examinations. • Women may not wish to get out of bed or walk without having covered their arms, legs and head. • Mothers may expect to sleep with their baby or child. • A male member of the family will recite special prayers into a newborn baby's ear shortly after the birth. • Children are not required to fast. • Male circumcision is practised in late childhood/early teenage years.
Useful contacts	**Spiritual and pastoral care team** The team has a Muslim chaplain and other members of the team who are able to advise: • Tel: 020 7288 5337 • E: whh-tr.chaplaincy@nhs.net **Muslim Council of Britain** www.mcb.org.uk

Jainism

Introduction
Jainism was established in India. Followers worship a number of teachers rather than a God. These teachers are believed to have attained infinite knowledge and perfect purity through spiritual effort. One such teacher is Mahavira, who lived at the same time as the Buddha in the 6th century BCE.

Like Buddhists, Jains believe in reincarnation and karma. They also reject material comforts and other desires. There are about 25,000 – 30,000 Jains in the UK.

Core beliefs	Jainism has equality at its heart and a respect for all living things. Jains live life according to the following principles: • Non-violence towards any living thing including humans, animals, plants and tiny airborne organisms. • Truthfulness. • Not stealing. • Celibacy (for monks and nuns) or chastity. • Not acquiring or desiring material goods. Living simply, with what one needs.

Festivals and holy days include:

- Mahavira Jayanti – March/April.
- New Year – October.
- Diwali – October/November. This differs from other Diwali celebrations.

Prayer, worship and holy texts

- Jain scriptures are known as the Shruta, Agamas or Siddhanta.
- Jains may pray before dawn, at sunset and at night.
- Many worship at shrines in their home, others at temples.
- Visits from members of the Jain religious community are likely to be welcome.

Names and titles

- It is usual to address a Jain with their family name and title, not their first name.
- Names depend on the person's ethnic origin.

Dress code

- Modesty is important, and many will wear Asian dress.

Diet and fasting	• Jains are vegetarian. An Asian vegetarian diet may be acceptable, but do ask. • Some Jains are very strict about which vegetables they eat because of the harm caused to living organisms during their harvest. For example, they

	may not eat root vegetables such as potatoes, carrots and cabbages. • Milk, curd and ghee (clarified butter) are all allowed. • Meat, eggs, butter, fish, honey and alcohol are not permitted. • Some Jains may not eat garlic and onions. • Some Jains may wish to eat with their curtain closed to avoid seeing others eating meat. • Jains have only boiled water when they fast, and it is usual to fast for one meal a day or for longer at other times.
Death and dying	• Patients may wish to meditate and worship with images, prayers or recordings. • These are used to achieve a sense of detachment and good thoughts, which is valued as death approaches. • Jains are likely to want their family present, and relatives may wish to chant and pray with the patient. • Relatives may also chant in the patient's ear, even if they are unconscious. • Incense is common, so explain carefully if this cannot be used in hospital. • When a Jain feels that no further treatment is appropriate, they may wish to fast and have a 'holy death'. They may refuse medication, fluids and food at such a time.
Organ transplants, blood transfusions and post-mortems	• There are generally no religious objections to transplants or transfusions. • Attitudes towards post-mortems vary and a sensitive discussion will be needed.
Other health care issues	• Some Jains will object to certain medication if they feel it harms a living creature. • They may also reject opiates because of their values of suffering and endurance.
Family planning and fertility treatment	• No religious objections to contraception. • Abortions are likely to be avoided if contraception fails.
Women and children	• Women usually rest for 40 days after childbirth, with relatives helping both the mother and baby. • Women will usually prefer to be seen by a female health care staff.
Useful contacts	Spiritual health care team

	• Tel: 020 7288 5337 • E: whh-tr.chaplaincy@nhs.net **Institute of Jainology** About IOJ – Institute of Jainology Email: info@jainology.org

Jehovah's Witnesses

Jehovah's Witnesses accept the Christian Bible as the word of the Almighty God and Creator Jehovah. Birthdays, Easter and Christmas are not celebrated. The main festival is the Memorial of Christ's death, which is a solemn occasion which takes place on the anniversary of the Last Supper.

Main health care issues	• Transfusions of whole blood and its primary components (red cells, white cells, platelets and plasma) are not accepted. • Baptised Witnesses will usually carry an advance directive or living will that states their wish not to receive any transfusions. • Autologous procedures which involve Witnesses' own blood are a matter of personal choice and should be checked with the patient. These include blood salvage (cell saver), haemodilution, wound drains, dialysis and heart bypass. • Accepting derivatives of the primary components such as immunoglobulins, coagulation factors and albumin is a matter of personal choice. • The Royal College of Surgeons' Code of Practice includes a section called 'Children of Jehovah's Witness Parents' that helps to foster a non-confrontational approach to surgery. • For patients refusing blood transfusion, including Jehovah's Witnesses further help can be obtained from your Minister. • Abortions are only acceptable in life-threatening situations. • Family planning is decided between a married couple, but will not usually include emergency contraception such as the morning-after pill. • Organ transplants are a matter of personal choice. • Pain relief including opiates is a matter of personal choice. • Access to elders (ministers) for the terminally ill or dying is usually welcomed. • No particular rites or observances need to be carried out around the time of death.
Useful contacts	Jehovah's Witnesses | Hospital Liaison Committee Contact: United Kingdom (jw.org) Tel: 020 8371 3415

Judaism

Introduction
Judaism has between 292,000 and 370,000 followers in the UK, depending on definition. There are five major traditions: Orthodox; Ultra-orthodox; Hasidic; Progressive (includes liberal); and Conservative (Masorti). Followers are known as Jews or are described as Jewish.

The religion is based on the Torah, which means 'teaching' or 'direction', that Jews believe was given to Moses by God on Mount Sinai.

Core beliefs	Jews believe that: • One God exists, though not in bodily form, and is eternal. • The Torah is of divine origin and is eternally valid. • The land of Israel is the eternal homeland. To practise Judaism means to worship one God, to carry out the Ten Commandments and to be charitable and tolerant towards others.

Festivals and holy days

Sabbath (Shabbat) – an important day of rest that begins at sunset on Friday evening and lasts until Saturday night. It is a time for the family and a day devoted to prayer and study, and work is forbidden. 'Work' includes activities such as using electricity, driving, using public transport, cooking, using the phone and writing. Hospital appointments, procedures and discharge should be avoided on Friday afternoons and evenings.

- Rosh Hashanah – September/October. Jewish New Year.
- Yom Kippur (Day of Atonement) – September/October. A fasting day and a solemn occasion.
- Purim – March/April. A festive occasion.
- Pesach (first day of Passover) – April. A major family festival.
- Shavuot – Seven weeks after Passover.
- Hanukkah – November/December. Festival of lights celebrated for eight nights.
- Sukkot – October.

Prayer, worship and holy texts

- Religious texts: The Torah and Psalms.
- The start of the Sabbath includes lighting candles and a blessing over wine and bread. Electric lights may be used where candles are not permitted.
- Observant Jews may need 30 minutes uninterrupted morning prayer before eating or washing.
- Strict Jews may not accept visitors or answer the phone on a Saturday.

- May wash hands and say a prayer before eating.

Names and titles

- Most names are linked to the person's culture.
- There is a traditional Hebrew naming system but this may not be used every day.

Dress code

- Liberal Jews may have no outward signs of religious dress.
- Orthodox Jewish men often wear long black coats and a hat.
- Women from some Jewish traditions may cover their head and/or wear a wig.
- Jewish men often cover their head with a skullcap (kippah).
- Some Jewish men will have a prayer shawl or other artefacts with them which should not be touched or removed without permission.

Diet and fasting	• Jewish people eat food that is kosher, which means "fitting" or "correct". • There are special slaughter methods for all meat and poultry. • Kosher hospital meals come in disposable containers wrapped in double tin foil or similar wrappings that are microwave friendly. Serve them fully sealed with disposable plates and cutlery. Do not probe the food with any non-kosher implement. • No pork, shellfish or blood can be eaten. Eggs with blood spots are not kosher. • Certain E-numbers and additives are not kosher – this would include some breads and crackers. • Meat and milk cannot be mixed together during cooking or eating. Tea or coffee with milk or any pudding containing milk products could not be eaten for several hours after a meat meal. • If a patient is seriously ill and needs a particular non-kosher food for their treatment, it may be given if a kosher alternative is unavailable. • There are exceptions for fasting when a person is ill and for 30 days after giving birth.
Death and dying	• Relatives may be anxious that the patient does not die alone. • Active intervention that could quicken the death of a terminally ill patient is not permitted. This includes moving a dying patient, unless absolutely necessary. • May want to see a Rabbi with whom to say prayers or wish for psalms to be recited. • Ask permission before touching the deceased patient and wear gloves.

	• The deceased is not usually washed by hospital staff. • The person handling the deceased should preferably be the same gender and, if possible, Jewish. If not, there should be minimal touching of the deceased. • Lay the deceased patient flat, with the hands open, arms parallel and legs straight. • It is important for the eyes and mouth to be firmly closed, preferably by the children or other family members. • Wrap the deceased patient in a plain, white sheet, preferably the same sheet the person died on. The deceased patient should at no time be left naked. • Remove jewellery in the presence of relatives, list it and give to the family as soon as possible. • Jews are buried, preferably within 24 hours of death, so paperwork should be completed as soon as possible.
Organ transplants, blood transfusions and post-mortems	• Post-mortem examinations are not permitted except in any emergency, or where civil law absolutely requires an autopsy. • Blood transfusions, which may not be kosher, are acceptable as they are necessary to save life.
Other health care issues	• Some may refuse shaving for an operation unless they have consulted a Rabbi. • Observant Jewish patients may prefer not to undergo medical treatment like an operation on the Sabbath or major festivals if it could be delayed without affecting their condition. • Ensure that single-sex facilities are made clear and that the Trust's single-sex policy is in force for ward bays. • Non-kosher products such as insulin are acceptable.
Family planning and fertility treatment	• Many use some form of contraception. • Orthodox Jews usually have large families and may be reluctant to use contraception. • Abortion is permitted in cases of rape or incest within the first 40 days, and in a medical emergency. • Families are important and infertility may be particularly distressing. IVF using the man's own sperm may be used, but donor eggs and sperm are not usually acceptable.

	• The person may to want to consult a Rabbi on these matters.
Women and children	• Childbirth is considered life-threatening, so all action that needs to be taken should be regardless of festivals or the Sabbath. • Women who have a miscarriage more than 35 days after a missed period are treated as if they have given birth. • The baby is viewed as an independent human being as soon as its head is born. • Boys are circumcised by a Mohel – a specially trained officiant, often also a doctor – when they are eight days old, unless they are not well enough. • Women are considered 'unclean' during menstruation within the Orthodox tradition. • Orthodox men may not touch their wife during childbirth.
Useful contacts	**Spiritual and pastoral care team** The team has a number of Christian chaplains and other members of the team who are able to advise. Please contact them either in person in the Kenwood wing of Whittington Hospital or: • Tel: 020 7288 5337 • E: whh-tr.chaplaincy@nhs.net **Board of Deputies of British Jews** The Board of Deputies of British Jews (bod.org.uk)

Church of Jesus Christ of Latter-Day Saints (Mormons)

The church was founded in the late 19th century and places a strong emphasis on family life and values. Followers are also known as Mormons. Mormons pray privately and in a congregation. Sunday is the main religious day, and Monday evenings are often set aside for time with the family. Boys are considered priests from the age of 12 and women usually marry young.

Mormons celebrate two Christian festivals, Easter and Christmas, as well as the faith's own Pioneer Day on July 24.

Main health care issues	• Fasting is common. • Tea, coffee, smoking and alcohol are not permitted. • Contraception is seen as a choice for a couple to make with God. • Organ donation is a matter of personal choice. • Women dress modestly.
Useful contacts	**Church of Jesus Christ of Latter-Day Saints** Official Website of The Church of Jesus Christ of Latter Day Saints in the United Kingdom and Ireland 64-68 Exhibition Road London SW7 2PA T 020 7838 1920

Paganism

Paganism is a religion with a wide range of traditions and practices, but it is grounded in respect for, and worship of, the natural world. There are over 30,000 Pagans in England and Wales.

The Pagan Federation outlines a number of themes that broadly describe the religion:

- Honouring the seasonal cycle, or 'wheel of the year', and participating in its festivals.
- Belief and participation in ritual as a means of effecting objective change.
- Honouring of deity as an objective divinity – a God/Goddess, or nature as deity, or a range of beliefs.
- Five examples of modern Pagan paths and traditions are:

    - Druidry – strong concern for ecology, the healing of the Earth and striving to live as part of nature.
    - Heathenry – honour many gods, goddesses and spiritual beings as well as ancestors.
    - Shamanism – a diverse tradition that emphasises individual practice and experience, and belief in, and contact with, the spirit world.
    - Witchcraft and Wicca – practices can include healing, spellcraft, counselling and public open rituals.
    - Women's traditions – largely female-focused, with a vision of the Earth as Goddess and a healing image of women.

Main health care issues	• Certain symbols or objects from the natural world may have significance and bring comfort. • Pregnant couples may wish to honour male and/or female deities within their spiritual path or honour each other. • May want a 'green' or woodland burial, where the body is buried in managed land that attracts wildlife, plants and flowers. Coffins may be made of cardboard or wicker.
Useful contacts	**The Pagan Federation** T 07528 793563 www.paganfed.org

Rastafarianism

Rastafarianism grew out of the history of European colonisation in the Caribbean and slavery, which saw black Africans taken from their country to other parts of the world. Marcus Garvey, a Jamaican politician, is credited as a leading figure in developing black rights and predicting the coming of a black king and 'redeemer'. Rastafarianism was founded in Jamaica after Haile Selassie I was crowned King of Ethiopia in the 1930s.

Increased awareness of Rastafarianism came with the international growth of reggae music in the 60s and 70s. Modern Rastafarianism is practised by both black and non-black people. The colours red, gold, green and black have religious symbolism.

The most important holy days take place on July 23, Haile Selassie's birthday, and September 11, Ethiopian New Year. Rastafarians differ in their practices, beliefs and dress, and may combine their beliefs with others, such as Christian Orthodox traditions.

Main health care issues	• Mutual discussion, where people are given respect and dignity, is highly valued. • Avoid pork. Many have a natural, vegetarian diet and do not drink alcohol. • Some are vegan, do not eat grape products and do not use salt. • Rastafarians may wear their hair long in dreadlocks which are never combed or cut, but are tidied with olive or coconut oil. • Some Rastafarians cover their dreadlocks, particularly women. • Some people wear their hair in dreadlocks as a fashion statement rather than for religious reasons, so do check with the person. • Prayers and chanting take place at weekly communal meetings. • Believe in reincarnation, so there is no funeral ceremony. • May seek herbal remedies before conventional medicine. • Marijuana is seen as a spiritual aid and is known as 'the wisdom weed' or 'the holy herb'. • Many Rastafarians oppose family planning for religious reasons but also because past programmes in the Caribbean were felt to be racist.
Useful contacts	Rastafari Movement UK Rastafari Movement UK (RMUK) Food and Wellbeing , organised by Sistah Stella - Co-operate (coop.co.uk)

Scientology (The Church of Scientology)

The Church of Scientology describes itself as 'an applied religious philosophy'. Scientologists believe that man is basically good. They use a number of tools to become happier, more able as a person and to improve conditions in life for themselves and others.

Scientology thinking extends from three main 'truths':

- Man is an immortal spiritual being.
- His experience extends well beyond a single lifetime.
- His capabilities are unlimited, even if not presently realised.

The ultimate goal of Scientology is true spiritual enlightenment and freedom for the individual.

Main health care issues	• Require a quiet or silent birth, at which no words are spoken by those attending unless absolutely necessary. The aim is to make the birth as peaceful as possible. • The woman giving birth is able to make noise. • Scientologists use a process called 'auditing' to help them question what is happening in their life and identify spiritual needs. This may be used to help the person understand their health care situation.
Useful contacts	Church Of Scientology of London Church of Scientology of London—All Are Welcome! (scientology-london.org.uk) Tel: 020 7246 2700

Sikhism

Introduction
Sikhism was founded in 1469 by Guru Nanak in the Punjab (north west India), where most of the world's 22 million Sikhs still live. There are about 336,000 Sikhs in the UK.

Sikhism is based on the teachings of Guru Nanak and the nine gurus who followed him. The community of men and women who have been initiated into the Sikh faith is called the Khalsa.

Core beliefs	Sikhism emphasises social and sexual equality and stresses the importance of working for the common good, with little emphasis on ritual. Sikhs believe that the way to lead a good life is to: • keep God in heart and mind at all times. • live honestly and work hard. • treat everyone equally. • be generous to the less fortunate. • serve others. Like Buddhists, Jains and Hindus, Sikhs believe in reincarnation.

Festivals and holy days

- Baisakhi – April 13 or 14. Sikh New Year, remembering 1699, when Sikhism was first identified as a shared faith.
- Birthday of Guru Gobind Singh – January.
- Birthday of Guru Nanak – November.

Prayer, worship and holy texts

- The Guru Grant Sahib is a revered scripture that may be wrapped in a golden cloth.
- It should not be touched or moved without permission.
- Rahit Nama is a code of discipline, a concept of great importance.
- Sikhs worship in a Gurdwara, which means ‘gateway to the Guru’.

Names and titles

- Sikhs usually have a personal, religious and family name.
- Sikhs rejected the caste system in India and do not use their family name as it often relates to social status or their place of origin.
- The religious name is used as a last name by most Sikhs: men may have the surname ‘Singh’ and women may have the surname ‘Kaur’ or ‘Singh’.

Dress code

- For female patients, modesty is very important. Women may wish to cover their arms and legs.
- Women may want to cover their head at all times.
- Do not remove the turban of a male patient in a public place.
- Sikhs of both sexes live by the 5 'Ks', which must not be removed:

    - Kesh: uncut hair
    - Kangha: wooden comb
    - Kara: bracelet
    - Kirpan: short sword
    - Kachhera: shorts

Not all Sikhs observe all of the five Ks. For example, some may cut their hair.

Diet and fasting	• Orthodox Sikhs are usually vegetarian. • Often will not eat fish or eggs. • If the person does eat meat, it should never be halal because of the slaughter method. • Running water or a bowl of water is needed before meals. • Smoking, alcohol and other intoxicants are forbidden for orthodox Sikhs.
Death and dying	• Never remove any of the 5 Ks (See: Dress code). • A dying patient may recite religious words, or a relative may wish to recite for the patient. • Their head should always be covered. • Patients may want to listen to taped music near the expected time of death. • The family will usually wash the deceased. • The face should look peaceful, with the eyes and mouth closed. • The person handling the deceased should preferably be the same gender and, if possible, a Sikh. If not, there should be minimal touching of the deceased. • The deceased patient should be covered in a plain white sheet, preferably with no emblems or writing. The deceased patient should at no time be left naked. • Expect lots of relatives and loud expressions of grief. Move the deceased to a separate room or to the viewing room as soon as possible. • Sikhs are cremated, not buried, preferably within 24 hours of death. • It is usual to have a funeral for stillborn babies and late miscarriages, and this could include cremation. Best practice is to encourage the family to arrange a

	funeral, although bereavement officers are able to offer a basic service.
Organ transplants, blood transfusions and post-mortems	• There is no religious objection to blood transfusions, organ transplants or postmortems, but these may be refused on cultural grounds. • Who you talk to, the tone of voice and how you ask will be important. For example: 'Would you find it acceptable for the hospital to remove an organ from your loved one to help another person who is seriously ill?'
Other health care issues	• Will want to die conscious and awake, and at home if possible. • Ensure that single-sex facilities are made clear and that the Trust's single-sex policy is in force for ward bays. • The person's culture may mean that they would prefer clinical treatment from a person of the same gender. • Running water or a bowl of water will be needed after using the toilet or bedpan. • May not be possible to carry out a scan such as an MRI unless the patient agrees to removal of the Kara (bracelet), so discuss this sensitively. • Unless impossible, leave the Kara in place during surgery using tape. • Do not cut or shave hair without discussing this with the patient first.
Family planning and fertility treatment	• Most methods of contraception are acceptable. • Abortion is only acceptable if the mother's life is in danger.
Women and children	• A naming ceremony takes place soon after birth. • Family prayers are very important at birth and in times of crisis.
Useful contacts	**Spiritual and pastoral care team** The team has a number of Christian chaplains and other members of the team who are able to advise. Please contact them either in person in the Kenwood wing of Whittington Hospital or: • Tel: 020 7288 5337 • E: whh-tr.chaplaincy@nhs.net **Network of Sikh Organisations UK** Network Of Sikh Organisations | Where Unity Is Strength (nsouk.co.uk)

Spiritualism

Spiritualism is an umbrella term for a diverse range of groups that includes Christian Spiritualists and New Age Spiritualists. Around 32,000 people in England and Wales describe themselves as Spiritualists.

Being a Spiritualist is not the same as being spiritual. Spiritualists believe that there is a spiritual world and that the spirit survives the physical world to make further progress in another realm. However, not all Spiritualists believe in reincarnation.

Spiritualists may believe in, or use, a medium to communicate with spirits on the 'other side'. They may also believe in 'wise spirits' that have a special knowledge of the person's past relations. Spirits are believed to be able to access the physical world directly through knocking, moving objects or showing certain symbols.

Main health care issues	• Healing is a strong part of a Spiritualist's religious traditions, although beliefs about its role in a person's physical recovery vary greatly. • Some people may use a spiritual healer. • Alternative therapies such as reiki and reflexology are popular. • Essential oils may be used. • Crystals are sometimes used by New Age Spiritualists to 'cleanse' the air around a person.
Useful contacts:	The Spiritualist Association of Great Britain The Spiritualist Association of Great Britain | Home (sagb.org.uk) 020 7931 6488 North London Spiritualist Church 425 Hornsey Road, London N19 4DX 020 7272 0438

Zoroastrianism

Introduction
Zoroastrianism was founded in eastern Iran by the prophet Zarathushtra. The name of the religion derives from the Greek for Zarathushtra's name, Zoroaster.
Today, there are about 200,000 Zoroastrians around the world. The majority can be found in India and Iran. Indian Zoroastrians are also known as Parsis. There are around 3,700 followers in the UK.

Core beliefs	Zoroastrians are encouraged to life live to the full while being honest, charitable and ethical. Teachings focus on a three-way pattern of devotion: • Humata – good thoughts. • Hukhta – good words. • Hvarshta – good deeds. Zoroastrians believe in one God, who is an all-knowing friend to all and should not be feared.

Festivals and holy days
Two major festivals are:
- Nao-Ruz (Nawruz)– March. Means 'new beginning' and falls at the time of the Spring Equinox.
- Birthday of the Prophet Zarathushtra – March. Falls on the sixth day of the Zoroastrian year.

Prayer, worship and holy texts
- The Avesta is the Zoroastrian scripture.
- Prayers takes place twice a day, preferably in a prayer room or behind bed curtains to give privacy.
- The kushti, a sacred cord, is untied and held before a source of light.
- Fire is revered, and temples are called 'fire temples'.

Names and titles
- Zoroastrians usually have a first name, their father's first name and a family name.
- A woman's middle name changes to her husband's middle name when she marries.

Dress code
Two items of clothing are worn at all times:
- Sudreh – a white sacred shirt made of muslin or cotton that symbolises purity and good deeds.
- Kushti – a sacred cord worn over the Sudreh.

