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, 30 September 2022** from **9.30am to 11.00am** in room A4 at the Whittington Education Centre, Highgate Hill, London N19 5NF & via video conference.

Item	Time	Title	Presenter	Action
		Standing agenda items		
1.	*930*	Welcome, apologies, declarations of interest	Trust Chair	Note
2.	*931*	Patient experience story	Chief Nurse & Director of Allied Health Professionals	Discuss
3.	*950*	22 July 2022 public Board meeting minutes, action log, matters arising	Trust Chair	Approve
4.	*955*	Chair's report	Trust Chair	Note
5.	*1000*	Chief Executive's report	Chief Executive	Note
		Board Committee reports		
6.	*1005*	Quality Assurance Committee Chair's report	Committee Chair	Note
7.	*1010*	Audit & Risk Committee Chair's report	Committee Chair	Note
		Performance		
8.	*1020*	Integrated performance report	Director of Strategy and Corporate Affairs	Discuss
9.	*1030*	Finance, capital expenditure and cost improvement report	Chief Finance Officer	Discuss
10.	*10:40*	Cost of living report and supporting staff financial wellbeing	Director of Workforce	Discuss
		Governance		
11.	*10:45*	Charitable Funds' Committee Chair's report	Committee Chair	Note
12.	*1050*	Strategy update	Director of Strategy and Corporate Affairs	Note
13.	*1055*	Questions to the Board on agenda items	Trust Chair	Note
14.	*1100*	Any other urgent business	Trust Chair	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 22 July 2022

Present:	
Baroness Julia Neuberger	Non-Executive Director and Chair
Dr Junaid Bajwa	Non-Executive Director
Helen Brown	Chief Executive Officer
Kevin Curnow	Chief Finance Officer
Dr Clare Dollery	Medical Director
Professor Naomi Fulop	Non-Executive Director
Amanda Gibbon	Non-Executive Director
Carol Gillen	Chief Operating Officer
Baroness Glenys Thornton	Non-Executive Director
Rob Vincent CBE	Non-Executive Director
In attendance:	
Ms E	Patient (item 2)
Deborah Clatworthy	Acting Chief Nurse
Charlie David	Patient Experience Manager (item 2)
Jonathan Gardner	Director of Strategy & Corporate Affairs
David McLean	Orthopaedic Therapy Team Leader (item 2)
Tina Jegede	Joint Director of Inclusion and Nurse Lead, Islington Care Homes
Tawanda Maposa	Chief Information Officer
Dale-Charlotte Moore	Deputy Chief Operating Officer
Marcia Marrast-Lewis	Assistant Trust Secretary
Swarnjit Singh	Joint Director of Inclusion and Trust Secretary
Kate Wilson	Associate Director of Workforce

No.	**Item**
1.	**Welcome, apologies and declarations of interest**
1.1	The Chair extended a warm welcome to everyone present and was especially pleased to welcome formally Helen Brown as the new Chief Executive Officer to her first Board meeting held in public. On a much sadder note, the Chair announced that this would be the last meeting for Carol Gillen, Chief Operating Officer, who had delayed her retirement for the last two years to support the Trust through the Covid-19 pandemic. Carol would finally step down at the end of July. The Chair thanked her for her tireless service to the Trust and wished her well for the future.
1.2	Apologies for absence were received from Sarah Humphrey, Medical Director for Integrated Care, Tony Rice Non-Executive Director, and Norma French, Director of Workforce. No new declarations of interest were reported.