Diet and fasting	• No specific requirements regarding food and alcohol. • Some may not eat pork or beef. • Some may be vegetarian.
Death and dying	• Death is seen as the work of evil. • Funerals are organised as quickly as possible because a dead body is thought to represent the presence of evil. Any potential delays to the funeral should be clearly explained. • If there are no relatives present, another Zoroastrian should be contacted. • The deceased should be washed and then dressed in white clothing. • The Sudreh and Kushti are worn next to the skin, under the white clothing. • The head may be covered in a scarf or cap. • Cremation and burial are both acceptable.
Organ transplants, blood transfusions and post-mortems	• Transfusions may not be acceptable, so discussion is required. • Post-mortems are only acceptable for legal reasons. • Orthodox Zoroastrians may object to transplants and donation.
Other health care issues	• Running water for washing is essential and a bowl of water with a jug/cup at the bedside is welcome.
Family planning and fertility treatment	• Generally no religious objections to contraception or fertility treatment.
Women and children	• No specific requirements for the birth of a baby. • Children aged between 7 and 15 are admitted to the faith at a special ceremony, called 'Navjote'.
Useful contacts	**Spiritual and pastoral care team** The team has a number of Christian chaplains and other members of the team who are able to advise. Please contact them either in person in the Kenwood wing of Whittington Hospital or: • Tel: 020 7288 5337 • E: whh-tr.chaplaincy@nhs.net **Zoroastrian Centre** 440, Alexandra Avenue, Rayners Lane, Harrow HA2 9TL T 020 8866 0765 ZTFE - Home

Different cultures

African

Africa is such a large continent that cultural identity and practices vary hugely across its regions. Therefore, this guide focuses on some of the ethnic groups which make up significant African communities in our local area.

- Eritrean.
- Ethiopian.
- Ghanaian.
- Nigerian.
- Somali.

Eritrean

Introduction

The Eritrean community in the UK mainly comprises refugees from the region which lies along the Red Sea coast of north eastern Ethiopia. Since 1961, Eritrea has been engaged in conflict or civil war with Ethiopia and as a result, thousands of Eritreans have been forced to take refuge in neighbouring countries like Sudan, and in western countries. Despite gaining independence from Ethiopia in 1993, relations between the two countries have remained unstable.

Language

- Tigrinya and Arabic are the two main languages.
- Many older generation or newly arrived Eritreans do not speak English or write.
- Saho and Tigre are minority languages that are spoken, not written.
- The ethnicity of an interpreter may affect the level of trust that is established
- because of Eritrea's political history. For example, an Eritrean interpreter would be preferred over an Ethiopian who speaks Tigrinya.

Religion

- About 60% of Eritreans in the UK are Christians, mainly Coptic Christian Orthodox. Others are Roman Catholic.
- The main holy days are Eritrean New Year (September 11), Christmas and Easter – these are celebrated later than the UK's Christian calendar.
- Islam.

Diet

- Largely linked to religion.
- Fasting for religious reasons is common among older generation Christians, who often do not eat fish, dairy or eggs on Wednesdays or Fridays.
- The period before Easter is the most common fasting period and is observed by all ages and both sexes.

- Food varies across regions, but examples are injera (bread) and stews made with mutton, beef or vegetables. Most Eritreans like spicy food. Tea is widely drunk and coffee is popular.
- Common foods during times of fasting are dhal, or other pulse-based dishes, vegetables and salads served with rice, pasta or bread.
- Eating with the right hand is common.

Names and titles

- Men are called ‘Ato’ and women ‘Wozeiro’ or ‘Wozeirit’. These roughly equate to ‘Mr’, ‘Mrs’ and ‘Miss’.
- Most Eritreans have a personal name followed by their father’s name then their grandfather’s name.
- Married women often retain their maiden name, but some may change to their husband’s name.

Main health care issues

- Death is very traumatic, with friends and family visiting the bereaved. Mourning takes place over months and years.
- Funerals and burials are a community event and some bodies may be taken back to Eritrea to be buried.
- Elders are treated with great respect, help to settle family disputes and are asked for their advice.
- May not openly share their feelings, and may feel ashamed or be in denial about their condition. Take care to ensure confidentiality is not breached and involve close family members or friends with sensitivity and consent.
- Organ donation may be more acceptable to younger Eritreans who grew up here.
- May need encouragement to keep taking, or to complete, a course of medicine.
- May seek traditional herbal remedies.
- Abortion is not common and may be concealed from the family.
- Sickle cell disease affects this community.
- Eritrean boys are circumcised. This is not religion-specific.
- Female genital mutilation is illegal in the UK but is still a widespread practice in Eritrea.
- It can cause recurring urinary tract infections, painful sex and psychological trauma.

Ethiopian

Introduction

The UK’s Ethiopian community has developed largely in three stages. The majority of the first group came before 1975, for education and business purposes. A second group of political refugees came in the wake of the revolution in 1974 to escape torture, imprisonment and harassment of their families.

The most recent group is chiefly made up of young people who are seeking refuge from the regime's compulsory military service and a picture of worsening political and economic conditions in the region.

Language

- Amharic is the official language and is spoken and read by the majority of Ethiopians in the UK.
- Tigrinya (from the north) and Orominga (from the south) have semi-official status.
- The ethnicity and gender of an interpreter may affect the level of trust that is established – take advice from language support services.
- Many of the older generation and newly arrived exiles do not speak, read or write English.
- Ethiopia is culturally diverse, with a variety of ethnic groups speaking as many as 200 languages and dialects.

Religion

- Islam and Christianity.
- The majority of Ethiopian Christians belong to the Ethiopian Orthodox Church which is closely related to the Egyptian Coptic Church and similar to the Eastern
- Orthodox Church. It has also been influenced by Judaism. The main holy days are Ethiopian New Year (September 11); Christmas; Epiphany; and Easter – these are celebrated later than the UK's Christian calendar.
- Other Christians may attend Catholic, Anglican, Egyptian, Greek and Russian Orthodox churches.
- A few members of the post-revolution generation are atheists.

Diet

- Largely linked to religion. Ethiopian Christians do not eat meat, eggs or dairy on the majority of Wednesdays and Fridays.
- Examples of Ethiopian foods are injera (a spongy pancake); wat (spicy stew); shivro and misir (chickpeas and lentils) and fish. Coffee is very popular.
- Eating with the hand is common.

Names and titles

- Men are called 'Ato' and women 'Wozeiro' or 'Wozeirit'. These roughly equate to 'Mr', 'Mrs' and 'Miss'.
- Elders usually have additional titles.
- Women usually retain their maiden names.
- Christians use a personal name followed by a religious or Christian name and the father's or grandfather's name.
- Muslims adopt a similar system but use Islamic names and additional titles such as 'Hajj' or 'Sheikh' according to their seniority in the religious community. In addition, they may have ceremonial titles such as 'Demino' or 'Garada'.

Main health care issues

- Elders are treated with great respect, help to settle family disputes and are asked for their advice.
- Sickle cell disease affects this community.
- Birth is an extremely important occasion and is accompanied by great festivities.
- Burial is preferred. Funerals are a major community event. Everyone in the community is expected to attend the services and visit the bereaved family.
- Mourning continues over a period of up to one year and on the anniversary of a death for seven years.
- Female genital mutilation is illegal in the UK but is still a widespread practice in Ethiopia. It can cause recurring urinary tract infections, painful sex and psychological trauma.
- An unexplained increase in the number of suicides is a cause of concern to this community.

Ghanaian

Introduction

Ghana is made up of numerous cultural identities linked to language and ethnic group. This means that members of the Ghanaian community can vary widely in their identity. The Ashanti constitute the largest ethnic group.

Language

- Twi (Ashanti, Akans)
- Dagbani, Ewe (pronounced 'ava') Ga, Fanti, Hausa, Nzema and other tribal languages and dialects.

Religion

- People from northern Ghana are likely to be Muslim or Roman Catholic.
- Ghanaians from other areas may be Protestant, Methodist, Seventh-Day Adventist and sometimes belong to small Christian sects.

Diet

- No specific dietary regulations, but can be linked to religion.
- Some members of a family may refuse to eat certain foods out of superstition because they are associated with negative influences within the family.

Names and titles

The traditional naming system is fairly complex.

- Ashantis name their children according to the day on which they were born.
- Children also have personal names and the name of a close relative or family
- friend who has a good reputation. The father's name may be used as a last name, but this is not strictly necessary.
- The Ga-Adangbe people have special names for first-born children. Many family names have particular significance, denoting royal blood or a family's reputation for a high level of education.

Main health care issues

- Sickle cell disease affects this community.
- Some older Ghanaians lack confidence in conventional health services, preferring self-diagnosis or self-medication at times.
- Medicines available over the counter in Ghana may require a prescription in Britain.
- Some patients expect only doctors to give injections and may ask to be referred to a specialist immediately.
- Muslim boys are traditionally circumcised. Non-Muslim boys may also be circumcised.
- Female genital mutilation is illegal in the UK but is still carried out to a significant extent in Ghana. It can cause recurring urinary tract infections, painful sex and psychological trauma.

Nigerian

Introduction

Most of the Nigerians living in the UK come from the Yoruba-speaking South and West and from the Ibo-speaking Eastern areas of Nigeria. The majority came to Britain in order to study.

Language

- Yoruba, Ibo and Hausa.
- Yoruba is widely understood, as it is the language of the capital, Lagos, as is English (often broken or pidgin English).
- Hausa is spoken in the north of the country, and used to be the main common language for business between ethnic groups.

Religion

- Islam and various Christian denominations including: Roman Catholic, Anglican, Protestant, the Church of Christ and Seventh-Day Adventist.
- Most Muslims come from the Hausa and Yoruba areas.
- Roughly half of Nigerians in the UK are Muslim and half are Christian.

Diet

- Largely linked to religion.

Names and titles

- As well as personal names, people may have other names that indicate the day and area in which they were born.
- Some may also have the name of a close relative or friend of the family.
- Some names commemorate an important event.

Main health care issues

- Female genital mutilation is illegal in the UK but is still carried out to a significant extent in Nigeria. It can cause recurring urinary tract infections, painful sex and psychological trauma.

- Sickle cell disease affects this community.

Somali

Introduction

There has been a small Somali community in the UK, predominantly in East London, Sheffield and Cardiff, since the end of the 19th century. The earliest immigrants were merchant seamen whose families stayed behind in Somalia and whom they visited from time to time.

Since the outbreak of civil war in northern Somalia in 1988, a large proportion of the region's population has been displaced. Many thousands have fled to Ethiopia, and also to western countries.

Language

- Somali and Arabic are both widely spoken in Somalia.
- English is understood mainly by the older generation from northern Somalia. This stems from the country's history as a British protectorate.
- Italian is understood mainly by the older generation from southern Somalia. This stems from the country's history as an Italian colony.
- Many newly-arrived Somali refugees have limited knowledge of English.
- A high proportion of the older generation are not literate in any language.

Religion

- The vast majority are Muslim.

Diet

- Largely linked to religion.

Names and titles

- One or two personal names are usually followed by the father's or grandfather's name.
- Family names are not used as they are in the West, so members of the same family do not share the same last name.
- Names may carry a religious title such as 'Aw', which means that the person has memorised the *Qur'an*.

Main health care issues

- Female genital mutilation is illegal in the UK but is still a widespread practice in Somalia. It can cause recurring urinary tract infections, painful sex and psychological trauma.
- Most Somali boys are circumcised.
- The right hand is considered 'clean' for eating, writing and greeting people, as in much of Africa and Asia.
- Bodies are buried, not cremated.

Arabian (Arab)

Introduction

'Arab' is a broad term to describe people of the Middle East and North Africa who speak Arabic and, for the most part, identify with Islamic culture. Arabs in the UK come from Algeria, Egypt, the Gulf states, Iraq, Iran, Lebanon, Morocco, Palestine, Sudan, Syria, Yemen and Somalia.

Language

- Arabic is spoken with a range of accents depending on the person's country of origin.
- All literate Arabs understand, read and write modern Standard Arabic based on Classical Arabic, the language of the Qur'an.
- Many Arabs resident in the UK also speak English and/or French. People of North African origin may, in addition, speak Berber.

Religion

- The majority of Arabs in Britain are Muslim.
- There are two distinct Muslim Arab communities: Sunnis and Shi'as.
- Some Lebanese and Palestinians are Christians, as are Egyptian Copts. Palestinian Christians are Protestant, Catholic or Greek Orthodox.
- The majority of Lebanese Christians belong to the Maronite Church, founded by the followers of St Maron in the 5th Century.

Diet

- Chiefly linked to religion.
- Arabic meals will often include khubz (bread); fava beans; stews; soups; fruit-based desserts and baklava.
- Generosity and hospitality are held in high esteem.

Names and titles

- Arabic names share many similarities with Bengali and Urdu names, because of their common Islamic origin.
- Personal names often have religious significance. Examples include 'Ali', 'Muhammad', 'Ahmad' and 'Fatima'.
- Other commonly encountered male religious names have the prefix 'Abdul'.

Main health care issues

- Arabs generally have great confidence in the medical profession.
- Older Arabs are highly respected and the community has a strong culture of caring for its older people.
- Family members often want to accompany patients to appointments and help to answer questions about their health.
- There may be a reluctance or embarrassment in revealing detailed health information to a relative stranger.
- Only good news about a person's health tends to be given in Arabic countries, so take great care if there is a need to break bad news.

- Patients may be anxious to receive medication as soon as possible.
- Diabetes is relatively common in North Africans.
- Many of the Palestinians, Lebanese, Somalis and Sudanese resident in the UK are refugees.
- Iraqis and Libyans may have felt, or been threatened by, persecution by their own security services.

Bangladeshi

Introduction

Bangladesh was part of Pakistan at the time India gained independence from Britain in 1947. It was known as East Pakistan until it gained independence from Pakistan in 1971.

The first Bangladeshis who migrated to Britain did so mainly for economic reasons. Men came from the agricultural region of Sylheti in the North East of the country from the 1950s onwards, with wives and children often following much later.

Language

- Bengali is the most common first language.
- Levels of literacy are variable – some women may not read or write Bengali and it is more common for men to speak, read and write English, although the person's age may be a factor.
- Younger Bangladeshis and children educated in the UK have more consistent levels of literacy.
- Sylheti, an unwritten dialect, is widely spoken.
- Urdu may also be spoken.

Religion

- The majority are Muslim, but around 10% of Bangladeshis are Hindu.
- A small number follow other religions including Buddhism and Christianity.

Diet

- Mainly linked to religion.
- Typical foods include meat (halal mutton or chicken); fish or eggs and vegetables in a hot spicy sauce; lentils (dhal) and plain rice. A popular drink is cha, a sweet milky tea.

Names and titles

- Men and women have different naming systems. Men traditionally have two or three names: personal, religious and a last name which may be a male title or a family name such as 'Khan'. Last names are optional.
- Sometimes the father's personal name may be used as a last name.

Main health care issues

- Higher rates of smoking in men.
- Patients may prefer injections to oral medication and often will not finish a course of tablets.
- Higher than average rates of angina and heart attack in men.
- Higher than average rates of doctor-diagnosed diabetes in both sexes.
- Anxiety and depression are relatively common.
- Food is eaten with the fingers, and the right hand is considered 'clean' for this purpose. This will affect the placement of a cannula.

- Chewing ‘pan’ after meals is customary for both sexes. Pan is a mixture of leaves, lime betel nuts and other ingredients combined with tobacco leaves. It can cause burns and ulcers and is linked to cancer.
- Families tend to be large, with several generations often living together.
- Higher than average rates of TB.

British

Introduction

The term British can relate to both Great Britain and the United Kingdom (UK). Great Britain is made up of three nations: England, Scotland and Wales. The UK also includes Northern Ireland.

Cultural identity is complex in Britain. English people will often call themselves English or British. Scottish and Welsh people may not use the term British to define themselves. People from all parts of the UK might call themselves European, although many do not, perhaps due in part to the physical separation of the British Isles from mainland Europe.

Scotland and Wales now have more control of their own governments through the devolved Scottish Parliament and the Welsh Assembly, and these play a part in preserving and promoting cultural identity. The issue of political control and religious identity in Northern Ireland was the source of much violence in the late 20th century, and talks continue between the British and Irish governments to end direct British rule.

Historically, the term 'English' has been associated with the white population. Times have moved on and in today's multi-cultural London, non-white populations may call themselves English, just as they may choose to call themselves British, Black British or European. The idea of what it is to be English and what represents English culture divides opinion.

Language

- English is the main language, but there are many different regional accents from around the UK. Literacy levels are generally good due to the education system, but they can vary.
- About 20% of people from Wales speak Welsh as well as English. Welsh language is thriving thanks to bi-lingual laws and policy.
- Gaelic is spoken by a minority of Scottish people who usually also speak English.
- Other languages may be spoken as a first or second language, largely because of immigration from across EU or Commonwealth countries or because people have come here as refugees.

Religion

- Largely Christian, although many people who describe themselves as Christians do not worship on a regular basis, and increasingly British people have no regular faith.
- Around 15% of people in England and Wales say they have no religious affiliation or call themselves an atheist, agnostic or humanist.
- London has churches, mosques, synagogues and other places of worship for most major religions.

Diet

- The British diet has changed dramatically over the last 50 years. Diverse foods from curry and Chinese to pizza and Thai are part of the everyday diet.
- Convenience and takeaway foods are widely available.
- Traditional British foods include sausages and mash; the English breakfast (usually includes sausages, bacon, eggs); fish and chips; pies; and Sunday roasts (most often chicken; pork; beef; lamb).
- Tea has long been a popular drink, but coffee is also widely drunk.
- Drinking beer, wine and spirits is common in pubs and bars.
- People may choose to be vegetarian for humane, rather than religious reasons.
- Many people eat a traditional Christmas dinner of roast turkey followed by Christmas pudding on December 25.
- A Scottish meal of haggis (a mixture of offal held together in a bag), turnips and potatoes is traditionally served on Burns night (January 25).
- Welsh foods include laverbread (made from seaweed) and Welsh cakes but again, these may not be eaten every day.

Names and titles

- Some people will refer to their first name as a Christian name and their last name as a surname. It is better to now ask for a 'first' and 'last' name together with the title by which the person wishes to be known. This reflects the increasing diversity of Britain and different naming systems around the world.
- Mr, Mrs, Miss and Ms are the most common titles in use in the UK. Some people have the title Professor, Sir or Doctor.
- Some married women will choose to keep their maiden name, and others may use it only at work.

Main health care issues

- A funeral director handles most of the arrangements after a person's death.
- Cremation is increasingly common for those without a specific religious need due to a lack of burial space.
- British people can be quite reserved at times of bereavement and may not want to display emotion in public.
- Older people may have very specific values and views about their dignity, privacy and independence that differ from younger members of society.
- An increasing number of people of all ages live alone and families may live many miles apart.

Caribbean

Introduction

Caribbean describes people from any one of a large number of islands in the Caribbean Sea, which can be found between North and South America. The majority of Caribbeans in the UK have Jamaican heritage, but others have their roots in islands that include Trinidad and Tobago, Grenada, Dominica, Barbados, St Lucia, St Vincent and the British Virgin Islands.

Shortages in the labour market after the Second World War led the British government to encourage mass immigration from the Caribbean. Many who came only intended to stay for a few years but the Caribbean community is now well established, with the majority living in London and other major cities including Birmingham, Manchester and Sheffield.

What it means to be Caribbean varies from island to island, and music, language, religion and food all form part of this identity. In the UK, the community is well known for Europe's largest street festival, the Notting Hill Carnival, which provides a link with a diverse range of celebrations taking place in the Caribbean.

Language

- English is widely spoken and written by most Caribbeans in the UK.
- Some speak 'patois', a dialect that combines a number of languages.
- Some Caribbeans may speak French, Portuguese, Spanish or Dutch as a first language.
- Street language, which is both informal and ever-changing, is popular with younger Caribbeans.

Religion

- Due to the islands' varied history, religion can be diverse.
- Many Caribbeans in the UK are Christians – often Evangelists, Pentecostalists, Baptists, Seventh-Day Adventists or Jehovah's Witnesses.
- Others may be Anglicans, Methodists or Roman Catholics.
- Rastafarianism is also popular.
- Islam is also practised.

Diet

- Traditional Jamaican foods are jerk chicken, plantain, roasted corn, yam, ackee and saltfish.
- Trinidad is best known for its curries and rotis (a flatbread).
- Fish, rice and peas (beans) are popular with most Caribbeans.
- Religion may also affect the person's diet.

Names and titles

- In most cases the family name is passed from the husband to the children.
- For some, the family name is inherited from the mother – this may reflect women's family status, which has tended to be stronger than in Europe.

- Greater diversity in personal names may also be found among Caribbean families because of the use of biblical names such as Moses and Esther.
- Caribbeans are also known for creating novel and original first names.

Main health care issues

- Family planning is often guided by the person's religion. Abortion may be unacceptable to Caribbean women.
- There is often an established family support network in the Caribbean community, with the extended family playing an important role.
- Sickle cell disease affects this community.
- Higher than average rates of doctor-diagnosed diabetes in both sexes.
- Higher than average rates of obesity in women.
- Higher than average rates of stroke in men.
- Higher than average rates of high blood pressure in women.
- Higher rates of smoking in men.
- Higher than average rates of diagnosed asthma in boys.
- Relatively high, but unexplained, rates of hospital admission for schizophrenia.

Chinese

Introduction

For the most part, the Chinese community in the UK originated from Hong Kong and the New Territories. Chinese immigration increased in the 1950s and 1960s, which saw a boom in the Chinese restaurant trade.

A smaller number of Chinese come from Singapore and Malaysia, many of whom came to study, with the remainder migrating from Vietnam, Taiwan and mainland China. Chinese people from Vietnam came as refugees, largely after 1978.

Major Chinese festivals are the New Year or Spring Festival (late January or February), Dragon Boat festival (June/July); mid-Autumn festival (late August/September). Exact dates follow the lunar calendar.

Language

- Most people of Hong Kong origin speak Cantonese.
- Hakko or Mandarin may also be spoken.
- Singaporean and Malaysian Chinese speak Hokien, Cantonese or Mandarin as their first language. Taiwanese speak Fukien, Taiwanese and Mandarin. Most Vietnamese speak Cantonese and Vietnamese. See also: Vietnamese.
- All dialects are written in Chinese script, but some younger people prefer to read and write English.
- Many older Chinese do not speak, read or write English.

Religion

- Buddhism.
- Taoism and Confucianism – philosophies rather than religions – are also common.
- Christianity, mainly Roman Catholic, Protestant or Baptist. Most Christians from Hong Kong are Protestants.
- Other religions include Islam and Shamanism.

Diet

- Food is considered important in Chinese culture, not only for social reasons but for physical and mental well-being.
- The harmony of yin and yang, upon which the Chinese often believe the stability of life in general depends, is reflected in the combination of food a person eats.
- Rice is regarded as an essential source of energy and nourishment.
- Religion will also play a part in the person's diet.

Names and titles

- The family name comes first, followed by a one or two part personal name such as Cheung Chi Lam. Women often keep their maiden names.
- Common family names are Li, Zhang, Wang, Zhao, Liu and Chen.
- Many Chinese in the UK have reversed their names to mirror British naming systems.

- Health professionals should check which is the family name. Chinese Christians may have Christian personal names, e.g. John Cheung.

Main health care issues

- There are no official cultural objections to blood transfusions or organ transplants.
- The person may be worried about being 'weakened' by too much blood being taken during tests.
- Figures of authority are respected if the person demonstrates an understanding of Chinese culture, although some may also feel wary.
- Alternative medicine such as acupuncture and Chinese medicines may be preferred over conventional treatment. Chinese men and women have much lower rates of hospital attendance and prescribed medicine use.
- Chinese medical care is based on principles of physical and spiritual harmony within the body.
- Most women prefer to be treated by a female, although the age and seniority of the member of staff may also be a factor.
- Older Chinese may lack familiarity with NHS referral and administration systems.
- Some families choose to wrap the body of the deceased in a special white shroud.
- Most will bury the person in their best clothes.
- Some older people may bring in their own burial gown in case younger relatives do not know how to dress them after their death.
- Post mortems are not prohibited.
- Chinese men and women have lower than average rates of angina, heart attack and obesity.
- The Chinese community is group orientated and members may feel responsible for the behaviour of others within a particular group.

Eastern European

Historically, many Eastern European people have come to the UK as a result of conflict. They include people from Poland, the Ukraine and former Yugoslavian countries such as Bosnia and Herzegovina, as well as the Roma community (See also: Gypsies (Roma) and Irish Travellers).

Refugees from Poland arrived during the Second World War and again in the early 1980s before the fall of communism.

More recently, the war in the former Yugoslavia between Bosnian Muslims, Serbs and Croats brought refugees to the UK in the 1990s and we have seen most recently refugees from Ukraine.

Since 2004, new arrivals were mostly from member countries of the European Union (EU), such as Albania, Bulgaria, Poland, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Slovakia and Slovenia.

Language

- Turkish, Polish and Albanian are the most common of the Eastern European languages that are requested from the Trust's language support services.
- Bosnian people speak Serbo-Croat (now called Bosnian).

Religion

- 95% of Poles are Roman Catholic.
- Bosnia and Herzegovina has Muslims (mainly Sunni) as well as Roman Catholics and Orthodox Christians.
- Most Roma (Gypsies) are Muslim.
- Eastern Europe also has a significant Jewish population.

Diet

- Meat is popular but there is also a preference for seasonal produce such as fresh and dried fruits, nuts and seeds.
- Traditional foods include pickled vegetables, beetroot salads and hearty soups with dumplings.
- Other foods include pies, pastries and dairy produce, with rye breads eaten at most meals.
- May prefer a larger number of freshly prepared smaller meals throughout the day.

Names and titles

- Polish last names have different endings that indicate the person's sex. For example: the suffixes '-wski' and '-ski' are male (Malinowski; Kowalski) and -wska' and '-ska' are female (Malinowska; Kowalska).
- Traditional forms of addressing strangers tend to be preferred. Older Poles would usually expect to be called 'Mr', 'Mrs' or 'Ms'.

Main health care issues

- Family ties are often strong and there are certain roles for certain family members.
- Older Eastern Europeans generally prefer to die at home with their family around them rather than in hospital.
- Respect for community elders is common.
- Attitudes to death largely depend on religious beliefs.
- Eastern Europeans who came to the UK under difficult circumstances may want to keep some cherished possessions with them at all times.
- Abortion is very restricted in Poland and all contraception, except condoms, is prescribed by a gynaecologist and is not free of charge.

Gypsies (Roma) and Irish Travellers

Introduction

Gypsies and Irish Travellers are recognised as an ethnic minority under the Equality Act (2010), which means they are identified as having shared culture, language and beliefs. There are between 200,000 and 300,000 Gypsies and Irish Travellers here in the UK.

Gypsies are also known as Romanies, or Roma. Roma have been part of Western society for many years, although the Romani language has its roots in India. Different groups of Travellers and Roma have been in the UK for many hundreds of years.

Many Irish Travellers came to the UK to work on the canals and railways when the potato famine of the 1840s struck, killing an eighth of Ireland's population. More came after the Second World War as a result of difficult economic conditions in Ireland. More recent Roma communities in the UK include asylum seekers from Eastern Europe.

There is a long history of discrimination and persecution against Travellers and Roma, including many killed by the Nazis in the Second World War. The community still faces difficulties protecting its culture to varying extents across Europe.

Nowadays, the mobility of Travellers and Gypsies is variable. Some move regularly to find new work opportunities, others live in one main area, travelling just a few times a year, and many live in houses. Their shared history and culture remains central to the everyday life of Travellers and Gypsies regardless of which choice they make.

Language

- Most speak English, although Roma from Eastern Europe may not.
- Romani is an unwritten language with Indian roots that is spoken by most Gypsies.
- Irish Travellers may speak Shelta or Gammon.
- Literacy levels can vary, as formal education is not always seen as a priority.

Religion

- There is no Roma religion, but many believe in good and evil magic forces.
- Gypsies tend to adopt the main religion of the country where they live.

Diet

- No particular dietary needs and most foods are eaten.
- Food hygiene and how, and by whom, food is served can be important.

Names and titles

- Children are often named after relations, with some archaic names being passed down through generations.

- A couple may use either of their parent's last names depending on the situation.
- Nicknames are commonly used.

Main health care issues

- Roma people are used to relying on themselves and are likely to look for their own remedies rather than ask for help.
- Irish Traveller communities have the highest death rates from TB in London. Standards of housing and access to basic health services vary considerably.
- Prenatal mortality, stillbirths and infant mortality are significantly higher than the national average1.
- Life expectancy is less than the national average for women and men respectively.
- When death occurs, mourning tends to be for an extended period and there may be large numbers of visitors.
- Gold jewellery is often worn and is a portable symbol of wealth.
- Women may wish to be treated by another female.
- European Roma women wear very modest clothing and may not wish to undress in front of a male doctor.
- Men traditionally tend to make decisions for the family although gender roles in a family are equal.

Indian

Introduction

India is a vast country with a population of about 1.1 billion. Indian culture is very diverse but the two most distinctive cultures represented here in the UK are Gujarati Indian and Punjabi Indian.

Gujarat state is found on the western coast of India and was created in 1960. The majority of Gujaratis in the UK came via East Africa. Towards the end of the 19th century, traders and railway workers settled in East Africa and, under British rule, Gujaratis became prominent in the region's business community. Idi Amin expelled all Asians from Uganda in 1972, which led many Gujaratis to flee to the UK.

The Punjab region straddles the border between India and Pakistan. After the partition of the Indian subcontinent in 1947 into largely Hindu India and Muslim Pakistan, the Punjab was divided along the new frontier. Partition was accompanied by much violence between ethnic groups. Some Punjabi Indians also came to the UK via East Africa as a result of Idi Amin's regime. Indians are the largest single minority ethnic group in the UK. London has the largest Indian population, followed by the West and East Midlands, the South East and North West England.

Language

- Hindi is usually spoken by Gujaratis and Punjabis born in India.
- Gujarati is widely understood by Indian-born Gujaratis and Punjabis.
- Punjabi is the official language of the Indian state of Punjab.
- Gujaratis may also speak the Kutchi dialect.

Religion

- Most Gujarati Indians are Hindu.
- Punjabis in the UK from the Indian state of Punjab may be Hindu or Sikh.
- Punjabis from the Pakistani state of Punjab are Muslim.
- Smaller numbers are Jain; Muslim; Christian or Buddhist.

Diet

- The majority of Gujaratis are strict vegetarians.
- Pulses, vegetables, fruit and spices are eaten at any meal.
- Chass or lassi (liquidised yoghurt) is a popular mealtime drink.
- Meat is eaten by Gujarati Muslims.
- Punjabis enjoy chapatis, nans, parathas and rotis, eating rice less often.
- Milk and its products in the form of malai (cream), paneer (cottage cheese), butter and curds are used in most Punjabi meals.

Names and titles

- Both Punjabis and Gujaratis have Indian, Hindu or Muslim names.
- Gujaratis have a first, middle and family (or sub-caste) name, e.g. Chopra or Patel..
- Gujarati men and unmarried women traditionally use their father's name as their middle name, and married women use their husband's name.

- Using a title and family name or title and full name are often acceptable in the
- UK, e.g Mr Patel or Mr Vijaykumar Patel, but check with the individual.

Main health care issues

- Preferences will usually depend on religious belief.
- Higher than average rates of angina and heart attack in both sexes.
- Higher than average rates of doctor-diagnosed diabetes in both sexes.
- Higher than average rates of stroke in men.
- Ayurvedic medicine is used by some people who also consult Vayds (traditional healers).

Iranian

Introduction

The first Iranians who migrated to the UK were fleeing from political persecution. This followed the 1979 revolution and the fall of the Shah of Iran. Further migration took place between 1980 and 1988, during the war with Iraq. Iran became an Islamic republic under Ayatollah Khomeini, who led the country after the revolution until his death in 1989. Around 80% of Iranians are Shi'a Muslims and the remainder are Sunni Muslims, including the majority of Iranian Kurds.

Language

- Farsi (Persian) is widely spoken.
- Iran's Kurdish population speaks Kurdish.
- A small number from North West Iran speak Turkish.

Religion

- Almost all Iranians are Muslims, the majority being Shi'a.
- Other minority religious groups include Armenian; Nestorian; Bahá'í; Zoroastrian; Jewish; Christian (Roman Catholic and Protestant).
- Main religious festivals are Ashura, the anniversary of the martyrdom of Husain, which falls on the tenth day of the Muslim month of Moharram, and Nowruz, Iranian New Year and the first day of Spring, which falls on March 21.

Diet

- Traditional Iranian food includes rich soups; rice; barbequed meats; pickles;
- pastries; fruit and yoghurt.
- Chai (tea) is often served very hot, black and strong, with sugar on the side.
- Strict Muslims will eat a halal diet.
- Food is usually eaten communally.

Names and titles

- Many last names end '-ni'. For example, Tehrani, Husseini.
- Women retain their maiden names.
- Children adopt their father's last name.

Main health care issues

- Iranians usually place great emphasis on family – ties are strong and there are clearly defined roles.
- Elders have a special role and are consulted on certain issues.
- Health care preferences are mainly linked to religion.
- Most Iranian boys are circumcised.

Irish (Republic of Ireland)

Introduction

Ireland has strong Celtic roots, but the Normans and Vikings also form part of the country's history. Until the 8th century, Irish Christianity flourished as a distinct religion.

Through the 1801 Act of Union, Ireland was made part of Britain. Dublin's parliament was abolished, the country was ruled from London and no Roman Catholics could hold public office.

The first main phase of immigration to the UK came during the potato famine of the 1840s, which is estimated to have killed a million Irish people. The British government of the time is well documented to have done little to help. Many Irish were forced to seek work and survival here, with many more making the journey to North America.

Ireland was divided politically in 1921, and Northern Ireland remains part of the UK today (See also: British). The second main phase of immigration from Ireland came after the Second World War, when the country was facing economic difficulties.

St Patrick's Day (March 17) began as a celebration of Irish culture and heritage in Dublin and is now marked by Irish and non-Irish people in the UK. Organised festivals involving Irish dancing, storytelling and music do take place but for many people the experience is limited to meeting friends in Irish pubs.

Irish Travellers are recognised as a minority ethnic group. (See also: Gypsies (Roma) and Irish Travellers).

Language

- Irish (Gaeilge) is the official language, but it is only spoken everyday by a minority.
- English is the second language but is widely spoken.

Religion

- The majority of Irish are Roman Catholics.
- About 3% are Protestant, which includes the Church of Ireland, Presbyterian and Methodist churches, but that proportion is growing.
- A small but long-established Jewish community.
- Around 6% of Irish have no religion.

Diet

- A wide range of foods are eaten everyday, but meat and potatoes are a popular staple.
- Tea is popular.
- Irish specialities include champ and colcannon (mashed potatoes mixed with spring onions and cabbage respectively); soda bread; the 'traditional fry' breakfast.

- Alcohol is widely drunk socially in pubs and bars and Ireland is famous for
- producing stout, particularly Guinness.

Names and titles

- Some people will refer to a Christian name and surname as their first and last names.
- Mr, Mrs, Miss and Ms are the most common titles. Some people have the title Professor, or Doctor. (no honours, unlike the UK)

Main health care issues

- Slightly higher than average rates of obesity in men.
- Higher than average rates of smoking in women.
- Higher than average alcohol consumption for both sexes.
- Some Roman Catholics will have more relaxed views on contraception and abortion than others.

Japanese

Introduction

The majority of the Japanese community in the UK are temporary residents who have contracts with Japanese companies that operate here. A number of young Japanese also come to the UK to study.

Language

- Written Japanese is extremely complex, with nearly two thousand characters to learn.

Religion

- The majority of Japanese people in the UK are Buddhists.
- Many also practise some of the rituals of Shintoism, a religion with its origins in Japan.
- Present day Shinto revolves largely around visits to shrines at which food offerings are made to the gods.
- Taoism and Confucianism, philosophies rather than religions, are also practised.
- The main religious festivals are the New Year, the Spring festival and the feast of Lanterns (All Souls).
- Christianity is also practised.

Diet

- Japanese dishes usually include rice; pickled vegetables; noodles; miso and seafood.
- Soya protein is commonly used instead of meat.

Names and titles

- There is a preference for formal address and the use of personal names could be considered disrespectful.
- A modern Japanese name comprises a family name, or surname, followed by a given, personal name. When written in Japanese characters, the family name precedes the personal name.
- Common surnames include Sato, Kato, Suzuki and Takahashi.

Main health care issues

- No cultural restrictions for organ donation, transplantation and family planning.
- Cultural values may have a bearing on how the person responds in a health care setting.
- Cooperation among the group is more important than the desire of an individual to put his or her interests first with respect, sensitivity and harmony considered more important.
- May want to avoid confrontation and direct questions that create discomfort or could mean a loss of face.
- Hierarchy, rank, position and status are generally important, and are usually linked to a code of accepted behaviours.

Kurdish

Introduction

Kurdish people are the largest ethnic group without a country of their own. They are scattered across the Middle East and South West Asia, including areas of Eastern Turkey, North Eastern Iraq, North Western Iran, parts of Armenia and North Eastern Syria. This region is called Kurdistan. A small Kurdish community can also be found in the Lebanon. Most Kurds in the UK are from Turkey or Iraq.

Language

- Kurdish is spoken irrespective of country of origin, although there are two dialects: Kurmanji and Sorani.
- Kurdish is usually preferred for interpreting and translation.
- Small numbers of Kurds may speak Turkish.

Religion

- Most Kurds are Muslim.
- Most Kurmanji speakers are Sunni Muslims.
- There are Shi'a Muslims in Southern and Eastern Kurdistan.
- Many Kurds in the UK from Turkey are Alevis, which has links with Shi'a Islam.
- The Birth of the Prophet (Mawlid) is important as well as the main Islamic festivals.

Diet

- Diet varies with the region the person is from, but bread or rice is eaten with all meals and strong, sweet tea is popular.
- Halal meat is usual for many Kurds.

Names and titles

- No specific naming system. Sometimes, a personal name is followed by the father's then the grandfather's name, or by that of a close relative. This reflects the tribal origins of Kurdish society.
- Iraqi Kurdish women tend to keep their name.
- Kurdish women from Turkey tend to take their husband's name.
- Some parents name their children after well-known Kurds.

Main health care issues

- Families gather around a dying parent to ask for forgiveness.
- Family ties, religion and tribal traditions are important when decisions and problems need to be solved.
- Women tend to have high status.
- Although still modest Muslims, women may not wear a veil or be shy of contact with men.
- Most Kurdish boys are circumcised.

Nigerian

Introduction

Most of the Nigerians living in the UK come from the Yoruba-speaking South and West and from the Ibo-speaking Eastern areas of Nigeria. The majority came to Britain in order to study.

Language

- Yoruba, Ibo and Hausa.
- Yoruba is widely understood, as it is the language of the capital, Lagos, as is English (often broken or pidgin English).
- Hausa is spoken in the north of the country, and used to be the main common language for business between ethnic groups.

Religion

- Islam and various Christian denominations including: Roman Catholic, Anglican, Protestant, the Church of Christ and Seventh-Day Adventist.
- Most Muslims come from the Hausa and Yoruba areas.
- Roughly half of Nigerians in the UK are Muslim and half are Christian.

Diet

- Largely linked to religion.

Names and titles

- As well as personal names, people may have other names that indicate the day and area in which they were born.
- Some may also have the name of a close relative or friend of the family.
- Some names commemorate an important event.

Main health care issues

- Female genital mutilation is illegal in the UK but is still carried out to a significant extent in Nigeria. It can cause recurring urinary tract infections, painful sex and psychological trauma.
- Sickle cell disease affects this community.

Pakistani

Introduction

Pakistan is an Islamic republic with over 161 million people. It is the second largest Muslim country in the world. Pakistan's culture is very diverse, largely due the region's history of invasion and occupation by many different peoples. From 1947 until 1971, the nation comprised West Pakistan and East Pakistan (now known as Bangladesh), separated from one another by India.

The Punjab region straddles the border between India and Pakistan. After the partition of the Indian subcontinent in 1947 into largely Hindu India and Muslim Pakistan, the Punjab was divided along the new frontier.

Most of the UK's Pakistani community comes from the provinces of the Punjab, the district of Mirpur in Kashmir, Karachi and Islamabad. Others came to the UK in 1972, when Idi Amin expelled 50,000 Pakistanis and Indians from Uganda, where they had settled in the 19th century. A smaller number come from the North West Frontier along the Afghan border. The largest Pakistani communities are in the West Midlands and Yorkshire and Humberside, followed by London.

Language

- Urdu is Pakistan's official language and a mixture of Persian, Arabic and local languages.
- Punjabi is spoken by people from the Punjab and Mirpur.
- Pushtu is spoken by Pushtu (Afghan) migrants from the North West Frontier province.
- Some Pakistanis in the UK speak dialects such as Sindhi, Baluchi and Kashmiri.
- Literacy levels vary hugely, but may be low for Pakistani-born older women.

Religion

- Pakistan is almost entirely Muslim, including a sizeable Shi'a Muslim community.

Diet

- As most Pakistanis are Muslims, they eat halal food.
- Fasting is known as 'Roza' in Urdu.
- Punjabi food is rich in texture and taste, and includes famous dishes such as Tandoori.
- Nans, parathas and rotis are popular breads.
- Milk and its products in the form of malai (cream), paneer (cottage cheese), butter and curds are used in most Punjabi meals.

Names and titles

- Traditionally, a personal name followed by a middle name which may or may not be an Islamic religious name.
- Women do not traditionally adopt their husband's family name.

- Most names have significant meaning and are often derived from Islamic customs.
- Others may be derived from Urdu or Persian traditions.

Main health care issues

- Preferences will usually depend on religious belief.
- Traditional dress for women consists of a long tunic (kameez) with long or half sleeves worn with trousers cut to ensure modesty. A long scarf may also be worn to cover the head.
- Hierarchy and family ties are often referred to as ‘brethren’ and are deeply rooted in culture.
- Most matters are decided by family consensus and led by male elders.
- Mosques and their leaders play a vital role in social and religious influences.
- Marriage within close family is very common.
- Traditional uani-medicine is used by some people who also consult healers called lakims.
- Higher than average rates of angina and heart attack in men.
- Higher than average rates of doctor-diagnosed diabetes in both sexes.
- Higher than average rates of obesity and high blood pressure in women.

Somali

Introduction

There has been a small Somali community in the UK, predominantly in East London, Sheffield and Cardiff, since the end of the 19th century. The earliest immigrants were merchant seamen whose families stayed behind in Somalia and whom they visited from time to time.

Since the outbreak of civil war in northern Somalia in 1988, a large proportion of the region's population has been displaced. Many thousands have fled to Ethiopia, and also to western countries.

Language

- Somali and Arabic are both widely spoken in Somalia.
- English is understood mainly by the older generation from northern Somalia. This stems from the country's history as a British protectorate.
- Italian is understood mainly by the older generation from southern Somalia. This stems from the country's history as an Italian colony.
- Many newly-arrived Somali refugees have limited knowledge of English.
- A high proportion of the older generation are not literate in any language.

Religion

- The vast majority are Muslim.

Diet

- Largely linked to religion.

Names and titles

- One or two personal names are usually followed by the father's or grandfather's name.
- Family names are not used as they are in the West, so members of the same family do not share the same last name.
- Names may carry a religious title such as 'Aw', which means that the person has memorised the *Qur'an*.

Main health care issues

- Female genital mutilation is illegal in the UK but is still a widespread practice in Somalia. It can cause recurring urinary tract infections, painful sex and psychological trauma.
- Most Somali boys are circumcised.
- The right hand is considered 'clean' for eating, writing and greeting people.
- Bodies are buried, not cremated.

Latin and South American

Introduction

Latin America is made up of the countries of South America and North America, including Central America and the islands of the Caribbean. Most often, the term Latin America is applied to those countries whose people speak either Spanish or Portuguese. However, the French-speaking areas of Haiti, French Guiana and the French West Indies may also be included. Historically, South American countries were colonised by the Spanish and Portuguese but their peoples fought for and won independence in the early 19th century

Over the last 30 years or so, political unrest and persecution have been key reasons for migration to the UK from a number of Latin American countries. For example, Chileans fled General Pinochet's regime in the 1970s and Columbians fled paramilitary and guerrilla violence. More recently, migration has mirrored the increasingly global market place.

Latin America is home to ancient native cultures such as Aztec, Inca and Maya, and to colourful street celebrations like the famous Rio Carnival. In the UK, music, food and dance are common expressions of the social side of Latin American culture.

Language

- Spanish is the official language in all countries except Brazil.
- Portuguese is spoken in Brazil.
- Many in the UK will speak English, but may need an interpreter for detailed health discussions.
- People from Haiti speak French.

Religion

- Most are Roman Catholics.
- Some may follow African-influenced religions.

Diet

- Foods vary across the region and the mix of flavours and styles reflects the European influence and native traditions.
- Typical snack foods are tacos and enchiladas. Soups are common with flavours such as creamed corn, tortilla and chicken.
- Beef is popular with people from the southern countries while more fish and tropical fruits are eaten further north.

Names and titles

- Usually follow Spanish patterns – a first name followed by their father's last name and then their mother's last name. Traditionally, it is the father's last name that would be used with a title such as Señor (Mr).
- Nowadays some may abbreviate or omit their mother's last name.

Main health care issues

- Many Latin Americans are Roman Catholic and this will influence their health care choices.

Tamil

Introduction

The Tamil community in the UK comes mainly from Sri Lanka and the southern Indian state of Tamil Nadu. A minority come from Malaysia and Singapore.

Independence in Sri Lanka saw Sinhalese become the country's official language and Buddhism the main religion. Some Tamils migrated to the UK in the early 1960s, but the majority came as a result of conflict between Sri Lanka's minority Tamil (largely Hindu) and majority Sinhalese (Buddhist) populations in the mid-1980s.

Tamil culture is very similar to Southern Indian culture.

Language

- Tamil is the first language.
- Sinhalese may be spoken.
- Tamils in some countries do not speak Tamil as their main language, but still follow Tamil traditions and practise Hinduism.

Religion

- About 80% of Tamils in the UK are Hindu.
- Around 16% are Christian (Anglicans and Roman Catholics).
- 3–4% are Muslim, mostly Sunni.
- Very small numbers are Jain or Buddhist.

Diet

- Rice and curry for a main meal is usual. Meals are prepared in similar way to Indian foods with more variety in spicing and frequent use of coconut.
- Vegetarian food for Hindus.
- Halal meat for Muslims.

Names and titles

- Names are linked to religion.
- Hindu Tamils use the father's name followed by personal name for men and personal name followed by the father's name for women.
- Christian Tamils use family names as last names.

Main health care issues

- Female patients would usually prefer to be examined by another woman.
- Tamils are generally very shy and will only display their body if absolutely necessary.
- Preferences will usually depend on religious belief.

Turkish

Introduction

London has the UK's largest Turkish-speaking community, most of whom are Turkish Cypriots, Turkish nationals or ethnic Kurds.

Turkish Cypriots have come to the UK since the 1950s, first as workers who were actively recruited to jobs here, and then in the 1960s and 1970s as a result of the bloodshed associated with the creation of the Republic and division of Cyprus.

Turkish nationals came as economic migrants to many cities across Europe in the 1960s and 1970s, and following the military coup in 1980.

Kurdish culture was not tolerated in Turkey for many years, with Kurds not able to speak their own language until 1986.

Language

- Turkish is spoken by Turkish Cypriots, Turkish nationals and ethnic Kurds.
- Kurdish people will usually prefer to speak Kurdish even if they speak Turkish.