2.	**Patient story**
2.1	Deborah Clatworthy introduced the patient, Ms E, who had experienced a fall in December 2021 which resulted in a fracture of her C1 vertebrate. She was treated at the Royal London Hospital and placed in a hard collar. A delay with the results of a follow-up scan meant that the patient had to remain in the collar for longer than 12 weeks. Her experience at the Royal London Hospital highlighted the difficulties in communication and navigation through a clear pathway.
2.2	Ms E explained that she attended the Royal London after the fall. She stated that the care received was adequate but that she had been told that she would need to wear the collar for a minimum of 12 weeks. It was decided that Ms E would attend outpatients at the Whittington Hospital every Tuesday to review the collar, and this took place regularly. Ms E found these visits very reassuring as she felt well looked after and supported by the Whittington team. She explained that a number of appointments were cancelled at the Royal London and the results of the initial CT scan were not reported to her. Georgia Cunningham, Whittington's Clinical Lead for Occupational Therapy made several unsuccessful attempts to obtain the results. However, eventually fruitful contact was made with the Royal London Hospital and the Whittington team managed her treatment and follow-up.
2.3	Ms E reported that her first follow-up appointment following discharge in December 2021 was postponed from March to 19 July 2022. This left her feeling confused and unsure as to whether she should continue to wear the collar for a total of six months. Once again, she was helped by the Whittington occupational therapy team, who made appropriate enquiries of the Royal London. Ms E was finally invited to attend an appointment at the Royal London to see a senior nurse, who then discharged her from clinic. She never saw a consultant or a doctor.
2.4	Ms E expressed her gratitude for the care and treatment received at Whittington Hospital and for the efforts made to allay her worries. She accepted that the Royal London was a very busy hospital but felt let down by the medical professionals.
2.5	The Chair thanked Ms E for sharing her patient experience story which demonstrated that good inter-hospital communications were necessary and that a system approach was needed to address the issues highlighted. David McLean agreed and stated that, unfortunately, stories such as these were not rare. He explained that, in recent years, there had been a significant increase in the number of patients requiring brace care for spinal injuries at Whittington Health who would have previously attended the Royal London Hospital for treatment. At Whittington Health, staff in the spinal injuries service would take a "hands on" approach often advocating on behalf of the patient and acting as a point of contact for patients who had to go home with collars *in-situ*. He confirmed that, while he had good lines of communication with the Nurse Specialist at the Royal London, the

	wider team was inundated with referrals which was not an ideal situation as it could take a number of days to receive a response.
2.6	The Chair suggested that steps should be taken to improve inter-organisational communication especially as hospitals were supposed to be working as one system. Clare Dollery acknowledged that wearing a collar for an extended length of time would have been very uncomfortable. She commented that Whittington Health had a very good elective spinal service which did not extend to spinal trauma, because it was so specialised. She wondered if there was a way to combine specialist surgeons between the two, as the Trust could share technical matters such as x-rays and pictures but not a diagnosis.
2.7	David McLean reflected that it came down to governance and that, as the Royal London was leading specialist for spinal matters, it would be too risky for clinicians at Whittington Health to proffer advice which may or may not accord with the advice given at the Royal London.
2.8	The Chair recommended that the issues highlighted through the patient story be taken offline and welcomed assurance that patients did not become embroiled with communication issues in the NHS.
2.9	Deborah Clatworthy confirmed that a group was in place which would review the pathway for spinal fractures. The work had been paused because of Covid-19 pressures, but now was a good time to resurrect this forum which was multi-disciplinary, and give it a fresh perspective.
2.10	David McLean confirmed that referrals were now expedited more quickly. In the case of Ms E, her scan was carried out at 3:00 am, advice from the Royal London was received at 5:00 am and a consultant was able to give a firm diagnosis and treatment plan by 10:00 am. This demonstrated that there was capacity for the service to change with the right level of inputs.
2.11	Amanda Gibbon asked whether there was a digital solution that could support communication between hospitals. David McLean advised that, currently, it was the responsibility of the Royal London (and depended on their capacity) to follow up with patients in a timely fashion. Access to specific shared systems was in place, and that could work better for a joint appointment booking system. He assured the Board that the issues raised would be taken forward with the relevant groups.
2.12	**The Chair thanked Ms E on behalf of the Trust Board, for her attendance at the meeting, she assured Ms E that her concerns would be taken forward and a progress update would be brought to the Board in three months.**
3.	**Minutes of the last meeting**
3.1	The minutes of the meeting held on 27 May 2022 were approved as an accurate record. Progress updates on all outstanding actions were noted.