Religion

- Mostly Muslim, the majority of whom are Sunni Muslims.
- Kurdish Muslims in the UK tend to be Shi'a Muslims.
- There is also a small Christian community.

Diet

- Traditional foods are soups; rice or bulgar pilaf; spiced lamb meatballs; chicken/lamb baked with peppers and aubergine; grilled fish with lemon.
- A typical breakfast might include tomatoes, cheese, olives, egg, bread and honey.
- Fresh fruit desserts and puddings made with filo pastry and syrups are popular.
- Coffee is long associated with Turkish trade and Turkish coffee is a strong blend.

Names and titles

- A personal name followed by a family name.
- Children take the father's family name.
- Women who marry add their husband's family name to their own or replace their own with their husband's family name.

Main health care issues

- Avoid pointing a finger directly towards a Turkish person as it is considered rude.
- May say 'Yes' by nodding their head forward and down and 'No' by nodding the head up and back, lifting the eyebrows at the same time.
- The sound 'Tsk' also means 'No'.
- Shaking head from side to side means 'I do not know'.

- Cleanliness is of great importance and frequent washing is common, preferably with flowing water.
- Offer a cup/jug and bowl of water for patients who are unable to leave their bed.

Vietnamese

Introduction

Since 1975, and particularly after 1978, many Vietnamese fled their country for political and economic reasons. A substantial number settled in the UK, many via Hong Kong.

Over 70% of Vietnamese immigrants are ethnic Chinese, approximately 16% are ethnic Vietnamese and the remainder are Laotians or Kampucheans. Most of the Vietnamese refugees in the UK come from rural areas of what was formerly North Vietnam.

Vietnamese people celebrate the Chinese New Year. Another main occasion for celebration is the Family Festival which falls on the fifth day of the fifth month of the lunar calendar.

Language

- Many Vietnamese people speak Vietnamese and Cantonese.
- Migrants from rural areas often have low literacy levels in their language.
- Levels of literacy and spoken English are low in first generation Vietnamese immigrants.

Religion

- Mainly Buddhism, plus influences from the Chinese philosophies of Taoism and Confucianism.
- Many Vietnamese grew up in an atheist environment under the communist government.

Diet

- Rice is a common staple in the Vietnamese diet.
- Some Vietnamese are vegetarian.
- Some don't eat meat for up to ten days each month and some don't eat meat in July.

Names and titles

- A family name followed by a middle name then a first name. This is often reversed in the UK to mirror British naming traditions.

Main health care issues

- Strong obligations to family members and respect for older people.
- The concept of self-reliance is important.
- Lowering the eyes when speaking to a more senior person is a sign of respect.
- Cremation is usual.
- Some Vietnamese prefer to be embalmed.
- Religion will determine many health care preferences.

References & Resources

Health Education England the Royal College of Midwives produced a cultural competence e-learning programme for healthcare professionals in the NHS.

The Department of Health and Social Care produced Religion or belief: A practical guide for the NHS.

The Royal College of Nursing created A guide to cultural and spiritual awareness (PDF, 255KB).

The Competency Standards Framework for culturally responsive clinical practice: working with people from migrant and refugee backgrounds was created in Australia. Its overarching principles and recommendations for practice are applicable to the UK context.

Blackpool, Fylde and Wyre Hospitals NHS Trust developed guidelines on religious and cultural beliefs (PDF, 390KB).

The NHS Chaplaincy Programme has published guidance on Promoting Excellence in Pastoral, Spiritual and Religious Care.

The Health Care Needs Assessment (HCNA) includes a chapter on Black and minority ethnic groups (PDF, 843KB); Culture, Health and Illness, 4th edition. By Cecil G Helman. London, Arnold. 2000.

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Afghan	2
Eritrean	2
Ivorian	2
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Maltese	2
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Senegalese	2
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Sudanese	2
Swiss	2
Ukrainian	2
Antiguan	1
Argentine	1
Belarusian	1
Chilean	1
Finnish	1
Gambian	1
Guinean	1
Haitian	1
Lebanese	1
Liswati	1
Macedonian	1
Motswana	1
Myanmar	1
Namibian	1
Nigerien	1
Northern Irish	1
Peruvian	1
Russian	1
Seychellois	1
Tanzanian	1
Thai	1
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Meeting Title	**Workforce Assurance Committee**	**Date: 22/07/2024**
Report Title	**People Pulse Results for April 2024**	**Agenda Item: 8**
Executive Director Lead	Liz O'Hara, Chief People Officer	
Report Owner	Eliana Chrysostomou, Assistant Director of Learning and OD	
Executive Summary	The National Quarterly Pulse Survey ran in April 2024 (wave 49). A total of 324 responses were collected from Whittington Health NHS Trust staff. Employee engagement was at 6.61 out of 10, which was slightly higher than the national average of 6.36 for April 2024. This paper summarises the key findings of the national quarterly people pulse results for April 2024. It can be used to support organisational development initiatives and cultural improvement across the Trust. The paper highlights that there is still work that needs to be done to improve wellbeing of staff including communication about changes in the organisation.	
Purpose:	Information	
Recommendation		
Risk Register or Board Assurance Framework		
Report history		

The National Quarterly Pulse Survey ran throughout April 2024 (wave 49). A total of 324 responses were collected from Whittington Health NHS Trust staff. Employee engagement was at **6.61** out of 10, which was slightly higher than the national average of 6.36 for the same period. This paper summarises the key findings of the national quarterly people pulse results for April 2024. It can be used to support organisational initiatives and cultural improvement across the Trust.

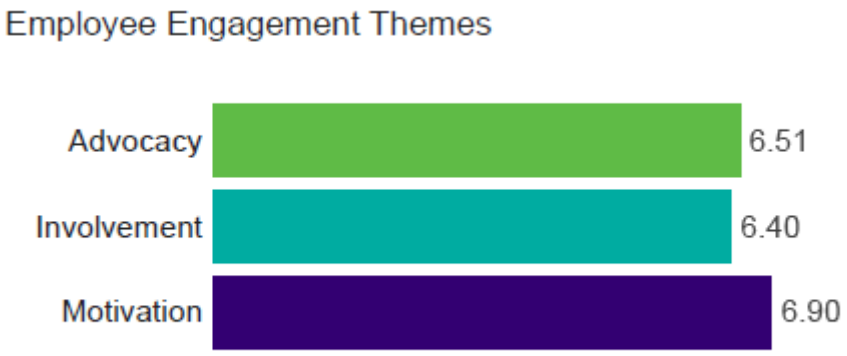
1.0 Employee Engagement

Employee engagement is highlighted to positively correlate with performance, innovation, retention and sickness absence (Engage for Success (2009) report). The NHS Long Term Workforce Plan (2023) supports this with *"we know there is an association between staff experience and engagement, productivity, patient outcomes and safety*".

In the NHS, employee engagement is defined as the combination of **motivation**, **advocacy** and **involvement**. This is measured in the annual NHS Staff Survey and the National Quarterly Pulse Survey through asking the following nine questions:

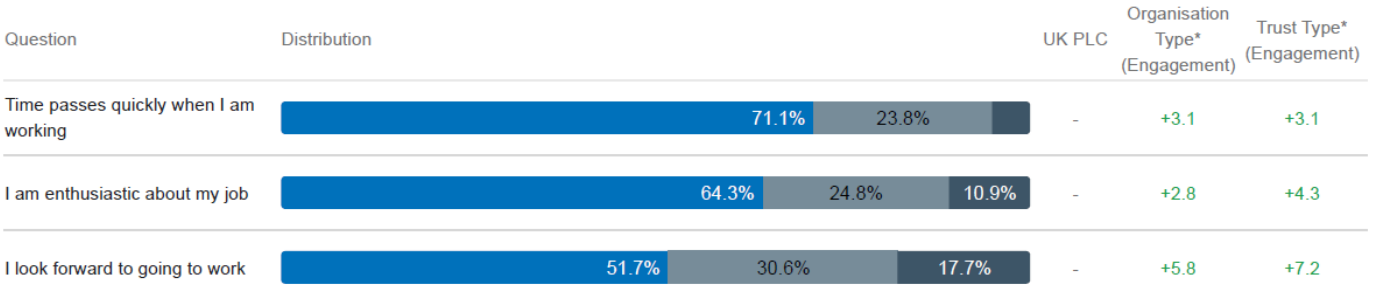
Motivation	Advocacy	Involvement
1. I look forward to going to work 2. I am enthusiastic about my job 3. Time passes quickly when I am working	4. Care of patients/service users is m organisations top priority 5. I would recommend my organisation as a place to work 6. If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation	7. There are frequent opportunities for me to show initiative in my role 8. I am able to make suggestions to improve the work of my team / department 9. I am able to make improvements happen in my area of work

Figure 1: Engagement Themes



The engagement themes for April 2024 tells us that advocacy for respondents was at 6.51, with the national average being 6.20. Involvement was 6.40, with the national average being 6.25 and motivation was at 6.90 with the national average being 6.61.

Under the theme of motivation, the results show the following (**figure 2**):



Under the theme of involvement, the results show the following (**figure 3**):

Question	Distribution	UK PLC	Organisation Type* (Engagement)	Trust Type* (Engagement)
I am able to make suggestions to improve the work of my team / department	68.4% 14.3% 17.3%	-4.6	+4.6	+5.0
There are frequent opportunities for me to show initiative in my role	66.3% 18.4% 15.3%	-	+3.9	+4.8
I am able to make improvements happen in my area of work	55.1% 23.8% 21.1%	-	+3.9	+4.7

Under the theme of advocacy, the results show the following (**figure 4**):

Question	Distribution	UK PLC	Organisation Type* (Engagement)	Trust Type* (Engagement)
Care of patients / service users is my organisation's top priority	72.1% 16.3% 11.6%	-	+7.9	+9.7
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	62.9% 19.7% 17.3%	-	+6.9	+9.0
I would recommend my organisation as a place to work	54.8% 23.5% 21.8%	-20.3	+5.6	+7.4

NB: UK PLC benchmark The benchmark used is the UK PLC benchmark, which is made up of data collected in the last 6 months from UK based organisations across industries. This benchmark will be refreshed each quarter.

2.0 Colleague Mood

Respondents were asked to describe how they were feeling on the day of answering the survey. 66.5% used positive words and 33.5% used negative words. The three top moods included; coping (20.3%), calm (16.8%) and demotivated (12.3%). The graph on page 3 shows all of the results for mood.

Figure 5: Respondents Mood Chart

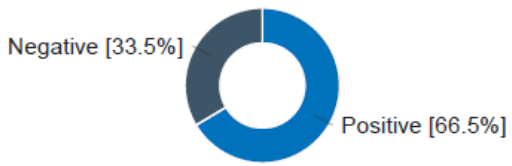
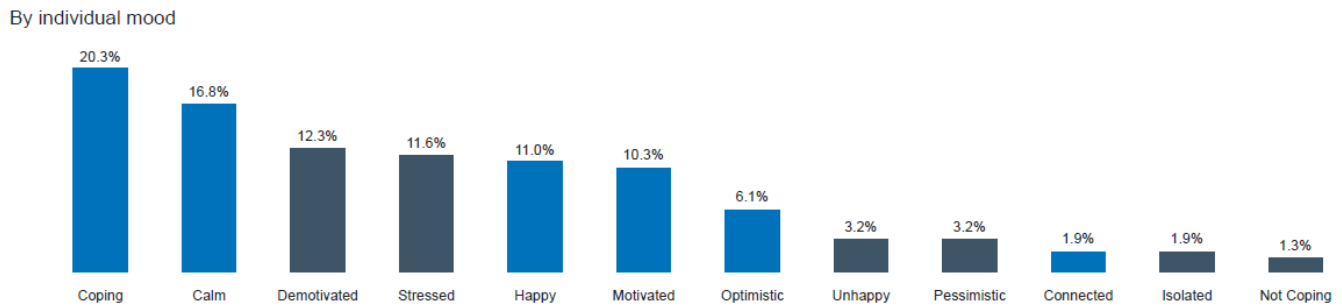
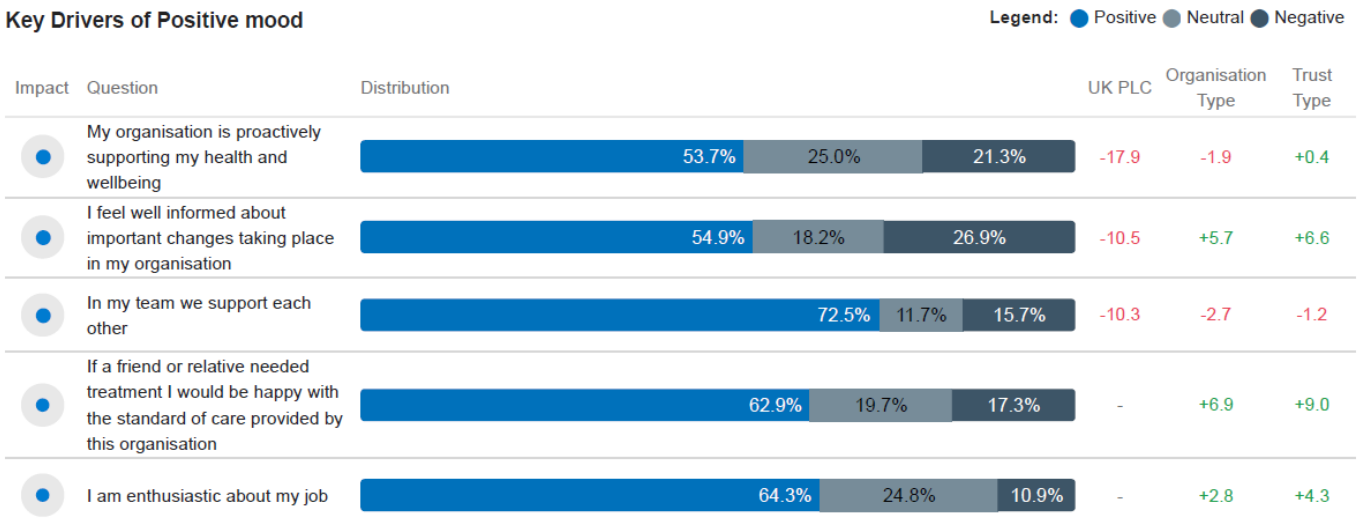


Figure 6: Individual mood words chosen by respondents



The below chart shows the key drivers behind the positive mood and what we can build on and sustain for positive outcomes.

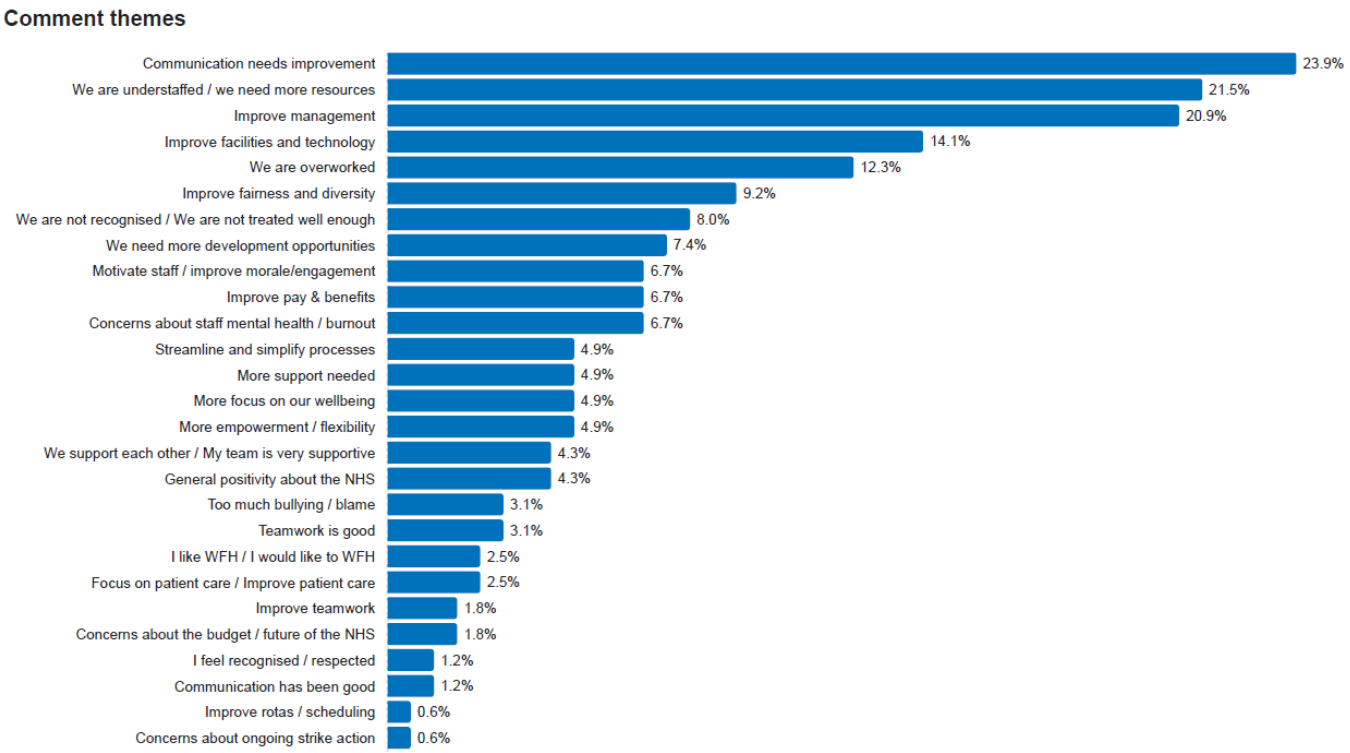
Figure 9: Key Drivers of Positive Mood



3.0 Feedback to the organisation

Staff were asked what one piece of feedback they would like to share with their senior local or national leadership team. **Figure 11** shows that 23.9% of respondents felt communication needs improvement and 21.5% of staff felt that the organisation needs more staffing and/or resources. 20.9% of staff said they would like management to be improved and 14.1% indicated that facilities and technology need to be improved.

Figure 11: Feedback to the organisation



4.0 Comparison of January 2024 and April 2024 Results

The number of respondents dropped from 464 to 324 from January to April 2024 despite following the same communication avenues.

The engagement score has experienced a slight decrease from January's which was 6.66 and in April the level was 6.61. There is a slight dip based on motivation (6.94 in January and April 6.90) and involvement (6.55 in January and 6.40 in April), however advocacy increased in April (6.51 in January and 6.50 in April).

In both January and April 2024, the top three areas staff provided feedback on where "we are understaffed/we need more resources, communication needs improvement and improve management.

5.0 Actions

The Organisational Development team who is leading on the Listening tools, is working on a two-year action plan based on the Trust-wide priorities which are:

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

Since January 2024 actions have been taken as a response to the previous People Pulse results and the 2023 National Staff Survey which include:

- Launched the Community Engagement Roadshow, part of the wider staff engagement strategy to increase awareness and access to staff support services.
- Established a monthly menopause café.
- An ongoing collaboration with Haringey Talking Therapies (formerly IAPT Haringey) to increase access to their Mental health support for our staff.
- Have held a forum to address the findings of the 'Too Hot to Handle' report published in February and ongoing work to address racism and inequalities in the workplace.
- Introduced a healthy eating stall (every Wednesday the hospital's atrium) to promote and support the nutritional wellbeing of staff patients and visitors.
- Increased our cohort of Wellbeing Champions and Mental Health First Aiders who are supported to develop and facilitate impactful peer wellbeing initiatives within a robust governance structure.
- Introduced in-house training to upskill more Mental Health First Aiders.
- Held wellbeing webinars hosted by an external Clinical Psychologist that focussed on navigating complex psychological issues caused by global conflict.
- Better coordinated Critical Incident Stress Debriefs and many teams have benefited from restorative outcome debriefs.
- Led team reflective sessions which are offered to foster healthier and more cohesive teams.
- Implemented manger/leader training on facilitating reflective sessions to reach teams across the organisation.
- Designed and are ready to launch our 'Flexible Working workshops' for managers and staff.
- Launched our new internal talent development programme for BME bands 8A and above called 'Working Uphill', in collaboration with brap, which launched in June 2024.
- Started building a Disability Support Hub which will act as a central repository of information for managers and staff for our intranet.
- Refreshed the disability and reasonable adjustment training to put a stronger focus and mechanisms to support colleagues with long-term conditions.

6.0 Conclusion

There is still work that needs to be done to improve wellbeing of staff. The results showed that having rest breaks is important and access to rest breaks in Whittington Health NHS Trust is limited. There are also improvements needed in making sure the rest areas are of good quality and Estates and Facilities department are starting some work on this.

Communication channels between trust management and staff required improvement including providing support around workload, clarity and wellbeing.

Work to improve People Pulse response numbers is required in order to have a more quantitative data to be representative of the whole organisation.

Meeting title	**Trust Board – public meeting**	**Date:**
Report title	**Finance Report**	**Agenda item: 12**
Executive director lead	Terry Whittle CFO	
Report author	Finance Team	
Executive summary	The Trust is reporting a deficit of £13.8m at the end of August which is £5.4m worse than plan. Trust delivered £5.3m of savings against a year-to-date target of £6.9m for August. Capital expenditure to the end of August was £2.98m excluding IFRS16 against a cumulative plan of £2.25m. The Trust's cash balance at end of August was £58.95m, which is £6.78m favourable to plan.	
Purpose:	To note financial performance.	
Recommendation(s)	To note the financial performance for August	
Risk Register or Board Assurance Framework	BAF risks S1 and S2	
Report history		
Appendices		

CFO Message

Finance Report M5

Trust is reporting a deficit of £13.8m at end of August. This is £5.4m adverse to plan.

The Trust is reporting a year-to-date deficit of £13.8m at the end of August, £5.4m adverse to plan. (£4m excluding Industrial Action impact).

Key drivers impacting year to date adverse performance are:

- Pay overspend relating to
  - Enhanced care - £0.7m
  - Ward general overspends - £0.5m
  - Domestics overspend - £0.4m; and
  - Unfunded pay pressures of - £0.4m.
- Cumulative agency staff costs (£6.9m) represent 4.4% of total pay costs and the national cap is 3.2%.
- Trust spent £2m on additional UEC bed capacity that continues to be open since April. Funding is being sought from NCL ICB to cover cost for reminder of the financial year.
- Non-Pay overspends driven by increased pathology tests (£0.9m), clinical supplies (£0.8m), legal fees (£0.5m) and reactive maintenance (£0.2m).
- Industrial action impact of £1.4m (£0.9m pay cost and £0.5m lost income).
- The Trust delivered £5.3m of savings against a year-to-date target of £6.9m.
  Income was £3.4m above plan explained by £1.9m NHS clinical income and £0.8m non-NHS clinical income. Cumulative underperformance on ERF income of £0.2m;

Cash of £58.95m as at end of M5

The Trust's cash balance on 31st August was £58.95m, which is £6.78m favourable to plan.

Capital expenditure allocation for 2024-25 is £12.2m

Capital expenditure to the end of August was £2.98m (exc. IFRS16) against a £2.25m plan.

Better Payment Practice Performance – 94.7% for non-NHS by value

Overall, the Trust's BPPC is 97% by volume and 93.9% by value. The BPPC for non-NHS invoices is 97.3% by volume and 94.7% by value.

Forecast for 2024-25

The Trust is continuing to forecast to deliver its financial plan (£10.9m deficit) for 2024-25. A series of review meetings focussing on financial recovery and temporary staffing usage was held with the Divisions in September.