3.2	The Chair observed the similarities in the patent story taken at the last board meeting in public and the patient story received from Ms E. Clare Dollery updated the Board with the actions taken since the May meeting. She explained that Mr A's experience was discussed by the Serious Incident Executive Assurance Group (SIEAG) where it was felt that the best way to address the issues raised was through an action plan which would be monitored by this forum. She explained that the incident occurred on Coyle ward during the height of the pandemic. There were many factors to consider including the blending of staff on the ward due to the closure of the other surgical ward. Although there were sufficient staff on duty, visiting was not allowed, except for patients who were at the end of life. This would have been extremely isolating for Mr A. However, patient visiting had since been reinstated. Furthermore, nurses reported that they were generally reluctant to go into side rooms if they felt that the patient was self-caring and did not need to have contact with other people. Again, the situation would now be materially different as the level of concern generated before Covid-19 vaccinations had substantially reduced.
3.3	Clare Dollery appreciated that the patient in question might have felt less confident moving around with a drip and catheter and agreed that this consideration would be revisited in study days for practice development nurses. She advised that changes had been made to handover sheets which looked at individual's mobility needs and personal care. Clare Dollery assured the Board that, following infection prevention and control guidance, more care would be exercised in identifying vulnerable patients who required isolation and added that there would need to be training in recognising the risk of isolation to these patients. All actions continued to be monitored by SIEAG. Deborah Clatworthy gave assurance on the actions taken thus far noting that the matron and senior nurses had reflected on the issues and subsequent actions very well. She explained that the patient story and all actions had been shared with the service team and there was a recognition that care and compassion for this patient on this occasion had been lacking, but the team would ensure that this did not happen again.
3.4	**The Board noted the update on actions.**
4.	**Chair's report**
4.1	The Chair expressed her huge thanks to staff at the Trust who continued to deliver safe and compassionate care. She noted her concern for staff who were exhausted and who may not have the opportunity to fully recuperate in readiness for winter.
4.2	The Chair reported that, following a selection and recruitment exercise, Chinyama Okunuga had been appointed to the role of Chief Operating Officer. She would join the Trust in early September.
4.3	**The Trust Board noted the report.**

5.	Chief Executive's report
5.1	Helen Brown echoed her thanks to staff for their consistent efforts to care for the patients at Whittington Health. She appreciated that operational pressures were relentless, particularly in the emergency and urgent care pathways and that additional pressures were felt during the Covid surges, heatwave and industrial action on the rail and tube network. Helen Brown informed the Board that operational pressures continued to be reviewed at executive level to ensure better preparation for future weather alerts and industrial action. Helen Brown explained that, while there was no material impact to service delivery because of the rail and tube strikes, they did cause significant inconvenience to staff and patients. She recounted the experience of the Pharmacy Stores Manager who had to wake up at 4.00am to ensure that he arrived at work on time during the strike days.
5.2	Helen Brown reported that the North Central London Integrated Care Board had been established formally on 1 July 2022. She highlighted the good start that North Central London had made and said that there was a good sense of collaboration and drive between provider and commissioning organisations for working together for a common purpose. Helen Brown noted that there were inherent challenges in balancing system work with organisational priorities, which were not always insurmountable. She also reported on her attendance at her first London Chief Executives' meeting, where discussions were very positive. She expressed her optimism in relation to future work.
5.3	Helen Brown apprised the Board on the ministerial announcement on the NHS pay award. There was recognition that, while the pay award was a positive response to the cost-of-living crisis, it was appreciated that some groups of staff may well be dissatisfied and there was some risk that unions could take further action over the coming months.
5.4	The impact of the cost of living on staff was also discussed at NHS London level and by the Finance and Business Development Committee. The Finance and Business Development Committee had agreed that a substantive report should be considered by the Board at its next meeting. In the meantime, guidance from NHS Providers would be disseminated through the organisation as and when it was received.
5.5	Naomi Fulop endorsed the need for a discussion on the impact of the cost of living crisis on staff and patients and appreciated that, although there was limited scope to make a difference, it was important to have those discussions.
5.6	Helen Brown confirmed the message at the London Chief Executives' meeting was that funding for the pay award would be secured centrally and therefore the cost pressure would not be passed to local systems. However, this would put an even stronger onus on local systems to deliver on their financial plans.

5.7	Helen Brown also noted the positive feedback received from an external team reviewing implementation of the Ockenden recommendations, particularly around team working within the service, as well as positive feedback received from midwifery students. The full report on the outcome of the visit would be shared as soon as it was received.
5.8	**The Board formally noted the Chief Executive's report, in particular the positive feedback received from the Ockenden visit team and agreed that a report on the cost of living would be brought to its next meeting.**
6.	**Quality Assurance Committee Chair's Assurance report**
6.1	Naomi Fulop presented an oral report on items considered at the Quality Assurance Committee held on 13 July 2022. She advised that the Committee could take significant and reasonable assurance on the Bi-annual Adult and Children's safeguarding report and on the 2021/22 Complaints and Compliments annual report.
6.2	Naomi Fulop highlighted the increase in both the numbers and the complexity of safeguarding cases, which presented certain challenges. Training compliance numbers were good. In terms of complaints and compliments, Naomi Fulop noted that numbers had returned to pre-pandemic levels.
6.3	The Committee reviewed a number of serious incidents that had been declared and received significant assurance that the Trust had fulfilled its duty of candour to families and that lessons had been shared.
6.4	The Committee discussed the following Quality risks and their mitigations: • Adverse impact of the current Covid-19 surge on staffing capacity and on increasing the number of patients that were admitted. The Committee noted the volatility of the present position which impacted negatively on planning. However, actions were being taken to improve staff capacity, with a renewed focus on recruitment and the use of professional development of nursing staff on wards. • Actions were in place to respond to internal incidents, which included staffing across the hospital and community settings.
6.5	The Committee received two excellent presentations from Adult Community Services. One was about a joint multidisciplinary team in Musculoskeletal and rheumatology services, and the other about group work to help stroke patients develop their upper limb mobility.
6.6	Deborah Clatworthy confirmed that discussions in relation to the complaints process were in progress and that agreed actions would be taken forward, This wouldinclude making sure that good quality responses were going out to patients and that processes were simplified to make reporting and monitoring of progress at Integrated Clinical Support Unit (ICSU) level easier. Helen Brown confirmed that all complaints were also within her line of sight and that she was well informed on the issues raised.

6.7	The Chair commended the good progress made on the complaints process suggesting that a detailed report on how the Trust works through the complaints process with its patients could be considered at a board seminar in 4 months' time.
6.8	**The Trust Board noted the report and agreed that a report be brought back to the Quality Assurance Committee in four months' time with a trajectory for patient complaints.**
7.	**Workforce Assurance Committee Chair's Assurance report**
7.1	Rob Vincent presented the report which detailed assurance received at the meeting held on 13 July 2022. He highlighted the issues covered at the meeting which included all workforce reports paying particular attention to sickness absence, turnover and vacancy levels which were slowly increasing. Rob Vincent observed that staff attrition rates continued and were most likely related to stress and overworking due to the pandemic. The meeting also considered the Trust's response to the cost of living crisis, and the work undertaken by the Trust as an anchor institution working with partners.
7.2	The Committee was encouraged by the slow but steady progress made on appraisals and compliance with mandatory training. The Committee discussed certain elements of the staff survey and noted staff dissatisfaction with pay levels. the Committee had also discussed a report from the Guardian of Safe Working where it was noted that some junior doctors were working unreasonably long hours.
7.3	The Committee noted the steady progress achieved on most aspects of the workforce race equality standard and had sought further information and assurance on the numbers of black and minority ethnic staff subjected to formal disciplinary processes. On the workforce disability equality standard, the Committee noted that only a small number of staff with disabilities were willing to declare their disability status and received assurance on the work taking place within individual integrated clinical service units and corporate departments to improve the position.
7.4	Glenys Thornton felt that it was important to communicate to staff that the Board was aware of the operational pressures affecting the workforce and that it would continue its efforts to support the executives in remedying the issues at hand.
7.5	Junaid Bajwa stated that the report was a helpful summary of the Trust's workforce position. He suggested that the anchor institution point was worth further consideration and acknowledged that the workforce position was likely to worsen by the winter across all sectors, not just healthcare. Junaid Bajwa suggested that as an anchor institution it might be worthwhile exploring potential opportunities outside of healthcare, providing there was capacity to do so.