Summary of Income & Expenditure Position – Month 5

	In Month			Year to Date			
	Plan	Actual	Variance	Plan	Actual	Variance	Annual Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income							
NHS Clinical Income	26,150	26,690	540	130,777	132,724	1,946	313,930
High Cost Drugs - Income	971	953	(18)	4,807	4,967	160	11,488
Non-NHS Clinical Income	1,657	1,881	224	8,287	9,102	815	19,888
Other Non-Patient Income	2,189	2,193	4	10,947	11,631	684	26,272
Elective Recovery Fund	4,870	4,459	(410)	25,566	25,325	(241)	60,384
	35,837	**36,177**	**340**	**180,384**	**183,748**	**3,364**	**431,962**
Pay							
Agency	(31)	(849)	(818)	(644)	(6,286)	(5,642)	(739)
Bank	(322)	(2,693)	(2,371)	(1,715)	(12,892)	(11,177)	(2,872)
Substantive	(26,557)	(24,503)	2,055	(132,190)	(122,348)	9,841	(319,313)
	(26,911)	**(28,044)**	**(1,134)**	**(134,549)**	**(141,527)**	**(6,978)**	**(322,924)**
Non Pay							
Non-Pay	(7,991)	(7,810)	181	(40,007)	(41,283)	(1,276)	(86,074)
High Cost Drugs - Exp	(883)	(895)	(11)	(4,417)	(4,929)	(511)	(10,602)
	(8,875)	**(8,705)**	**170**	**(44,425)**	**(46,212)**	**(1,787)**	**(96,676)**
EBITDA	**51**	**(572)**	**(623)**	**1,410**	**(3,990)**	**(5,401)**	**12,362**
Post EBITDA							
Depreciation	(1,546)	(1,729)	(183)	(7,740)	(8,541)	(801)	(18,471)
Interest Payable	(69)	(73)	(4)	(346)	(364)	(18)	(830)
Interest Receivable	177	286	109	885	1,661	775	2,125
Dividends Payable	(506)	(506)	0	(2,528)	(2,528)	0	(6,068)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(1,944)	**(2,021)**	**(77)**	**(9,729)**	**(9,772)**	**(43)**	**(23,244)**
Reported Surplus/(Deficit)	**(1,893)**	**(2,594)**	**(701)**	**(8,319)**	**(13,763)**	**(5,444)**	**(10,882)**
Impairments	0	0	0	0	0	0	0
IFRS & Donated	(5)	(5)	0	(25)	(24)	1	(60)
Reported Surplus/(Deficit) after Impairments and IFRIC12	**(1,898)**	**(2,598)**	**(700)**	**(8,344)**	**(13,786)**	**(5,443)**	**(10,942)**

- The Trust is reporting a YTD deficit of £13.8m (excluding donated asset depreciation and impairments) against a planned deficit of £8.3m. This is £5.4m worse than plan.
- Year to date position includes impact of industrial action of £1.4m.
- Included in the year-to-date position is non-recurrent benefit of £3.1m

2.0 Income and Activity Performance

2.1 Income Performance – August

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	1,730	1,772	42	8,538	9,611	1,072
Elective	2,192	2,084	(108)	11,504	11,462	(42)
Non-Elective	4,932	4,481	(451)	24,341	23,731	(610)
Critical care	467	860	394	2,302	2,637	335
Outpatients	4,763	4,295	(468)	24,916	24,476	(440)
Direct access	1,413	1,387	(26)	7,418	7,626	208
Community	6,538	6,538	0	32,689	32,689	0
Other clinical income NHS	5,086	6,227	1,140	23,875	25,459	1,584
NHS Clinical Income	**27,120**	**27,643**	**523**	**135,585**	**137,691**	**2,106**
Non NHS clinical income	1,657	1,881	224	8,287	9,102	815
Elective recovery fund (ERF)	4,870	4,459	(410)	25,566	25,325	(241)
Income From Patient Care Activities	**33,647**	**33,984**	**336**	**169,437**	**172,118**	**2,681**
Other Operating Income	**2,189**	**2,193**	**4**	**10,947**	**11,631**	**684**
Total	35,837	36,177	340	180,384	183,748	3,364

- Income was £3.3m over plan. £2.1m NHS clinical income, £0.8m non-NHS clinical income, £0.2m ERF underperformance and £0.7m other operating income.

- £2.1m NHS clinical income is driven mainly by £0.4m consultant pay award, £0.2m drugs overperformance, £0.9m miscellaneous ICB income and £0.4m foundation trust income. This overperformance is offset by additional cost.

- £0.8m non-NHS clinical income is driven by £1m local authority income relating to Barnet 0-19 (£0.3m), Barnet therapies (£0.3m), PIPS (£0.2m) and start for life (£0.2m).

- £0.7m overperformance on other operating income is driven by £0.2m HSL pathology, £0.1m education & training income, £0.2m research & development and other miscellaneous corporate services income.

2.2 Elective recovery fund (ERF) – August

- Trust is estimated to have underperformed by £0.2m against its elective recovery target of 104%. The position is based on early data and an adjustment for outpatient un-outcome estimate. In month £0.4 underperformance due to £0.2m in month underperformance and £0.2m reduction for previous months.

- EIM & CYP overperformance on ERF is offset by S&C underperformance.

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	1,440	(98)	8,075	8,346	271
EL	7,785	628	596	(32)	3,296	3,077	(219)
OP First	23,493	1,895	1,910	16	9,946	10,015	68
OP Procedure	10,034	809	513	(296)	4,248	3,887	(361)
Grand Total	60,384	4,870	4,459	(410)	25,566	25,325	(241)

ERF Income by ICSU

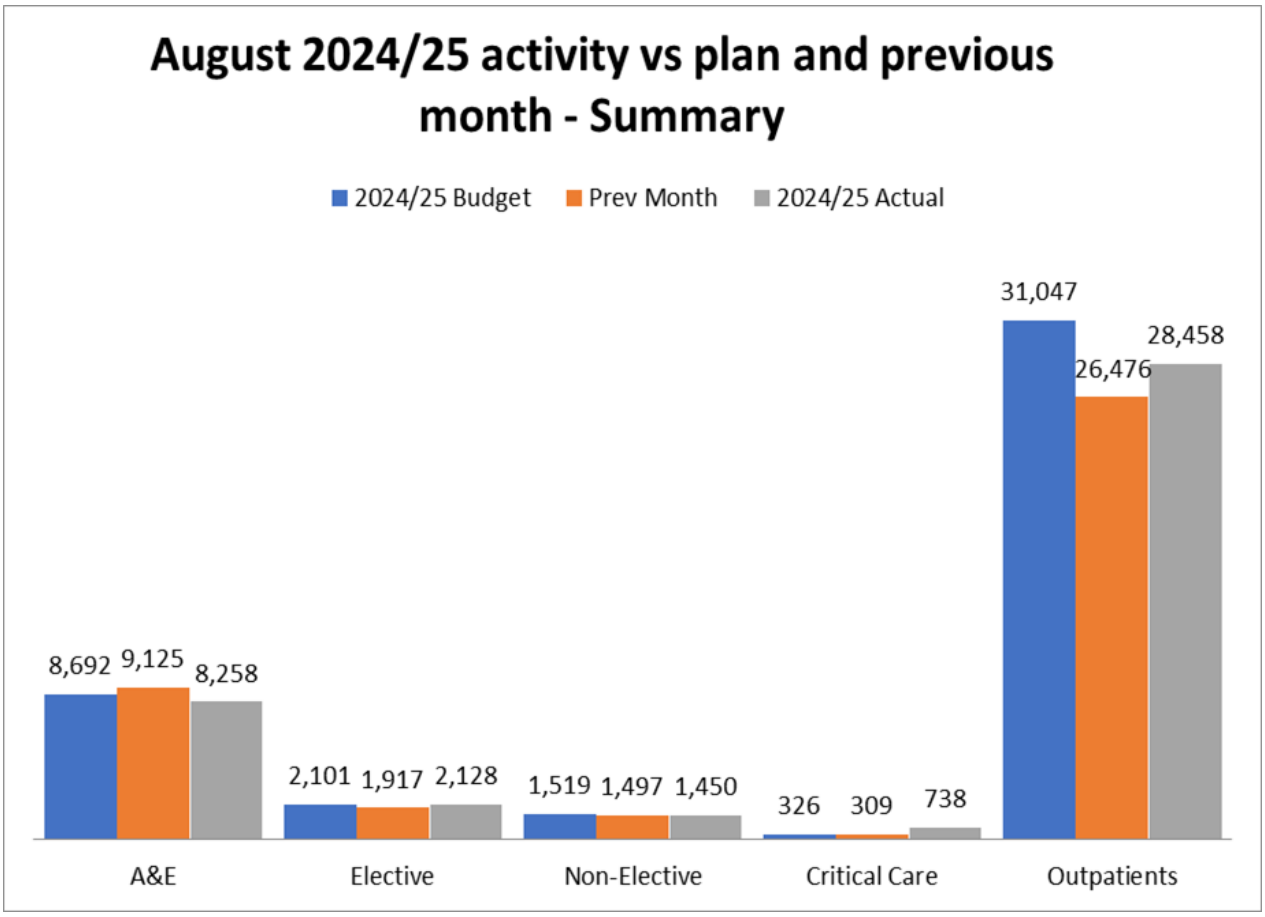
ICSU	Annual Plan £000's	In Month Income Plan £000's	In Month Income Actual £000's	In Month Income Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Income Variance £000's
ACW	7,396	596	607	10	3,131	3,123	(8)
CYP	6,148	496	521	25	2,603	3,129	527
EIM	19,813	1,598	1,616	18	8,389	9,175	786
S&C	27,028	2,180	1,716	(464)	11,443	9,898	(1,546)
Grand Total	60,385	4,870	4,459	(410)	25,566	25,325	(241)

2.3 Activity Performance – August

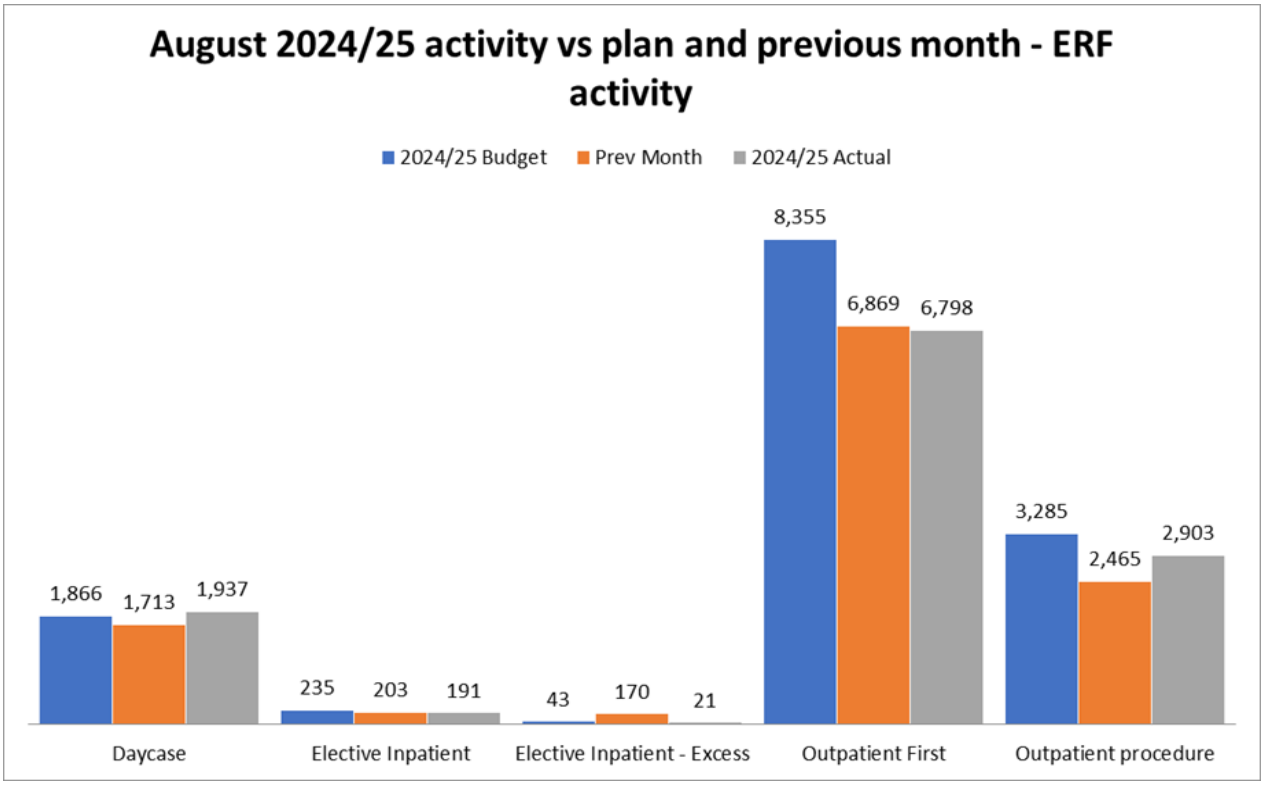
- Activity plan includes two-day reduction to account for summer annual leave. Activity underperformed against plan in all areas, except for elective inpatients and critical care.

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	8,692	8,258	(434)	(5%)	42,899	45,250	2,351	5%
Elective	2,101	2,135	34	2%	11,029	11,859	830	8%
Non-Elective	1,521	1,451	(70)	(5%)	7,505	7,600	95	1%
Critical care	326	738	412	126%	1,610	2,057	447	28%
Outpatients	33,209	30,538	(2,671)	(8%)	173,901	171,708	(2,193)	(1%)
Direct Access	120,129	110,733	(9,396)	(8%)	630,677	643,693	13,016	2%

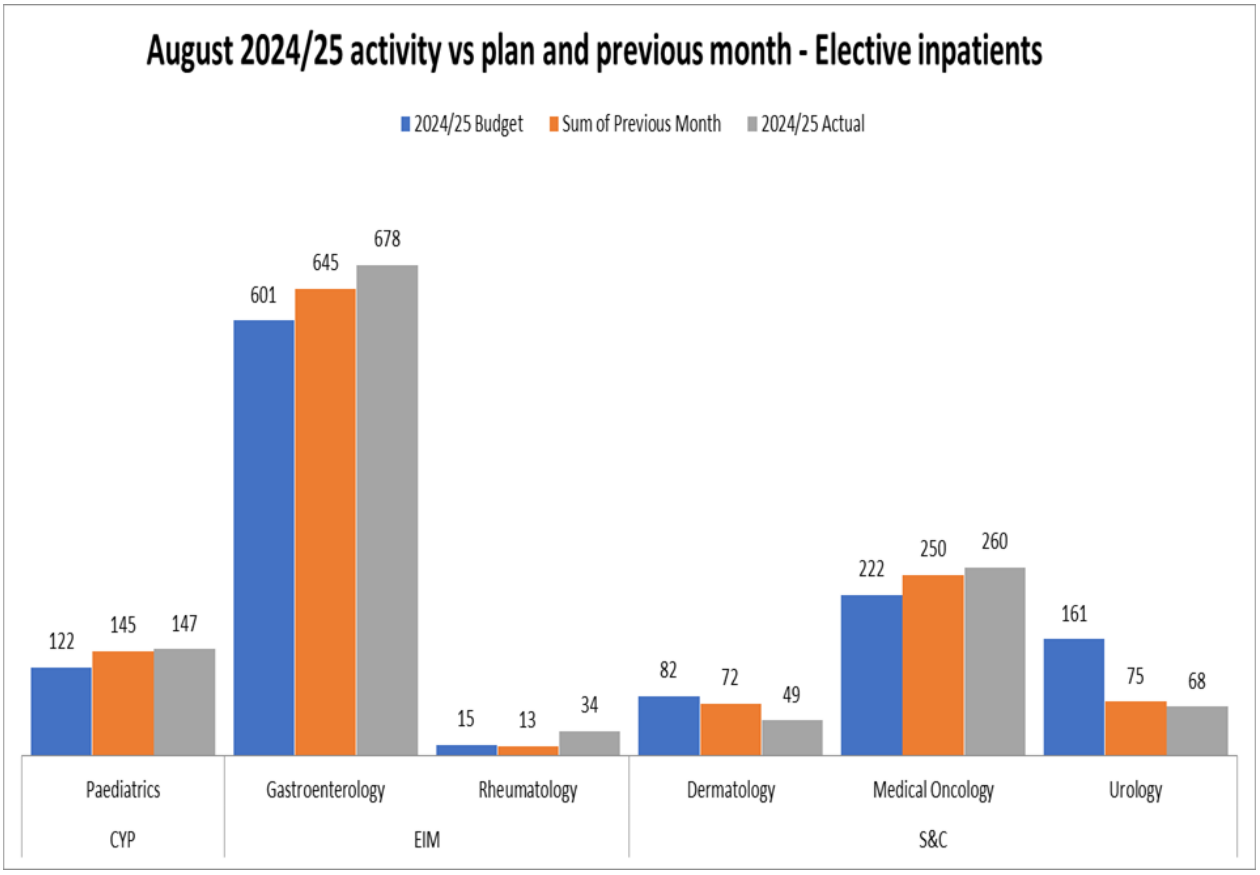
- Activity is slightly higher than July (adjusted for working/calendar days) across all points of delivery, except for A&E and non-elective inpatients. Outpatients likely to be higher when late outcoming is coded.



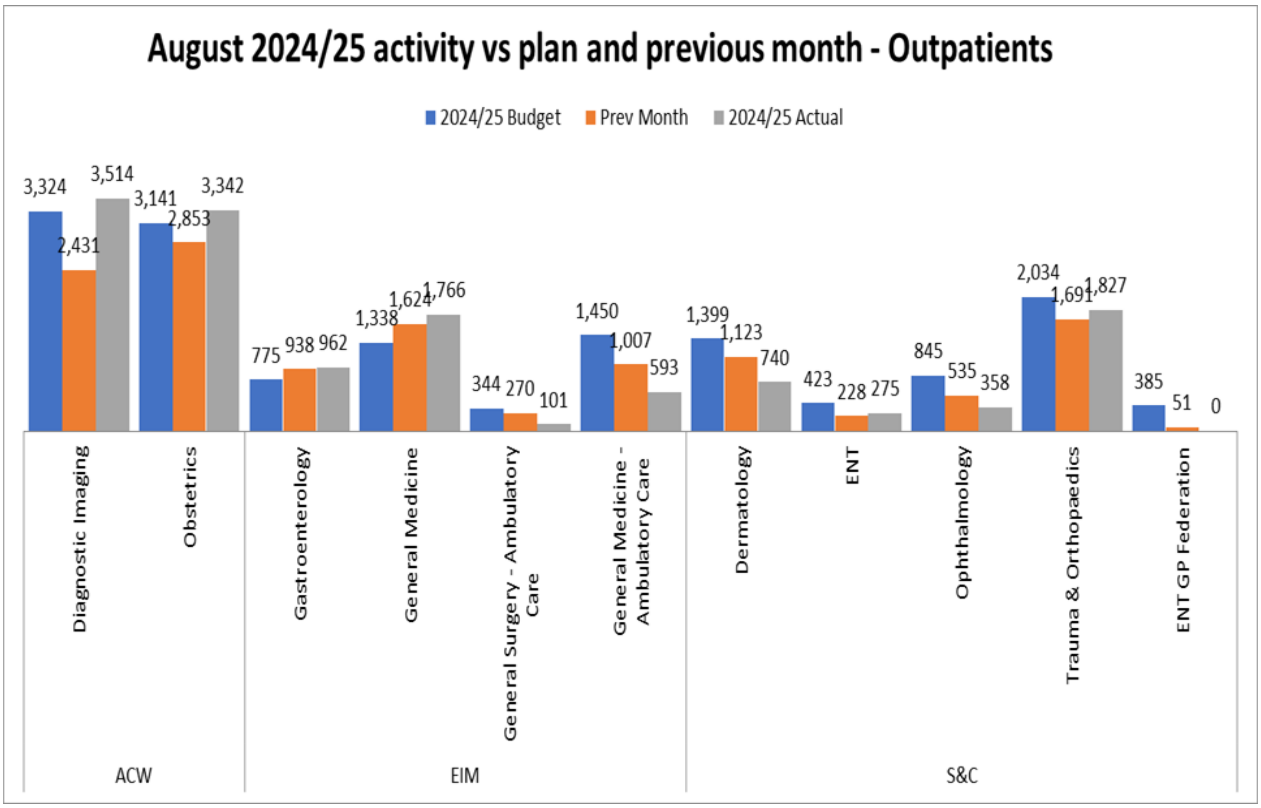
- ERF inpatient activity is over plan, with underperformance in outpatients. Although outpatient underperforming, performance will be improved when late outcoming activity coded.



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



- Outpatients overall underperforming, with significant drivers in surgery and cancer.



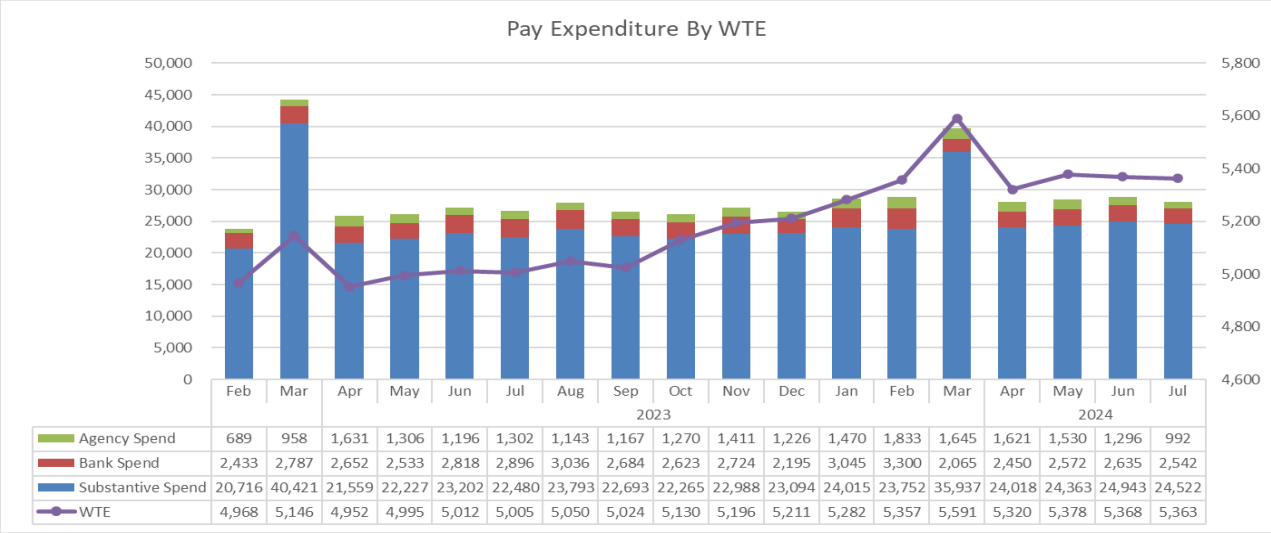
3. Expenditure – Pay & Non-pay

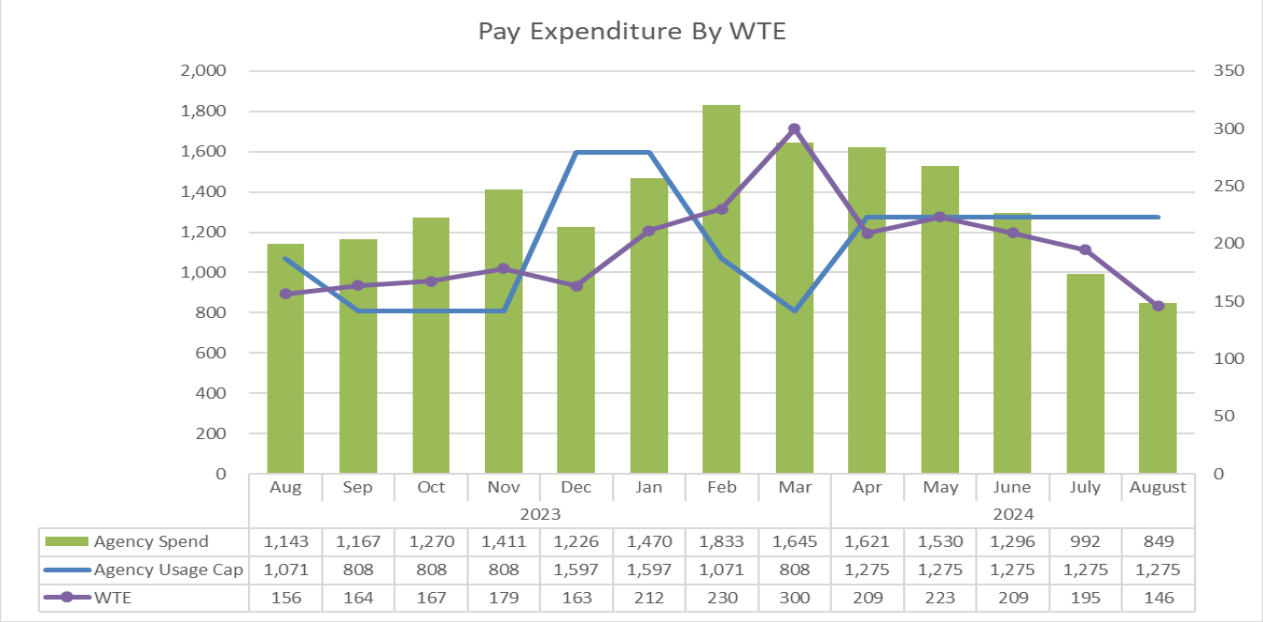
3.1 Pay Expenditure

Pay expenditure for August was £28m. There was a marginal reduction of £0.01m from the July position.