7.6	Clare Dollery advised that Dr Zara Sayer was appointed as the new Guardian of Safe Working Hours and she would take over from Dr Rebecca Sullivan who had concluded her three-year term. She added that a review of the formal disciplinary processes against medical staff had been undertaken and that it had confirmed that no doctors from a black and minority ethnic background had been disciplined.
7.7	Amanda Gibbon queried whether any follow-up actions had been undertaken in response to the immediate safety concerns outlined by the Guardian of Safe Working, particularly around patient harm and learning. Clare Dollery assured the Board that risks to the patient were fully mitigated at the time and the Guardian was requested to escalate any incidents that might need to be recorded on Datix.
7.8	**The Trust Board noted the report.**
8.	**Innovation and Digital Assurance Committee**
8.1	Junaid Bajwa drew the Trust Board's attention to the deep dive into the virtual ward app which had highlighted a tension between the work undertaken by the Trust and North Central London. He felt that there were opportunities to accelerate and do the right thing for the Trust and its patients while supporting work undertaken by the local system. He emphasised that the Committee was keen to focus on activities and the outcomes both in near and longer term.
8.2	Junaid Bajwa noted the need to engage with allied health professionals and primary care professionals and to use technology to drive outcomes. He explained the Committee had held a considered discussion on anchor institutions, noting that there was no dedicated committee with oversight for anchor institution work at this stage. The Committee proffered its willingness to be that forum, with support from the executive team. It was agreed that the work of an anchor institution would fit well with data analytics and provide a collective view of activity across the health population.
8.3	The Committee received a verbal update on the electronic patient record (EPR) procurement and recognised the work undertaken and the risks around the project in the absence of any firm decision made in relation to the business case.
8.4	Jonathan Gardner confirmed that discussions were underway to commission a consultancy firm to support the outline business case for the procurement of an EPR. He advised that it was anticipated an outline business case would be ready before Christmas for the Board to review. He endorsed the comments made in relation to anchor institutions which was a very important piece of work with a good action plan which was with the Innovation and Data Digital Group and also with workforce committees. He stated that it could benefit from better integration.
8.5	**The Trust Board noted the report.**

9.	**Integrated performance report**
9.1	Carol Gillen highlighted key headlines, as follows: • The emergency department remained challenged throughout June and July. • There was moderate improvement on 4 hour access times during the month of June, which was higher than the London and North Central London averages. • There was a small reduction in 12 hour trolley waits, 8 of which were acute. • Increased challenges in the bed position were experienced in the latter part of June and in early July. This was largely due to patients awaiting beds in care homes. • There was an improvement in the 60 minute response for London Ambulance Service handovers. • Referral to treatment performance was making good traction around 52 week waits. • Additional capacity had been sourced to support surgery capacity. The contract was in place until the end of the year and would be used as and when required. • There were no patients who had waited longer than 104 weeks for treatment following referral. • The Trust was on track to see the elimination of 78 week waits by October. • Diagnostic testing was still challenged, particularly around endoscopy. Other areas of challenge included imaging due to workforce challenges. • Performance against cancer targets remained very challenging with some improvement seen in breast and urology services. • Musculoskeletal services had created additional capacity to help address backlogs in the community. • There was a trend downwards on the Friends and Family Test • There were minor improvements in statutory and mandatory training which would be picked up quarterly in performance reviews.
9.2	Naomi Fulop noted the recommendation was that the Board should take assurance that the Trust was managing performance compliance and was putting into place remedial actions for areas off plan. She stated that she was prepared to take such assurance, with the proviso that the current environment was challenging and the impact on patient and staff needed to be recognised.
9.3	Amanda Gibbon asked whether any consideration was given to helping patients to wait better and what steps, if any, could the Trust take to help patients on the waiting list to look after themselves and keep them better informed. She queried whether sufficient mutual aid was obtained to help patients on the waiting lists.
9.4	In terms of the time to hire, Amanda Gibbon sought assurance that an anomaly with the system of the shared services had been addressed.