- Increase in bank pay of £151k in month to cover higher annual leave, gaps in junior doctor rotation and vacancies.
- There was a reduction in agency spend of £0.02m compared to prior months. The Trust is breaching the agency cap by £0.6m at end of August.

	2023-24			2024-25					
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Mov^t
Agency	1,470	1,833	1,883	1,581	1,569	1,196	992	971	(21)
Bank	3,079	3,308	2,039	2,442	2,579	2,740	2,542	2,693	151
Substantive	23,906	23,844	24,353	23,407	23,748	24,211	23,853	23,811	(42)
Total Operational Pay	**28,456**	**28,985**	**28,275**	**27,430**	**27,897**	**28,147**	**27,387**	**27,475**	**88**
Non Operational Pay Costs	74	(100)	11,372	658	567	727	669	569	(100)
Total Pay Costs	**28,530**	**28,885**	**39,647**	**28,089**	**28,464**	**28,874**	**28,056**	**28,044**	**(11)**





3.2 Non-pay Expenditure

Non-pay spend for August was £7.8m, a £0.07m decrease from July spend. The decrease mainly relates to the release of bad debt provisions and other non recurrent benefits.

	2023-24												2024-25					
Non-Pay Costs	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**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	4,109	3,775	(334)
Supplies & Servs - Gen	333	376	442	310	440	341	391	332	456	585	294	356	394	417	390	87	347	260
Establishment	263	240	284	237	273	324	320	334	293	517	278	(6)	291	295	354	332	269	(63)
Healthcare From Non Nhs	95	79	85	76	80	75	75	56	75	78	45	(85)	82	115	99	113	103	(10)
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	2,163	1,999	(164)
Ext Cont Staffing & Cons	193	388	265	13	169	218	127	16	152	114	146	117	140	230	192	220	301	81
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	852	1,006	154
Chairman & Non-Executives	9	9	9	9	9	9	9	11	11	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	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**	**7,886**	**7,810**	**(76)**

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**	**Jul**	**Aug**	**Mov^t**
Ambulance Contract	175	206	185	172	199	139	207	137	174	213	75	138	190	171	189	163	196	33
Other Expenditure	155	85	166	100	(483)	66	92	60	120	(289)	144	(10,306)	125	162	(472)	(804)	(64)	741
Audit Fees	15	12	(17)	11	13	11	11	11	11	12	12	0	9	12	15	14	13	(1)
Provision For Bad Debts	65	94	(238)	250	(596)	(212)	57	(34)	34	188	(997)	(15)	(54)	(112)	(190)	(14)	(304)	(289)
Cnst Premium	821	821	821	821	821	577	780	778	765	827	810	827	765	674	765	761	766	5
Fire Security Equip & Maint	5	5	6	10	7	13	4	47	2	11	16	14	9	5	12	4	3	(1)
Interpretation/Translation	27	8	31	21	14	21	10	102	36	15	5	47	42	12	31	27	24	(3)
Membership Subscriptions	125	159	117	161	135	146	146	149	61	119	131	166	141	144	121	141	122	(19)
Professional Services	355	354	115	288	495	399	387	389	374	408	162	(73)	354	263	228	494	168	(326)
Research & Development Exp	(1)	(1)	(1)	4	12	(1)	8	6	286	124	7	312	3	2	1	1	2	1
Security Internal Recharge	10	11	14	13	(0)	12	10	7	10	10	10	12	10	11	10	15	32	17
Teaching/Training Expenditure	66	77	92	89	49	84	152	73	124	30	155	633	62	62	94	46	42	(4)
Travel & Subs-Patients	2	4	4	1	4	0	5	7	0	3	7	3	3	4	1	3	3	1
Work Permits	0	0	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	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**	**852**	**1,006**	**154**

3.3 Cost Improvement Programme (CIP)

The CIP target for 2024-25 is £16.6m. As at M5, £11.4m has been identified (69% of the target). This is an improvement of £1.0m since M4. Identified CIP value includes 80% of ideas in progress, i.e. schemes that Divisions are working on, but have not yet been fully signed off.

72% of the identified schemes are non-recurrent. The 25/26 full year effect of the identified recurrent schemes is £4.1m (24% 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**	63	421	**484**	(1,602)	23%	125	(1,961)	6%
CHILDREN & YOUNG PEOPLE	**3,073**	402	1,022	**1,423**	(1,650)	46%	463	(2,610)	15%
EMERGENCY & INTEGRATED MEDECINE	**2,729**	479	253	**732**	(1,997)	27%	802	(1,927)	29%
SURGERY & CANCER	**2,565**	83	267	**350**	(2,215)	14%	241	(2,324)	9%
ACW	**2,928**	222	590	**811**	(2,117)	28%	251	(2,677)	9%
DIVISIONS TOTAL	**13,381**	**1,249**	**2,553**	**3,801**	**(9,580)**	**28%**	**1,881**	**(11,500)**	**14%**
CORPORATE SERVICES	**1,547**	344	837	**1,181**	(490)	71%	515	(1,156)	31%
ESTATES AND FACILITIES	**0**	806	180	**986**	(561)	64%	904	(643)	58%
CENTRAL	**1,671**	832	4,579	**5,411**	5,411	0%	750	750	0%
TRUST TOTAL	**16,599**	**3,231**	**8,149**	**11,380**	**(5,219)**	**69%**	**4,051**	**(12,548)**	**24%**
CORPORATE									
CHIEF OPERATING OFFICER	87	7	0	**7**	(80)	8%	7	(80)	8%
FINANCE	270	0	513	**513**	243	190%	0	(270)	0%
IM&T	426	170	132	**302**	(124)	71%	328	(98)	77%
MEDICAL DIRECTOR	119	61	34	**96**	(23)	80%	61	(58)	51%
NURSING & PATIENT EXPERIENCE	295	0	23	**23**	(272)	8%	0	(295)	0%
TRUST SECRETARIAT	166	102	10	**111**	(55)	67%	102	(64)	61%
WORKFORCE	308	4	125	**129**	(179)	42%	18	(290)	6%
CORPORATE TOTAL	**1,671**	**344**	**837**	**1,181**	**(490)**	**71%**	**515**	**(1,156)**	**31%**

Trust is reporting actual CIP delivery of £5.3m against a YTD target of £6.9m, i.e. a YTD shortfall of £1.6m (23% of the YTD target).

		2024/25 YTD DELIVERY					24/25 FORECAST DELIVERY		
Divisions	24/25 CIP Target '£000	YTD CIP target '£000	YTD Actuals Recurrent '£000	YTD Actuals Non-Recurrent '£000	YTD Actuals Total '£000	YTD Variance to target '£000	Forecast '£000	Forecast Variance	% of target
ADULT COMMUNITY	**2,086**	869	14	**175**	**189**	(680)	484	(1,602)	23%
CHILDREN & YOUNG PEOPLE	**3,073**	1,280	82	**420**	**502**	(778)	1,423	(1,650)	46%
EMERGENCY & INTEGRATED MEDECINE	**2,729**	1,137	52	**205**	**257**	(880)	732	(1,997)	27%
SURGERY & CANCER	**2,565**	1,069	0	**28**	**28**	(1,041)	350	(2,215)	14%
ACW	**2,928**	1,220	77	**486**	**563**	(657)	811	(2,117)	28%
DIVISIONS TOTAL	**13,381**	**5,575**	**225**	**1,315**	**1,539**	**(4,036)**	**3,802**	**(9,579)**	**28%**
CORPORATE SERVICES	**1,547**	696	87	**668**	**755**	59	1,181	(490)	76%
ESTATES AND FACILITIES	**0**	645	280	**180**	**460**	(185)	986	(561)	0%
CENTRAL	**1,671**	0	0	**2,579**	**2,579**	2,579	5,411	5,411	324%
TRUST TOTAL	**16,599**	**6,916**	**592**	**4,742**	**5,333**	**(1,583)**	**11,380**	**(5,219)**	**69%**
CORPORATE									
CHIEF OPERATING OFFICER	87	36	3	**0**	**3**	(34)	7	(80)	8%
FINANCE	270	113	0	**513**	**513**	401	513	243	190%
IM&T	426	178	21	**132**	**153**	(24)	302	(124)	71%
MEDICAL DIRECTOR	119	50	21	**0**	**21**	(29)	96	(23)	80%
NURSING & PATIENT EXPERIENCE	295	123	0	**23**	**23**	(100)	23	(272)	8%
TRUST SECRETARIAT	166	69	42	**0**	**42**	(27)	111	(55)	67%
WORKFORCE	308	128	0	**0**	**0**	(128)	129	(179)	42%
CORPORATE TOTAL	**1,671**	**696**	**87**	**668**	**755**	**59**	**1,181**	**(490)**	**71%**

4.0 Statement of Financial Position (SoFP)

The net Statement of Final Position as of 31st August 2024 is £222.79m, £2.54m lower than July 31st 2024, as shown in the table below:

Statement of Financial Position as at 31st August 2024	2023/24 M12 Balance	2024/25 M04 Balance	2024/25 M05 Balance	Movement in Month
	£000	£000	£000	£000
NON-CURRENT ASSETS:				
Property, Plant And Equipment	219,465	223,183	221,177	(2,006)
Intangible Assets	5,701	5,221	5,070	(151)
Right of Use Assets	43,136	46,595	46,131	(463)
Assets Under Construction	40,916	34,150	35,752	1,602
Trade & Other Rec-Non-Current	561	533	517	(16)
TOTAL NON-CURRENT ASSETS	**309,779**	**309,682**	**308,648**	**(1,034)**
CURRENT ASSETS:				
Inventories	1,090	1,210	1,270	60
Trade And Other Receivables	27,135	22,410	19,122	(3,289)
Cash And Cash Equivalents	68,549	60,444	58,960	(1,485)
TOTAL CURRENT ASSETS	**96,774**	**84,064**	**79,351**	**(4,713)**
CURRENT LIABILITIES				
Trade And Other Payables	(92,997)	(85,805)	(83,735)	2,070
Borrowings: Finance Leases	235	578	664	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)	(645)	(645)	0
Other Liabilities	(5,470)	(7,919)	(7,281)	638
TOTAL CURRENT LIABILITIES	**(103,379)**	**(98,278)**	**(95,484)**	**2,794**
NET CURRENT ASSETS / (LIABILITIES)	**(6,605)**	**(14,213)**	**(16,133)**	**(1,919)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**303,174**	**295,469**	**292,515**	**(2,954)**
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)	(42,357)	(41,946)	410
Provisions for Liabilities & Charges	(22,827)	(22,778)	(22,778)	0
TOTAL NON-CURRENT LIABILITIES	**(66,657)**	**(70,141)**	**(69,730)**	**410**
TOTAL ASSETS EMPLOYED	**236,516**	**225,328**	**222,785**	**(2,543)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	137,948	137,948	137,948	0
Retained Earnings	16,743	5,555	3,011	(2,543)
Revaluation Reserve	81,826	81,826	81,826	0
TOTAL TAXPAYERS EQUITY	**236,516**	**225,328**	**222,785**	**(2,543)**

The most significant movements in the month to 31st August 2024 were as follows:

NON-CURRENT ASSETS

Non -Current assets closed at £308.65m in August 2024, a net decrease of £1.03m from previous month due the following:

- Capital expenditure for owned assets £0.73m
- Monthly depreciation (£1.73m).

CURRENT ASSETS

Current assets closed at £79.35m in August 2024, a net decrease of £4.71m from the previous month. Principal movements comprised Trade and other receivables (decrease of £3.30m mainly trade debtors and Cash decrease of £1.49m as analysed below).

CURRENT LIABILITIES

Current liabilities decreased by £2.79m in month. Trade and other payables decreased by £2.01m in month and other liabilities increased by £0.64m in month, predominantly deferred income arising from quarterly payment.

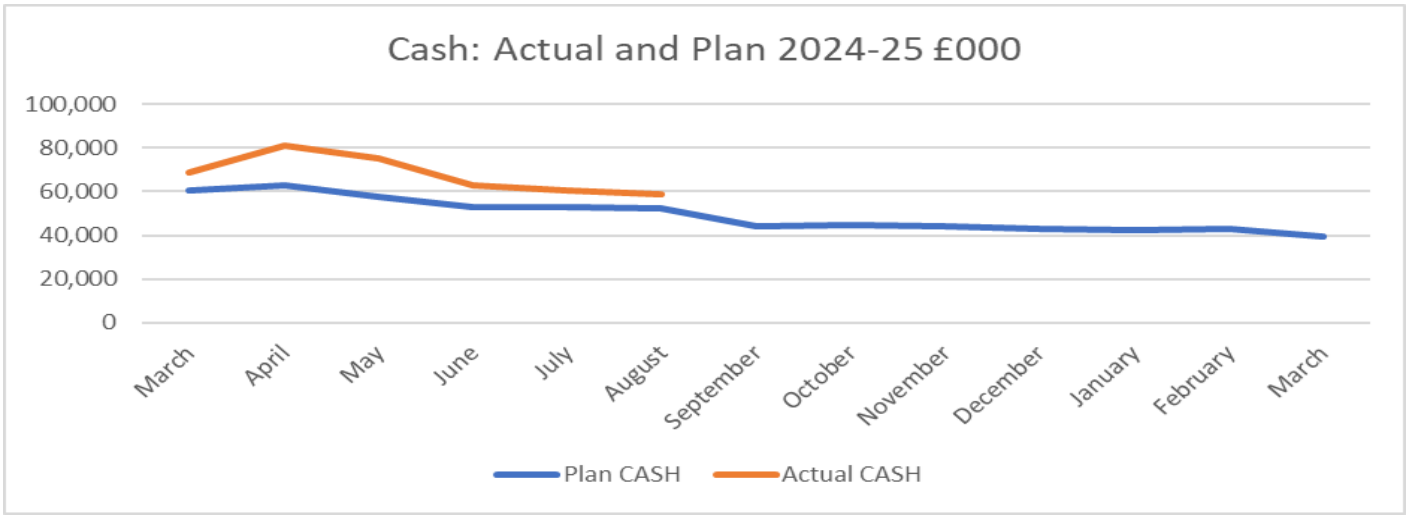
NON-CURRENT LIABILITIES

Non -Current liability assets closed at £41.95m in August 2024, a net decrease of £0.41m from previous month due the following:

- Repayment of the liability for Aug 2024 £0.41

CASH

The Trust's cash balance at 31st August was £58.95m, which is £6.78m favourable to Plan.



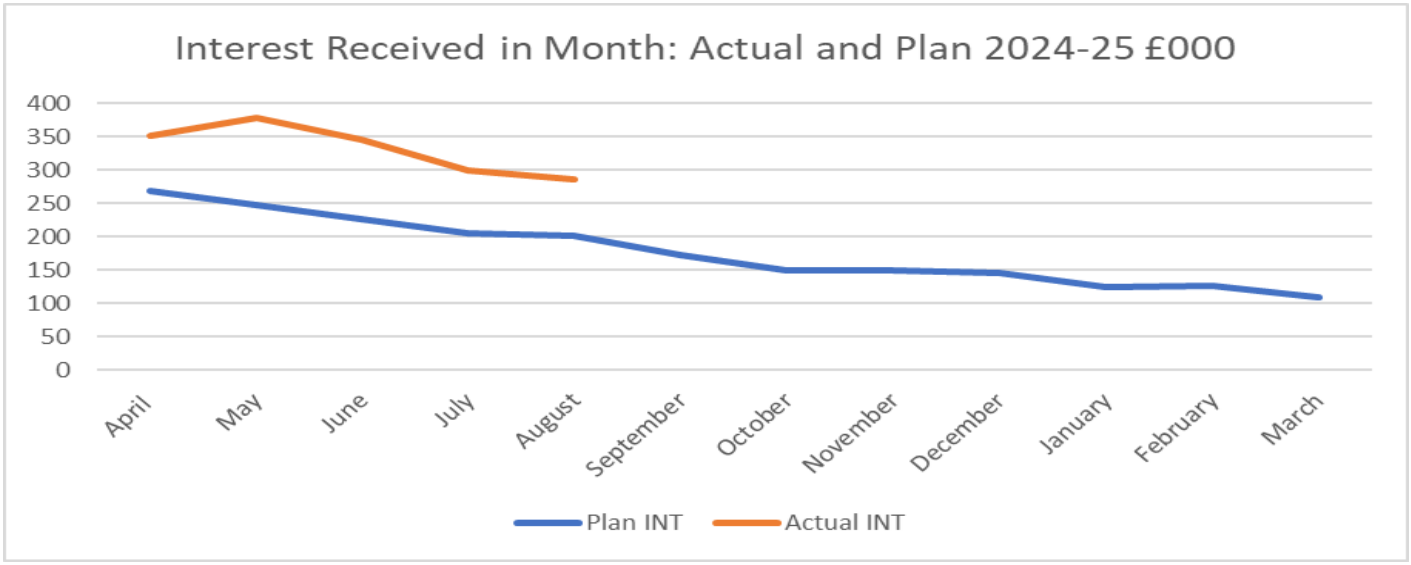
The closing cash balance at 31st August was £1.48m lower in-month due to the following factors:

- Deficit in month £2.6m
- Decrease in capital Trade and other Payables £2.10m

The 2024/25 Plan as revised encompasses a reduction of £20.60m of cash over the 12 months to 31st March 2025. The Trust closely monitors its actual and forecast cash position against Plan.

Interest Received

Year-to-date interest received of £1.66m is favourable to Plan by £0.51m. 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. Encompassed in Plan was a rate reduction for July of 0.49%. The actual reduction was 0.25%, which took effect on 1st August.



5.0 Capital Expenditure

The core capital allocation for 2024-25 has been confirmed as £10.24m, which is significantly reduced from previous years' totals. The Trust has received notification of potential additional allocation of £2.01m to be confirmed comprising of which need to be confirmed soon:

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: M05 Month to 31st August 2024				
	Original allocation £000	Overprogrammed at risk £000	Total Budget M1-12 £000	YTD M05 Actuals £000
Internally Funded:				
Estates Capital 2425	2,836	964	3,800	454
Strategy Capital 2425	5,800		5,800	1,523
Ligature Risks		500	500	8
Fire Remediation BC		2,500	2,500	719
ICSUs 2425	200		200	33
ICT 2425	400		400	33
Equipment 2425	400		400	33
Theatre Upgrade 2324 project				60
Estates Capitalised salaries	600		600	114
Total Internally Funded	*10,236*	*3,964*	*14,200*	*2,977*
Externally funded (PDC):				
DDC: Image Sharing	72		72	
Total Externally Funded	*72*	*0*	*72*	*0*
ROU funded (Leases):				
IFRS16 Remeasurement	5,479		5,479	5,173
Total ROU	*5,479*	*0*	*5,479*	*5173*
Total Capital Expenditure : Actuals	*15,787*	*3,964*	*19,751*	*8,150*

The current year-to-date expenditure at 31st August is £2.98m excluding IFRS16 against cumulative plan of £2.25m. This is comprised of Estates £0.46m, Strategic Projects £2.24m ICSUs, ICT, Equipment and Contingency totalled £0.27m. The Strategic Projects expenditure of £2.24m is comprised of: Mortuary £0.53m, Power Upgrade £0.87m, Fire £0.72m.

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 £0.40m relating to LV intake panel. This is currently on the risk register at a score of 20.

- Further expenditure for 2023/24 projects

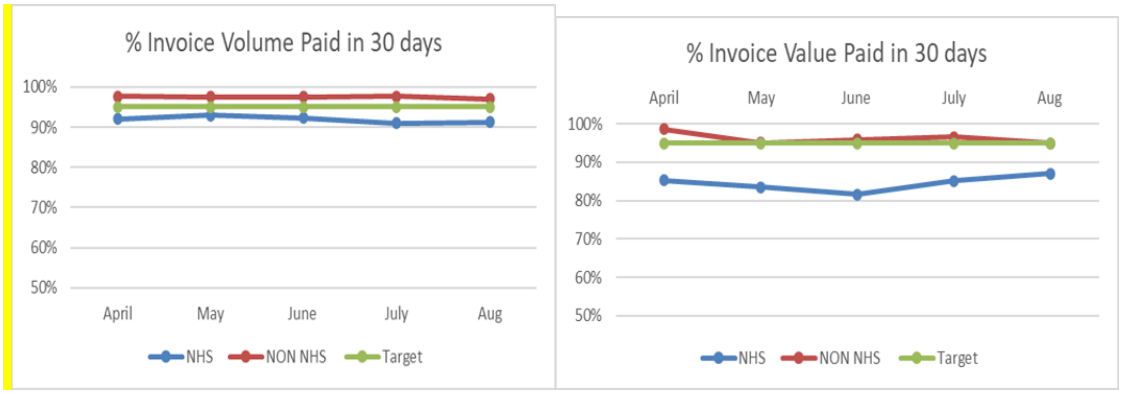
A significant risk to the 2024-25 plan exists in the form of capital projects which were not completed in 2023-24 with expenditure being incurred in 2024-25.

- PACS procurement project

The Trust has been asked to earmark £0.40m 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.

Better Payments Practice Code – Monitoring for 2024/25

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 97.0% by volume and 93.9% by value. The BPPC for non-NHS invoices is 97.3% by volume and 94.7% by value.