	Kate Wilson explained that the Trust had moved to North Central London shared recruitment service in December 2021. In May 2022, there was a restructuring which was serviced by a help desk system, which was taking time to be embedded. Coupled with higher staff turnover and increased recruitment activity in all partner trusts, this had created serious delays with recruitment. The issue had not created any problems with bank and agency rates, but it was having an impact on services and productivity levels. Kate Wilson advised that meetings with partner organisations' Human Resources Directors were taking place on a daily basis. The recruitment team at Whittington Health would provide additional support to the North London shared service. A review would take place once the current issues had been resolved.
9.5	Helen Brown agreed that that communication could be improved for patient complaints. She felt that it was important to maintain focus on the right areas as much as possible. In terms of data analysis, Helen Brown noted that a Making Data Count Board seminar was scheduled to take place in the following week and that it would help to identify areas to improve performance reporting so that trends could be quickly identified.
9.6	Carol Gillen explained that a breast transformation group was in place to address the challenges around breast cancer services. Some improvement was experienced at the Trust as additional support was put in place. She highlighted the biggest concern as being around dermatology. In terms of information given to patients, there were some areas, such as trauma and orthopaedic, where that was carried out as part of the North Central London clinical priority groups looking at ways to help patients while they were waiting.
9.7	Clare Dollery mentioned that additional information was available online under My Planned Care which was designed to help patients wait well. She advised that breast cancer services were challenged across North Central London. Work was focussed on a single point of access which would avoid problems between institutions. Work was also underway on a pathway for people with breast pain without breast lumps who were assessed as lower risk.
9.8	**The Trust Board noted the integrated performance report**
10.	**Month three Finance and capital expenditure report**
10.1	Kevin Curnow presented the finance report. He advised that the Trust reported a deficit of circa £5m at the end of Quarter 1 which was £1.31m off plan. He assured the Board that the finance team would work towards reducing the deficit over the next nine months. Kevin Curnow explained that the key drivers for the deficit related to non-delivery of savings on cost improvement programmes, pay pressures relating to Covid-19 above funded levels, unfunded escalation beds and ongoing costs relating to the private finance initiative. He confirmed that a private consultancy firm had been commissioned to support the Project Management Office and cost improvement agenda to help make the positive impact on the level of

	savings required. Progress would be monitored through the Finance and Business Development Committee and the Trust Management Group.
10.2	Kevin Curnow talked through the current operational pressures in the emergency department and explained that the increased acuity of patients, pressure on beds and increased inpatient length of stay had all driven expenditure in the wrong direction. He noted that there was additional capacity across North Central London, particularly at the Royal Free and University College London Hospitals (UCLH), where they were funded for additional capacity. Discussions at a system level were planned in order to ensure a more equitable spread of patients requiring intensive care at hospitals which were funded to receive these patients. In terms of ward pressures and escalated beds, there was an understanding that closer working with social care partners and residential nursing homes was needed to mobilise the medically optimised. For the emergency department, Kevin Curnow stated that a review was needed on attendances and potentially a different operating model.
10.3	Kevin Curnow referred the Trust Board to activity performance and highlighted the fact that activity was lower than planned with the current establishment and workforce. He also drew attention to productivity levels not being at the same level as pre-pandemic.
10.4	Kevin Curnow reported that capital expenditure was £1.5m for the year-to-date and was significantly below target. He gave assurance that an increase in expenditure was expected over the remainder of the financial year. Kevin Curnow also noted that an agency cap was planned which would help drive down costs.
10.5	Clare Dollery commented on the level of productivity at the Trust and stated that staff sickness from Covid-19 was, in part, responsible, as staffing for non-elective surge wards was needed, coupled with the cancellation of activity to release staff. She noted that nursing and medical staff were exhausted and were less likely now to be prepared to take on extra shifts.
10.6	**The Board noted the financial and capital expenditure report.**
11.	**Delivery of 2022/23 corporate objectives**
11.1	Jonathan Gardner presented the report which detailed progress against the Trust's corporate objectives for quarter one. The Trust Board were navigated through each of the objectives, noting that the Trust was largely on target. Jonathan Gardner also referred the Trust Board to the quarter two Board Assurance framework.
11.2	**The Trust Board noted the progress with delivery of the quarter two corporate objectives and the Board Assurance Framework.**