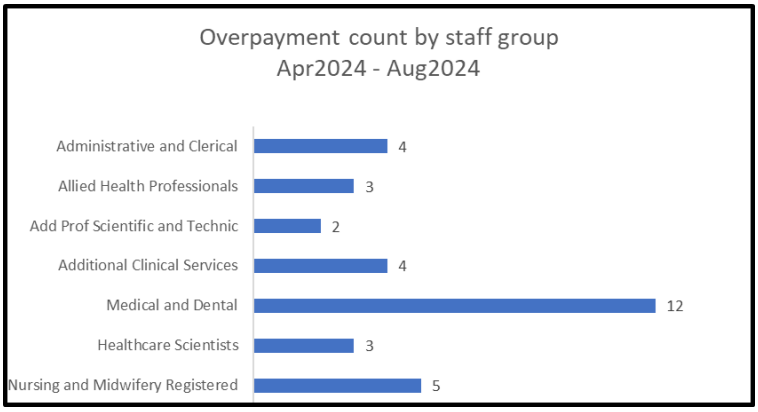
Salary Overpayments

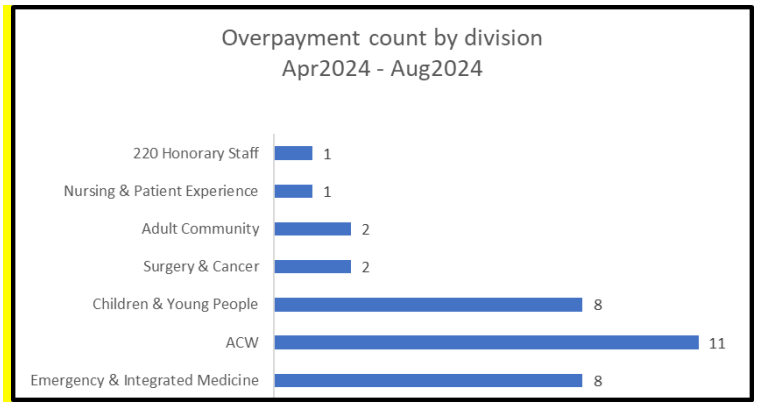
Salary overpayments occur when a member of staff is inadvertently paid more than they are entitled to receive. If the individual is in post when the overpayment comes to light, it is deducted from subsequent salary payments. If the individual has left the Trust's employment, the Trust invoices the individual and pursues 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 caring for its patients.

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 31.8.2024 the numbers are 33 overpayments totalling £33,779.

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





Meeting Title	**Trust Board – public meeting**	**Date: 29.09.2024**
Report Title	**Integrated Performance Report**	**Agenda Item: 13**
Executive lead	Jonathan Gardner, Chief Strategy, Digital and Improvement Officer	
Report Owners	Paul Attwal, Head of Performance, Jennifer Marlow, Performance Manager	
Executive Summary	Board members should note that all metrics are shown in summary, but only certain measures have been highlighted for further analysis and explanation based on their trajectory, importance, and assurance. This report should be read in the context of considerable pressures of high demand in our urgent care and elective care pathways as a result of industrial action. The organisation has put considerable effort at every level to mitigate these issues where possible. **Infection Prevention and Control** During August 2024, there were 5 HCAI C Difficile infections bringing the total to 8 against a target of less than 22 for the year (April 2024 – March 2025), **Emergency Care Flow** During August 2024, performance against the 4-hour access standard was 74%, which is lower than the NCL average of 76.44%, lower than the London average of 78.09%, and the national average of 76.33%. There were 113 12-hour trolley breaches in August 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 68.9% in July 2024 against the standard of 75%. This is a worsening of 1.4% compared to 70.3% in June 2024. 62-day Combined Treatments performance was at 68.9% for July 2024 against a target of 85%. This is an improvement of 3.3% compared to 65.6% in June 2024. At the end of August 2024, the Trusts position against the 62-day backlog was 81 patients. **Referral to Treatment: 52+ Week Waits** Performance against 18-week standard for August 2024 was 64%, this is a worsening of 1.9% from July's performance of 65.9%. The Trust position against the 52-week performance has improved from 395 patients waiting more than 52-weeks for treatment in July 2024 to 349 in August 2024. The Trust had 3 patients waiting over 78-weeks at the end of August 2024 against a target of 0. **Workforce** Appraisal rates for August 2024 were at 78.3%, this is a worsening of 1.1% from July's performance of 79.4%. Work continues to support service areas to improve overall compliance.	

	Complaints Complaints Responded to Within 25 or 40 Working Days has worsened from 77.4% in July 2024, to 47.1% in August 2024, but remains below the required standard of 80%. The Complaints Team continue to work closely with the ICSUs to support with the completion of these and all complaint investigations.
Purpose:	Review and assurance of Trust performance compliance
Recommendation	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan
Risk Register or Board Assurance Framework	The following BAF entries are linked: Quality 1; Quality 2; People 1; and People 2.
Report history	Trust Management Group

Whittington Health NHS Trust

Performance Report

September 2024

Month 5 (2024-2025)

Community - Performance Dashboard

Whittington Health NHS Trust

Indicator	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	2024-2025	Activity
IAPT Moving to Recovery	50.0%	46.8%	45.5%	45.2%	52.5%	48.1%	51.9%	54.9%	49.2%	48.1%	56.9%	54.2%		52.2%	
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	90.7%	91.9%	90.4%	96.6%	91.9%	93.8%	93.0%	95.7%	94.4%	94.6%	95.0%		94.9%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	84.7%	79.5%	74.8%	72.0%	83.3%	84.7%	75.6%	87.4%	78.7%	79.6%	88.1%	72.7%	81.6%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	66.7%	81.8%	94.1%	83.3%	76.1%	88.2%	85.4%	84.2%	90.0%	100.0%	100.0%	91.7%	91.7%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	72.0%	71.2%	73.9%	70.4%	70.3%	71.3%	72.8%	43.8%	76.3%	72.4%	69.9%	78.3%	69.5%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	91.7%	91.7%	95.3%	88.9%	91.5%	90.3%	83.1%	53.6%	84.1%	83.5%	93.1%	95.4%	84.9%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	100.0%	100.0%	50.0%	50.0%	100.0%	80.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	91.7%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 weeks	>45%	54.1%			56.1%			54.5%							

Community Performance Dashboard

MSK: There has been a dip in performance in August 2024 which is under review.

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	Jun-24	Jul-24	Aug-24	Average Wait (Latest Month)	No. of Patients Seen
Community Matron	>95%	6	100.0%	100.0%	100.0%	1.8	28
Adult Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	2.3	55
Community Rehabilitation (CRT)	>95%	12	80.6%	72.5%	53.8%	18.6	39
ICTT - Other	>95%	12	98.2%	97.0%	98.3%	5.2	118
ICTT - Stroke and Neuro	>95%	12	16.7%	9.5%	15.4%	20.0	13
Home-based Intermediate Care Service	>95%	-	61.7%	51.7%	61.4%	7.6	44
Paediatric Wheelchair Service	>95%	8	100.0%	66.7%	75.0%	7.1	4
Bladder and Bowel - Adult	>95%	12	29.3%	57.4%	54.8%	12.0	270
Musculoskeletal Service - CATS	>95%	6	30.6%	35.6%	37.2%	10.3	446
Musculoskeletal Service - Routine	>95%	6	32.1%	38.0%	40.3%	9.8	1478
Nutrition and Dietetics	>95%	6	90.1%	91.9%	96.6%	2.8	118
Podiatry (Foot Health)	>95%	6	20.0%	19.6%	22.4%	12.1	407
Lymphodema Care	>95%	6	44.1%	53.8%	68.0%	4.9	25
Tissue Viability	>95%	6	100.0%	100.0%	100.0%	1.3	51
Cardiology Service	>95%	6	100.0%	100.0%	100.0%	0.9	76
Diabetes Service	>95%	6	67.7%	99.3%	94.4%	4.2	144
Respiratory Service	>95%	6	83.6%	93.0%	100.0%	2.5	46
Spirometry Service	>95%	6	100.0%	100.0%	100.0%	1.9	80
Integrated MDT	>95%	6	89.3%	93.8%	88.6%	1.9	132
Self-Management	>95%	6	45.5%	42.9%	38.5%	8.0	13
Covid	>95%	6	92.3%	84.6%	95.5%	2.6	22
Indicator (Urgent Appointments)							
Adult Wheelchair Service	>95%	2	100.0%	100.0%	100.0%	0.4	1
Community Rehabilitation (CRT)	>95%	2	8.7%	52.9%	52.2%	15.9	23
ICTT - Other	>95%	2	16.7%	25.0%	4.5%	11.2	22
ICTT - Stroke and Neuro	>95%	2	0.0%	25.0%	25.0%	4.0	4
Home-based Intermediate Care Service	>95%	2	83.7%	89.0%	86.7%	1.8	90
Musculoskeletal Service - CATS	>95%	2	14.3%	60.0%	68.8%	1.8	16
Musculoskeletal Service - Routine	>95%	2	52.6%	53.1%	61.9%	2.0	118

Adult Community Waiting Times

Podiatry: Since June 2024, there has been a slight increase in referrals to the service, impacting waiting times. Despite this, the team has made significant progress in reducing the backlog, prioritising those who have been waiting the longest. As a result, the maximum waiting time has decreased from 52 weeks to 30 weeks. However, the increased referrals this month have caused a temporary rise in the average waiting time. The team remains committed to further reducing these times as they continue to work through the remaining backlog.

Islington Community Neuro-Rehabilitation (Formally CRT/ICTT): Recovery in this area has been slow, particularly in Speech and Language Therapy (SLT) and Occupational Therapy (OT), where both fields have faced persistent vacancies and long-term staff absences. To address this, agency staff have been brought in to manage capacity, with a primary focus on reducing long waiting times. Discussions are currently underway regarding collaboration with UCLH therapy services to further support these efforts.

Bladder and Bowel Service: The Bladder and Bowel service remains fragile; however, recovery plans are actively in progress. A nurse lead was appointed this month, and additional operational support has been implemented to help the team manage the current waiting list and caseload. A plan to clear the backlog is in place, with improvements expected to be reflected in the performance data by September 2024.

MSK Routine: The service has made significant progress in reducing backlogs, with the longest wait times now down to 18 weeks. Additionally, the average waiting time has improved, decreasing from 14.1 weeks last month to the current 9.8 weeks.

MSK CATS: There has been a steady improvement in the overall backlog, with consistent progress each month. The average waiting time has decreased from 10.7 weeks to 10.3 weeks, reflecting month-on-month improvement. The service remains on a positive trajectory.

Recovery planning for all other services in red are currently under way

ICARE EQUITY

Children's Community – Waiting Times

Indicator (Routine Appointments)	Target	Target Weeks	May-24	Jun-24	Jul-24	Average Wait (Latest Month)	No. of Patients Seen
CAMHS	>95%	4	44.7%	50.0%	53.1%	11.5	130
Community Children's Nursing	>95%	6	84.3%	86.9%	78.9%	2.6	38
Community Paediatrics - Haringey	>95%	18	76.3%	85.7%	66.7%	14.1	21
Community Paediatrics - Islington	>95%	18	95.5%	100.0%	100.0%	1.3	6
Haringey - SCT	>95%	20	0.0%	0.0%	0.0%	60.6	20
Islington SCT (0-5s)	>95%	20	4.8%	6.7%	14.3%	51.3	7
CLA Initial Assessments - Haringey	>95%	4	100.0%	85.7%	100.0%	1.7	4
CLA Initial Assessments - Islington	>95%	4	25.0%	80.0%	71.4%	3.6	7
Occupational Therapy - Barnet	>95%	18	100.0%	100.0%	100.0%	5.9	33
Occupational Therapy - Haringey	>95%	18	100.0%	100.0%	100.0%	11.3	23
Occupational Therapy - Islington	>95%	18	65.0%	72.7%	20.0%	19.2	5
Paediatrics Nutrition and Dietetics - Haringey	>95%	12	100.0%	83.3%	100.0%	3.4	3
Paediatrics Nutrition and Dietetics - Islington	>95%	12	91.7%	100.0%	100.0%	7.3	10
Physiotherapy - Barnet	>95%	18	100.0%	100.0%	100.0%	5.5	36
Physiotherapy - Haringey	>95%	18	100.0%	100.0%	100.0%	4.3	36
Physiotherapy - Islington	>95%	18	98.6%	98.7%	100.0%	3.2	65
PIPS	>95%	12	100.0%	100.0%	100.0%	2.1	2
SALT - Barnet	>95%	18	73.5%	54.4%	63.7%	17.9	80
SALT - Camden	>95%	6	50.9%	39.5%	45.5%	7.8	33
SALT - Haringey	>95%	13	25.8%	60.0%	51.0%	12.7	51
SALT - Islington	>95%	13	82.4%	76.9%	77.8%	9.8	18
SALT - MPC	>95%	18	81.8%	72.7%	83.3%	10.8	12
School Nursing - Haringey	>95%	12	95.0%	95.6%	96.7%	1.9	30
School Nursing - Islington	>95%	12	93.3%	100.0%	100.0%	1.8	18
Indicator (Urgent Appointments)							
CAMHS	>95%	2	100.0%	100.0%	100.0%	1.0	4
Community Children's Nursing	>95%	1	100.0%	100.0%	100.0%	0.0	5
SALT - Barnet	>95%	6	100.0%	88.9%	83.3%	3.3	6
SALT - Haringey	>95%	2	14.3%	22.2%	50.0%	2.1	2

Children's Community Waits

Autism Assessments

Sustained increased demand for assessments continues to have an impact on waiting times in Haringey and Islington. Here are the detailed figures for July:

Metric	Haringey (0-5s)	Haringey (5-11s)	Islington (0-5s)	Islington (5-18s)
Number of children and young people waiting to start an autism assessment	350	400	353	529
Number of children and young people who started a formal autism assessment in July	19	9	22	27
Average weeks wait from referral to completion of assessment in July	69	69	66	114

NCL providers have collaborated to develop an investment proposal aimed at reducing waiting times, which is currently under consideration by the NCL ICB as part of the NCL Community Services Review Programme.

The proposal seeks to standardise assessment processes and increase capacity across all boroughs in NCL. While service model changes are planned, significant efforts and additional investment are needed to effectively tackle the backlog and substantially reduce waiting times.

Locally, teams are continuing to enhance family support. In Haringey, the social communication team is expanding its offer to children on the waiting list and post-diagnosis, providing a variety of workshops and signposting resources.Meanwhile, in Islington, the social communication team published a summer newsletter featuring top tips and information on summer activities for parents of children with social communication difficulties. A review of the Stay and Play group, introduced in January at Bemerton Children's Centre, found that all participating families would recommend the group to others with preschool children facing social communication challenges. Families also reported that the sessions gave them valuable new ideas for supporting their children.

Safe

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
HCAI C Difficile	<22	Aug	5	2	8	H	
Actual Falls	400	Aug	37	36	176		
Category 3 or 4 Pressure Ulcers	64	Aug	28	26	117	H	
Medication Errors causing serious harm	0	Aug	0	0	0		P
MRSA Bacteraemia Incidences	0	Aug	0	0	2		
Patient Safety Incident Investigations	N/A	Aug	1	1	3		
VTE Risk Assessment %	>95%	Aug	95.4%	96.5%	95.8%		P
Mixed Sex Accomodation Breaches	0	Aug	10	12	69	L	F
Summary Hospital Level Mortality Indicator (SHMI)	1.14	April 2023 - March 2024	1				

Category 3 or 4 Pressure Ulcers - *Target 0*

August Performance – 28 Pressures on 22 Patients

This is a worsening of 2 compared to 26 in July 2024.

Category 3 = 28

Category 4 = 0

Issues: There were no category 4 pressure ulcers acquired in Whittington Health in August 2024. In the hospital setting nine category 3 pressure ulcers developed on seven patients in six clinical areas. In the community setting nineteen category pressure ulcers developed on patients in all six district nursing team caseloads.

Actions:

- The Trust and ICSUs are working through action plans and improvement work as part of implementing the patient safety incident review framework (PSIRF).
- Senior leadership and specialist oversight into supporting teams in implementing improvements.
- Increased engagement with Social Care Partners, safeguarding, and multi-disciplinary teams to support patients where challenges with concordance, carer concerns and equipment has been identified.

HCAI C Difficile

August Performance – 5

This is a worsening of 3 compared to 2 in July 2024.

Issues: There were 4 Hospital onset Hospital Associated (HOHA) C.Difficile cases and 1 Community onset Hospital associated (COHA) cases in August. 3 cases linked to Meyrick Ward.

Actions: All patients have received treatment, and a post infection review has been commenced on each of them. Samples sent for Ribotyping. Multi-disciplinary team involvement occurring to ensure appropriate processes followed and help identify any new learning. Still compiling findings and these will be shared and disseminated to all.

Responsive - Access

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Cancer - 62 Days Combined Treatments	>85%	Jul	68.9%	65.6%	64.1%	H	F
Cancer - % Pathways Received a Diagnosis Within 28 Days of Referral	>75%	Jul	68.9%	70.3%	69.0%		F
Cancer - 31 Days to First & Subsequent Treatment	>96%	Jul	98.1%	83.7%	93.4%	H	F
DM01 - Diagnostic Waits (<6 Weeks)	>99%	Aug	94.3%	94.9%	93.1%		F
RTT - Incomplete % Waiting <18 Weeks	>92%	Aug	64.0%	65.9%	66.9%	L	F
Referral to Treatment 18 Weeks - 52 Week Waits	0	Aug	349	395	2266	L	F
% Seen <=48 Hours of Referral to District Nursing Service	>95%	Aug	94.9%	94.3%	96.4%	L	P
% Of Rapid Response Urgent Referrals Seen Within 2 Hours of Referral		Aug	64.7%	70.9%	71.0%		

What the Data Tells Us	Issues	Actions and Mitigations
Referral to Treatment Incomplete % Waiting <18 Week – *Target 92%* **August Performance – 64%** This is a worsening of 1.9% compared to July's performance of 65.9%.	• Compliance against the 18-weeks standard is declining, this is as a result of changes in ASI management and a Trust wide focus on reducing the over 65-weeks backlog. • All services are now working towards achieving the 65-week target for September 2024. • There were 3 over 78-week waiters at the end of August 2024 that will be treated in September 2024.	• Actions are in place to ensure capacity in September 2024 is prioritised to manage over 65-week patients. • Risks remain in the delivery of compliance against the targets in the following services: Lower Urinary Tract Syndrome, General Surgery, and Orthopaedics.
Referral to Treatment 18 Weeks - 52 Week Waits – *Target 0* **August Performance – 349** This is an improvement of 46 compared to July's performance of 395. At the end of August there were 3 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.* **August Performance – 94.3%** This is an improvement of 0.6% compared to July's performance of 94.9%.	• DM01 performance remains consistent with imaging remaining compliant. • Neurophysiology remains non-compliant following a dip in capacity in August 2024 however plans in place to recover over the next two months.	• Capacity review of Neurophysiology and review of long-term plans for the service are being discussed within NCLs local health care system.

Responsive - Access

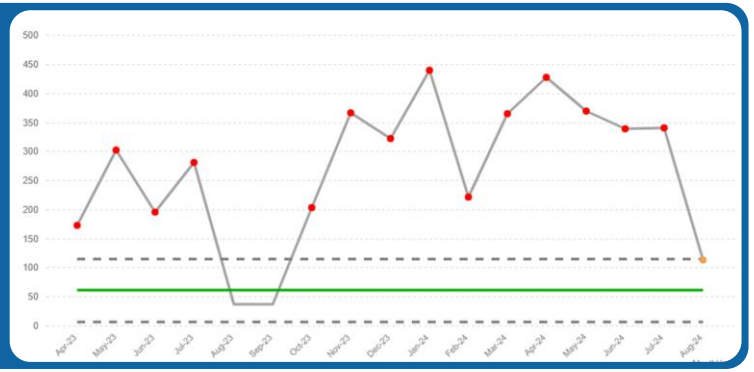
What the Data Tells Us	Issues	Actions
Cancer: 28-Day Faster Diagnosis Standard (FDS) - ***Target >75%*** **July Performance – 68.9%** This is a worsening of 1.4% compared to June's performance of 70.3%.	Breast, Breast Symptomatic, Lung & Upper GI all performed above the national standard for July. • Colorectal performance for July was 69.8%, this is an improvement of 0.6% from June, however performance is still below the national standard. • Average wait time for first appointment in Dermatology is 38 days. FDS position declined by 15.8% in July to 55.9% from 71.7% in June. • Gynaecology performance for July was 41.3%, this is an improvement of 4.6% from June, however performance is still below the national standard. • Urology performance for July was 33.3%, this is a decline of 7.7% from 41% in June.	• The Skin service has been affected by summer leave and high referral demand. A plan for additional weekend clinics is in place, with the first Waiting List Initiative (WLI) clinic scheduled for late September. The skin cancer PTL is currently the largest in the Trust, including ASI referrals. • Urology performance remains challenging due to annual leave and workforce capacity constraints. • The NCL Cancer Alliance has funded WLI weekends for Gynaecology while recruitment progresses for new clinical roles approved in the recent business case.
Cancer: 31 Days to First & Subsequent Treatment - ***Target >96%*** **July Performance – 98.1%** This is an improvement of 14.4% compared to June's performance of 83.7%.	All tumour groups performed at 100% except for the Breast service who performed at 92.3% in July.	• The breast service reviewed booking rules for surgical patients, leading to improved 62-day compliance in July 2024.
Cancer: 62-Day Combined Treatments - ***Target >85%*** **July Performance – 68.9%** This is an improvement of 3.3% compared to June's performance of 65.6%.	Overall trust performance improved by 3.3% to 68.9% in July. Haematology, Skin & Upper GI all performed above the national standard of 75%. • Colorectal performance of 45.5% was impacted by emergency leave required within the surgical team. • Gynaecology performance stayed the same from June to July at 50%. • Lung performance improved to 47.1% in July from 36.4% in June. • Urology performance improved to 63.6% in July from 57.1% in June.	• The colorectal surgical service was impacted by annual and emergency leave, but the issue has been resolved, and August performance is expected to improve. • Gynaecology will begin NCL-funded WLI weekends in September to enhance the front-end of the pathway and improve 62-day performance. • To support the 49-day Lung pathway, wait times for CT Chest scans were audited in July and August, with a median wait of 5 days plus 1 day for reporting. Plans are in place to reduce this to 3 days by the end of 2024. A funding request has also been submitted to the Cancer Alliance to implement EBUS and further improve the pathway.