12.	**Strategy update**
12.1	Jonathan Gardner highlighted the imminent launch of the Community Diagnostic Centre in the last week of August. He confirmed that approval for phase 2 had been received and that funding had also been formally approved. Jonathan Gardner also advised that the consultation on the Wood Green Community Health and Wellbeing hub had concluded, and a report had been submitted to the Overview and Scrutiny Committee and would be discussed at a public meeting the following week.
12.2	**The Trust Board noted the report.**
13.	**Questions from the public**
13.1	The Chair advised that several questions had been received which would be responded to separately. She highlighted a question on the engagement and consultation with local people on the Start Well case for change taking place. The Chair explained that the consultation was being taken forward by the North Central London system.
14.	**Any other business**
14.1	The Chair expressed her heartfelt thanks to Carol Gillen and wished her well for her retirement. There being no further items to discuss, the Chair closed the meeting.

Action log, 22 July 2022 Public Board meeting

Agenda item	Action	Lead(s)	Progress
Patient story	Provide assurance that the issues raised in patient story did not impact patients or become embroiled with communication issues between hospital trusts in the NHS.	Deborah Clatworthy / Sarah Wilding	Meetings have been set up with appropriate operational leads at the spinal/orthopaedic department at the Royal London to improve the communication and care of patients who receive shared care. A clinical lead will also ensure patients are followed up and any issues raised are tracked for completion. This case will also be the subject of a quality improvement project to share the learning
Chief Executive Officer's Report	Provide a substantive report on the cost-of-living crisis and its impact on staff and patients.	Norma French	On agenda

Meeting title	**Trust Board – public meeting**	**Date: 30 September 2022**
Report title	**Chair's report**	**Agenda item: 4**
Non-Executive Director	Julia Neuberger, Trust Chair	
Executive director lead	Jonathan Gardner, Director of Strategy and Corporate Affairs	
Report authors	Swarnjit Singh, Joint Director of Inclusion and Trust Secretary, and Julia Neuberger	
Executive summary	This report provides a summary of activity since the last Board meeting held in public on 22 July 2022	
Purpose	Noting	
Recommendation	Board members are asked to note the report.	
Board Assurance Framework	All entries	
Report history	Report to each Board meeting held in public	
Appendices	None	

Chair's report

This report updates Board members on recent activities.

Her Majesty Queen Elizabeth II
I know that, along with all our Board members, many of our staff were deeply saddened by the news of the death of Her Majesty The Queen on 8 September 2022. The Queen had been a constant in all our lives for the past 70 years and it is vital to pay tribute to her life of service to the United Kingdom, the Commonwealth and to the world. She was a commanding figure who led with wise judgement, compassion, and an inherent belief in the good within everyone. Many of us will have our own special memories of The Queen and what she meant to us. Indeed, many of our nursing colleagues have enjoyed receiving the gift of daffodils each spring from Her Majesty's Sandringham estate, a tradition started by Her Majesty dating back nearly 40 years. Furthermore, the Queen awarded the George Cross to the NHS and its staff earlier this year, for their compassion and courage over the last 74 years, and especially during the pandemic. I want to also thank all our staff who worked on the Bank Holiday to provide healthcare services in the hospital and community sites.

Covid-19
I am so glad that we have been able to hold this Board meeting in public and I want to thank our staff for their hard work in preparation for the rollout of Covid-19 boosters for local people and our staff from next week and, from early October, for the start of the winter influenza vaccination programme. Our staff have been remarkable in the face of significant challenges presented by the pandemic and by the need to start services again and catch up with backlogs, and I want to thank each and every one of them for their continued hard work.