Responsive - Emergency Care

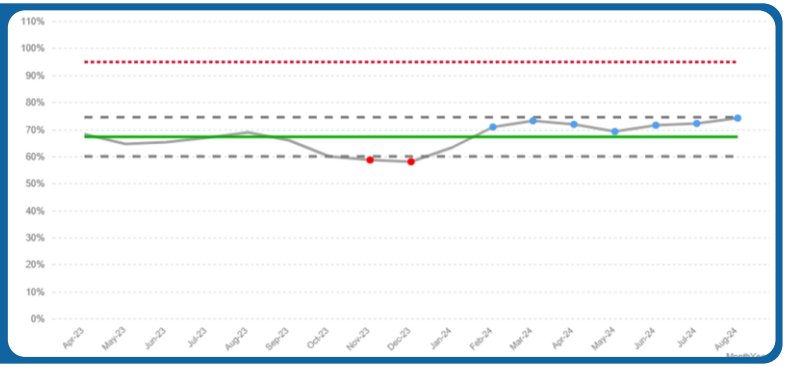
Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Las Patient Handover Times - 30 Mins	0	Aug	40	120	449		
Las Patient Handover Times - 60 Mins	0	Aug	3	10	33		
% Streamed to an Onsite Service	>7.5%	Aug	3.0%	3.0%	3.1%		
Median Wait for Treatment (Minutes)	< 60 min	Aug	76 Mins	86 Mins	87 Mins		
% Of ED Attendance Seen by Clinician Within 60 Mins of Arrival		Aug	42.8%	39.2%	38.2%		
Median Time From Arrival to Decision to Admit		Aug	04:16	04:24	04:27		
12 Hour Trolley Waits in ED	0	Aug	113	341	1590		
Total ED Attendances in Dept for More Than 12 Hours (Arrival to Dept)		Aug	429	648	3307		
% Of ED Attendances Over 12 Hours From Arrival to Departure	<2%	Aug	5.2%	7.7%	7.3%		
ED Waits (4 Hrs Wait)	>95%	Aug	74.0%	72.3%	71.7%		
% Left ED Before Being Seen		Aug	7.7%	9.1%	8.5%		
% ED Re-Attendance Within 7 Days		Aug	10.1%	10.7%	10.1%		

ED Attendances Over 12 Hours

12-Hour Trolley Waits in ED



ED 4-hour Waits



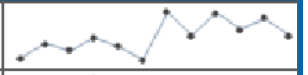
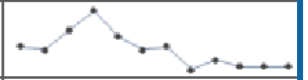
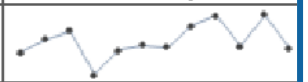
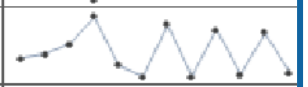
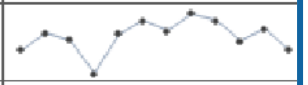
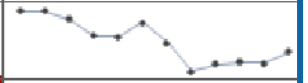
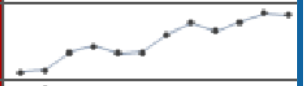
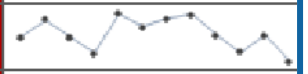
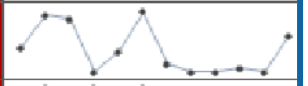
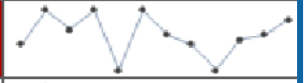
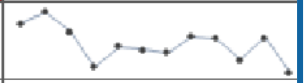
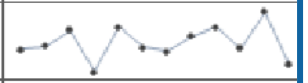
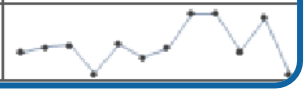
Responsive - Emergency Care

NHS Whittington Health NHS Trust

What the Data Tells Us	Issues	Actions and Mitigations
% of ED Attendances Over 12 Hours - *Target <2%* **August Performance – 5.2%** This is an improvement of 2.5% compared to July's performance of 7.7%. **12-Hour Trolley Waits in ED - *Target 0*** *No. of patients who waited longer than 12 hours to be admitted to the ward following decision to admit.* **August Performance – 113** This is an improvement of 228 compared to July's performance of 341. **Emergency Department Waits (4 hrs wait) - *Target >95%*** *No. of patients treated within 4 hours of arrival in ED.* **August Performance – 74%** This is an improvement of 1.7% compared to July's performance of 72.3%. **LAS Handovers - *Target 0*** *Number of Ambulance Handover delays of greater than 30 minutes and 60 minutes.* **August Performance (30 mins) – 40** This is an improvement of 80 compared to July's performance of 120. **August Performance (60 mins) – 3** This is an improvement of 7 compared to July's performance of 10. **Median Wait for Treatment - *Target <60 minutes*** *Time from arrival to seeing a doctor or nurse practitioner.* **August Performance – 76 Minutes** This is an improvement of 10 minutes compared to July's performance of 86 minutes.	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 lower (8258) when compared to July 2023 (9125) •Increased acuity resulting in longer length of stay on the wards. •Increase in ambulance arrivals to the site including out of area patients. Improved hospital flow and reduced NCTR in August	**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 and CDU in September 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 • 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

ICARE EQUITY

Activity

Indicator	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Activity
ED Attendances		8426	8772	8592	8911	8704	8364	9562	8958	9522	9125	9386	8979	
ED Admission Rate %		10.3%	10.2%	10.8%	11.4%	10.6%	10.2%	10.3%	9.6%	9.9%	9.7%	9.7%	9.7%	
Elective and Daycase		2160	2307	2407	1908	2179	2244	2217	2461	2576	2231	2592	2210	
Emergency Inpatients		1622	1638	1674	1777	1598	1557	1746	1556	1727	1563	1714	1571	
GP Referrals to an Acute Service		7831	8760	8362	6552	8702	9391	8846	9828	9425	8316	8959	7818	
% Of GP Referrals Completed via eRS		73.0%	73.0%	71.1%	67.3%	67.1%	70.3%	65.6%	59.2%	60.7%	61.2%	61.1%	63.5%	
% e-Referral Service (e-RS) Slot Issues	<4%	60.3%	61.2%	69.6%	71.9%	68.9%	69.4%	77.6%	82.7%	78.9%	83.1%	87.4%	86.4%	
Maternity Births	320	245	266	256	237	229	206	237	227	218	192	218	212	
Maternity Bookings	377	271	300	271	245	310	288	301	308	275	246	275	231	
Outpatient DNA Rate % - New	<10%	12.1%	12.9%	12.8%	11.5%	12.0%	13.0%	11.7%	11.5%	11.5%	11.6%	11.5%	12.4%	
Outpatient DNA Rate % - FUp	<10%	10.2%	10.9%	10.5%	10.9%	9.7%	10.9%	10.4%	10.2%	9.7%	10.3%	10.4%	10.7%	
Outpatient New Attendances		12279	13076	11750	9295	10676	10460	10230	11366	11241	9754	11333	8934	
Outpatient FUp Attendances		17365	17552	18760	15793	18938	17500	17248	18291	18959	17405	20063	16269	
Outpatient Procedures		6172	6344	6410	5534	6444	6034	6299	7391	7387	6223	7241	5525	

GP Referrals

August Performance – 7,818

This is a decrease of 1,141 compared to July's performance of 8,959.

It a decrease of 94 compared to 7,912 in August's 2023.

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

August Performance – 86.4%

This is a decrease of 1% compared to July's performance of 87.4%.

It an increase of 20.6% compared to 65.8% in August's 2023.

Activity - Highlights

Activity Highlights

Maternity Births August Performance – 212

This is a worsening of 6 compared to July's performance of 218, and a worsening of 51 from 263 in August 2023.

ED Attendances August Performance – 8,979 (Daily Average Attendance 290)

This is a decrease of 407 Compared to July's performance of 9,386 (Daily Average Attendance 303), and an increase of 937 from 8,042 in August 2023.

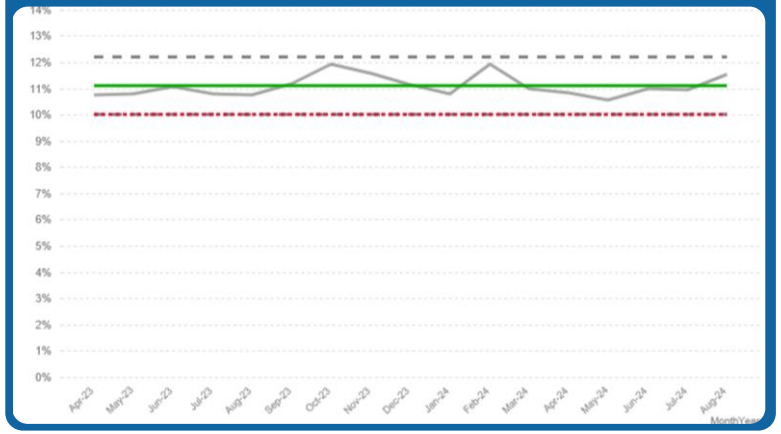
DNA Rates August 2024:

Acute DNA rate for August was 11.5%, this is a worsening of 0.6% from July's performance of 10.9%.

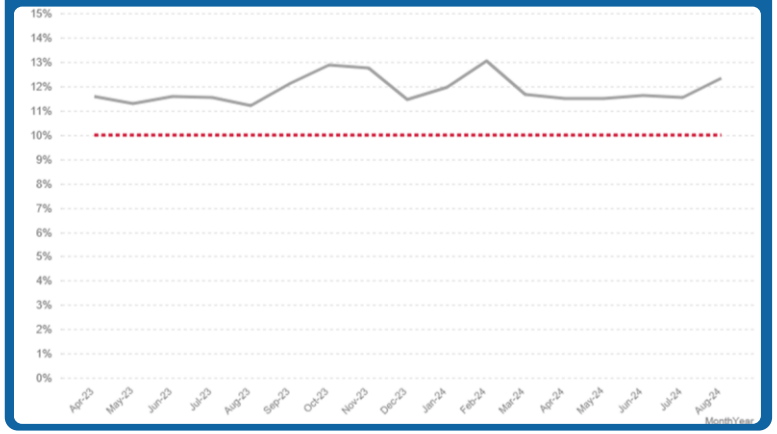
Outpatient DNA rate for new appointments was 12.4% for August, this is a worsening of 0.9% from July's performance of 11.5%.

Outpatient DNA rates for follow-up appointments was 10.7% for August, this is a worsening of 0.3% from July's performance of 10.4%.

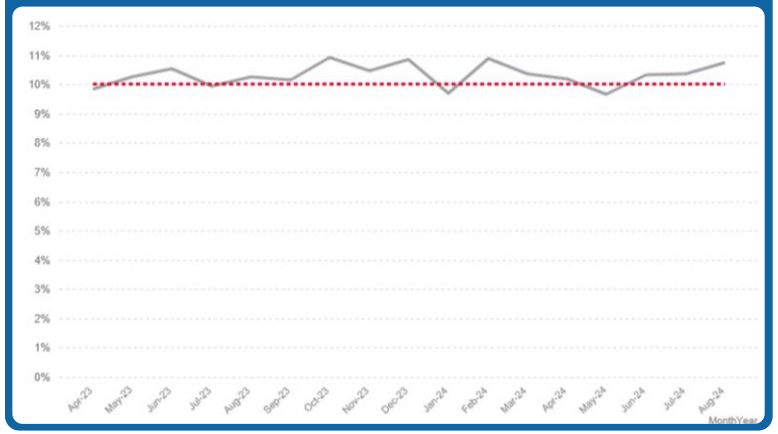
Acute DNA % Rate



Outpatient DNA % Rate - New



Outpatient DNA % Rate – Follow-Up



Activity – Activity and Forecasts

Activity Highlights

Outpatient First Appointments: There were 13,538 Firsts Appointments in the last 4 weeks of August 2024, this is 113% of 19/20 levels.

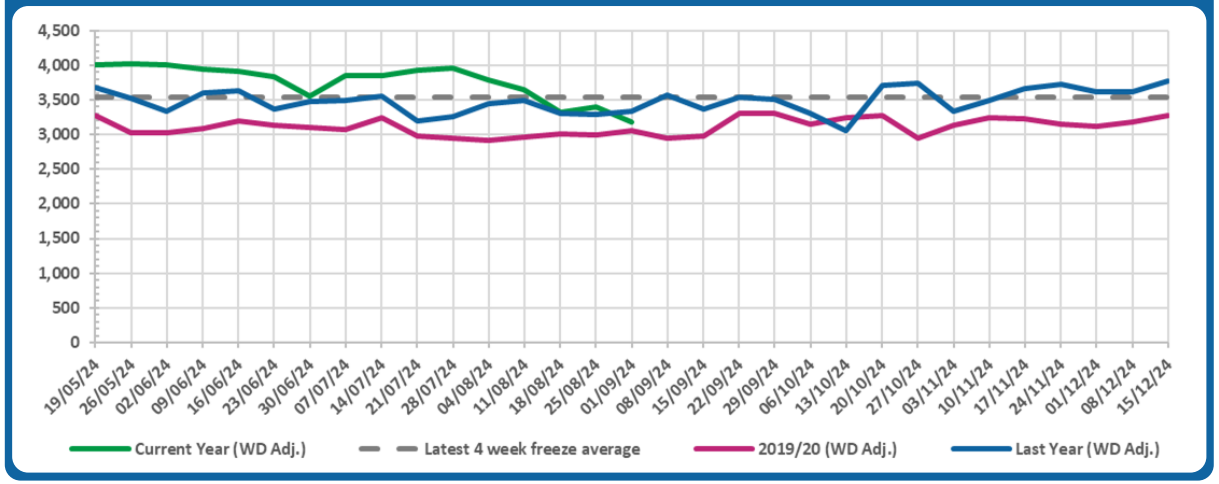
Outpatient Follow-up Appointments: There were 11,212 Follow-p appointments in the last 4 weeks of August 2024, this is 92% of 19/20 levels.

Follow-up activity is in line with productivity improvements.

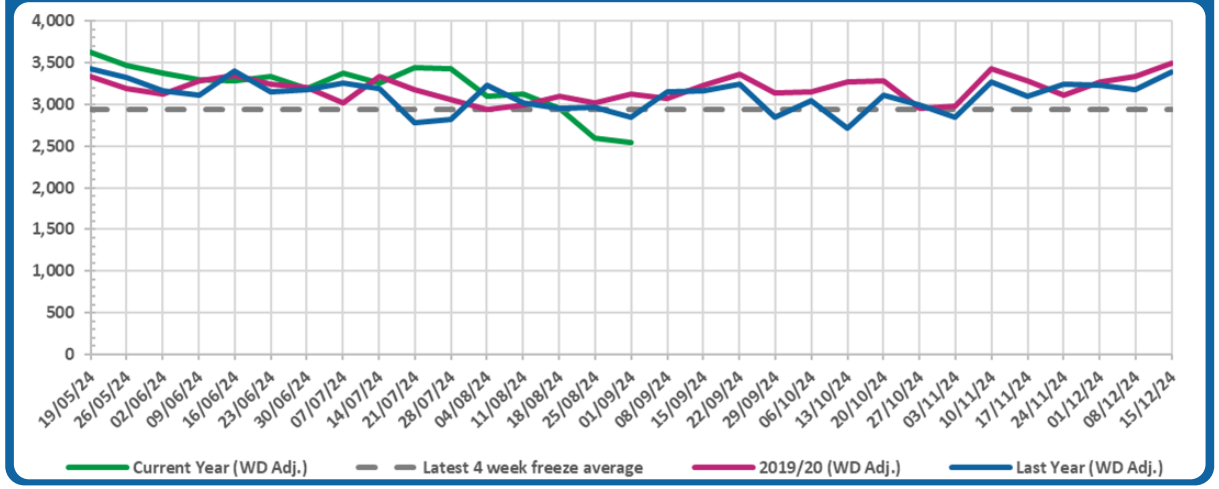
Elective Activity: There were 2,069 cases in the last 4 weeks of August 2024, this is 117% of 19/20 levels. However, there is a variation in case mix where we have seen less inpatient activity and increased day cases.

Please note that data is for elective activity only and does not include diagnostic activity.

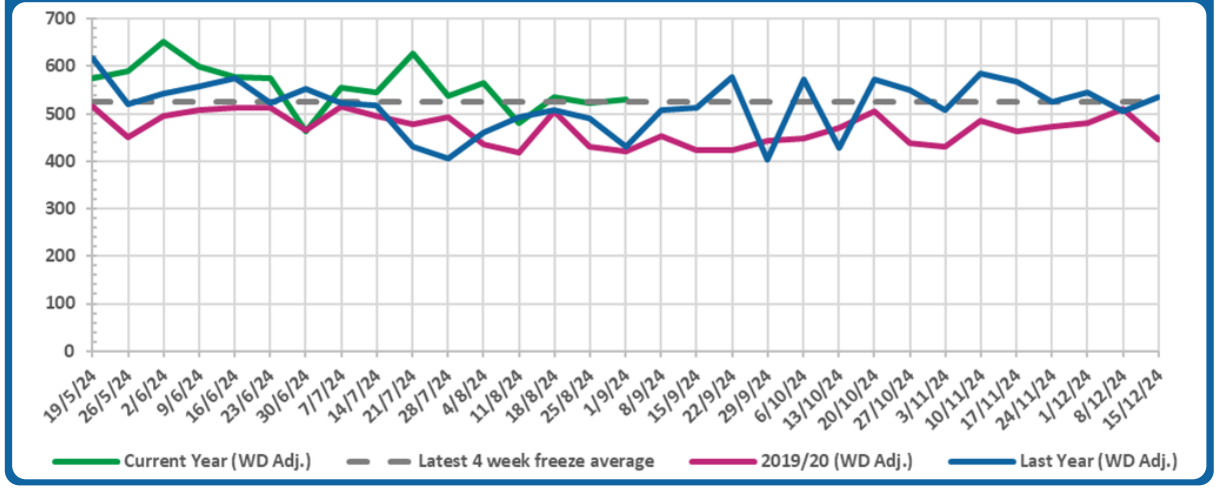
Weekly Outpatient First Attendances



Weekly Outpatient Follow-up Attendances

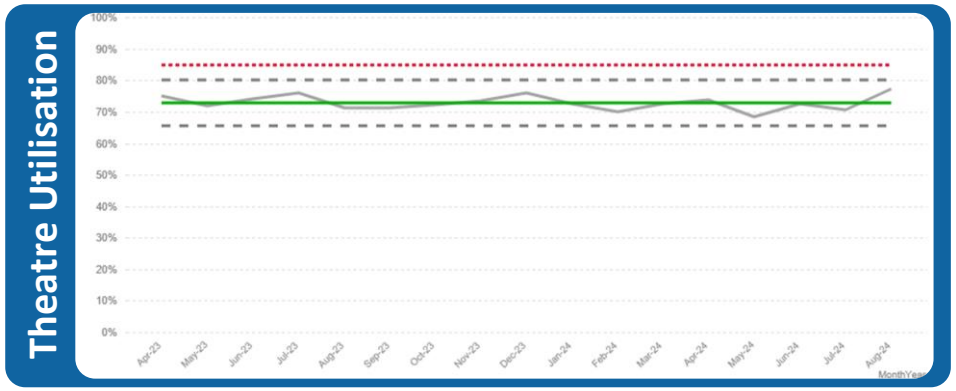


Weekly Elective Activity



Effective

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Cancelled Ops Not Rebooked <28 Days	0	Jul	3	1	11	H	F
Hospital Cancelled Operations	0	Jul	12	12	58		F
Theatre Utilisation	>85%	Aug	77.2%	70.6%	72.4%	H	F
Community DNA % Rate	<10%	Aug	7.1%	7.2%	7.1%		P
Acute DNA % Rate	<10%	Aug	11.5%	10.9%	10.9%	H	F
Outpatients New:Follow Up Ratio	2.3	Aug	1.82	1.77	1.73		
Non Elective Re-Admissions Within 30 Days	<5.5%	Aug	3.6%	3.4%	3.7%		P
Rapid Response - % Of Referrals With an Improvement in Care		Aug	71.8%	64.3%	71.2%		



Theatre Utilisation - Target 85%

Percentage of available Theatre time used for elective procedure.

August Performance – 77.2%

This is an improvement of 6.6% from July's performance of 70.6%.

Issues: Managing late-notice cancellations over the holiday period has been challenging, but efforts to improve list utilisation are underway. Addressing late starts, early finishes, and under-booking will help enhance efficiency moving forward.

Actions:

- Efforts are focused on improving utilisation by addressing early finish times and supporting specialties with below-average performance, such as Dental and Urology, with input from the Productivity and Efficiency team. This approach aims to enhance overall efficiency and optimise service delivery.
- Theatre scheduling meetings now focus on addressing under-booked lists and escalating issues as needed to ensure optimal resource utilisation.
- Clinician input has improved following the Theatre User Group, helping optimise list composition and bookings. The goal now is to embed this enhanced process as a standard practice.

Hospital Cancelled Operations - Target 0

July Performance – 12

This is the same as June's performance of 12.

Issues: Five operations were cancelled due to list overruns caused by clinical complications during and after surgery across two lists. Four were cancelled due to the short-notice sickness of an anaesthetist, where the case mix didn't allow for solo list management by a middle grade. Two operations were postponed due to ventilation issues in theatres, and one was rescheduled due to the unavailability of a Critical Care bed for a complex case, which was successfully completed at the next available opportunity.

Actions:

- Staged replacement of ventilation systems across all theatres to begin in January 2025
- A business case has been submitted to secure additional anaesthetic resources, aimed at maximising theatre capacity and improving overall efficiency
- Collaboration with UCLH is being explored to offer vacant shifts to their anaesthetists, along with considering the use of anaesthetic associates for low-complexity lists to enhance coverage and efficiency

Caring

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
ED - FFT % Positive	>90%	Aug	89.2%	82.6%	83.3%	H	F
ED - FFT Response Rate	>15%	Aug	9.7%	7.4%	8.3%	H	F
Inpatients - FFT % Positive	>90%	Aug	94.7%	95.3%	94.2%		P
Inpatients - FFT Response Rate	>25%	Aug	18.3%	18.8%	17.8%		F
Maternity - FFT % Positive	>90%	Aug	97.5%	98.9%	98.0%		P
Maternity - FFT Response Rate	>15%	Aug	24.0%	32.6%	26.1%	L	P
Outpatients - FFT % Positive	>90%	Aug	92.9%	89.9%	92.1%		P
Outpatients - FFT Response Rate	400	Aug	253	338	1610	L	F
Community - FFT % Positive	>90%	Aug	94.3%	93.5%	94.0%		P
Community - FFT Response Rate	1500	Aug	610	1265	4412	L	F
Complaints Responded to Within 25 or 40 Working Days	>80%	Aug	47.1%	77.4%	71.1%	L	F
Complaints (Including Complaints Against Corporate Division)		Aug	17	31	149		

Friends and Family Test (FFT)

August Performance – 93%

Trust wide: 93% in line with the previous month for positive responses and 4.08% for negative the lowest it has been for over a year. All ICSU's remain above the 85% NHS benchmark for 7 months.

ED: 89% up 7% on last month again the highest it's been in over a year, 7% for negative down 6% on the previous month.

Maternity: 97% positive and 2% negative

Outpatients: 92% positive and 6% negative down 3% on last month.

Feedback Outpatients: 260 comments were received much of it positive, relating to great staff, good communication. Negative feedback related to communication and a more efficient service in pharmacy.

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

August Performance – 47.1%

This is a worsening of 30.3% from July's performance of 77.4%.

There were 17 complaints received where a response was required in August 2024.

The 17 complaints due a response in August 2024 were allocated to ACW 35% (6), E&IM 29% (5), S&C 18% (3), CYPS 12% (2) & ACS 6% (1)

Severity of complaints: 53% (9) were designated 'moderate' risk & 47% (8) were designated as 'low risk'.

Themes: A review of the complaints due a response in August 2024 shows that 'Medical Care' 24% (4), 'Delay' 18% (3), 'Attitude' 18% (3) & 'Communication' 18% (3) were the main issues for complainants.

Of the 8 complaints that have closed, 4 (50%) were 'upheld', 2 (25%) were 'partially upheld', and 2 (33%) were 'not upheld', meaning that 75% of the closed complaints in August 2024 were upheld in one form or another.

Well Led

Indicator	Target	Current Month		Previous Month	2024-2025	Variation	Assurance
Appraisals % Rate	>85%	Aug	78.3%	79.4%	77.8%	H	F
Mandatory Training % Rate	>85%	Aug	86.7%	89.5%	87.3%	L	P
Permanent Staffing WTEs Utilised	>90%	Aug	91.3%	91.5%	91.8%		P
Staff Sickness Abscence %	<3.5%	Jul	4.3%	4.3%	4.0%		F
Staff Turnover %	<13%	Aug	12.1%	10.2%	11.2%	H	P
Vacancy % Rate Against Establishment	<10%	Aug	8.7%	8.5%	8.2%		P
Average Time to Hire	<=63	Aug	59	65	60	L	P
Safe Staffing Alerts - Number of Red Shifts		Aug	1	0	3		
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		Aug	11.1	10.4	8.5		

Appraisals % Rate - *Target >85%*

August Performance – 78.3%

This is a worsening of 1.1% from July's performance of 79.4%

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 in the last quarter.

Actions: The Trust is actively working with services to support the completion of appraisals, and the Learning and Development team is running training to support staff.

Staff Sickness Absence % - *Target <3.5%*

August Performance – 4.3%

This is the same as July's performance of 4.3%.

Issue: Overall, Trust rate has plateaued over last quarter.

Actions: HR Business partnering team to hold 'sickness absence surgeries' throughout October, November and December targeting 'hot-spot' areas within ICSU's providing additional support and education to managers.

National Quarterly Pulse Survey (NQPS)

National Quarterly Pulse Survey (NQPS): **586**

NQPS Staff% Recommended work: **54.3%**

Issue: % of staff recommending the organisation as a place to work dropped by 0.5%.

Actions: Targeted development opportunities and wellbeing initiatives aimed to increase job satisfaction and advocacy. A further deep dive in the upcoming National Staff Survey aims at developing plans to aid staff engagement and retention.