22 July Board meeting and 27 July Board seminar
A private meeting of the Trust Board was held on 22 July and key items covered included updates on fire remediation and the private finance initiative building and on pathology services. On 27 July, Board members received a presentation on Making Data Count from NHS England and Improvement colleagues and also received a briefing from NHS England's Chief Midwifery Officer.

NED appraisals
In line with national guidance, appraisals have been completed for our Non-Executive Directors and sent to NHS England and Improvement.

Amanda Pritchard
On 16 September, I attended a joint meeting of NHS Chairs and Chief Executives which was addressed by Amanda Pritchard, NHS Chief Executive, who shared her priorities for the NHS.

Corporate Induction
On 11 July and on 8 August, I was pleased to meet new recruits to Whittington Health at the monthly corporate induction. In addition, on 22 August, I welcomed Sarah Wilding to the Trust as our new Chief Nurse and Director of Allied Health Professionals.

Charitable Funds Committee
On 18 July, I attended a meeting of the Trust's Charitable Funds Committee. The Committee Chair's assurance report for that meeting is a separate item later on today's meeting agenda.

University College London Health Alliance and North Central London Integrated Care Board
With the exception of August, there have been weekly calls regarding business for the University College London Health Alliance. I also attended meetings of the North Central London Integrated Care Board on 9 August and 27 September.

Consultant recruitment panels
I am very grateful to Glenys Thornton for participating in a recruitment panel on 23 August to select to two Consultant posts for geriatric medicine and again on 20 September when she took part in the selection panel for a Community Paediatric Consultant. On 22 September, I was part of a panel for the recruitment and selection of a Consult in general surgery.

Farewell to Carol Gillen 27 July
On 27 July, I was grateful to be part of the Trust's amazing farewell to Carol Gillen, our former Chief Operating Officer.

Members of Parliament (MP) visit to maternity services
On 7 September, along with Helen Brown, Chief Executive, and Glenys Thornton, Non-Executive Director, and maternity lead, I was pleased to welcome Emily Thornberry, MP for Islington South and Finsbury, and Catherine West, MP for Hornsey and Wood Green, on a visit to our maternity services. They welcomed the opportunity to learn about our plans to expand maternity and neo-natal services for local women and their children and gave support for our maternity services.

Meeting title	**Trust Board – public meeting**	**Date: 30 September 2022**
Report title	**Chief Executive's report**	**Agenda item: 5**
Executive director lead	Helen Brown, Chief Executive	
Report authors	Swarnjit Singh, Joint Director of Inclusion and Trust Secretary, and Helen Brown	
Executive summary	This report provides Board members with updates on developments nationally and locally since the last meeting held in public on 22 July 2022.	
Purpose	Noting	
Recommendation	Board members are invited to note the report.	
Board Assurance Framework	All Board Assurance Framework entries	
Report history	Report to each Board meeting held in public	
Appendices	None	

Chief Executive's report

Her Majesty Queen Elizabeth II

The thoughts of everybody at Whittington Health NHS Trust are with King Charles III and the Royal family on the on the very sad news of Her Majesty The Queen's passing. Her Majesty dedicated her life to public service and was a regular visitor to NHS frontline services. Many of us will have our own special memories of The Queen and what she meant to us. Indeed, many of our nursing colleagues have enjoyed receiving the gift of daffodils each spring from Her Majesty's Sandringham estate, a tradition started by Her Majesty dating back nearly 40 years. I know that many of our staff felt a deep sorrow and sadness at the news of this loss and have taken the opportunity to express their condolences in a book in the chapel at the hospital site and in local town halls. I would also like to thank all staff who worked on Her Majesty's funeral bank holiday and for the hard work that went into putting in place operational plans for the bank holiday.

Our plan for patients

On 22 September, the Health and Social care Secretary and Deputy Prime Minister. Therese Coffey announced the Government's new strategy to improve care for patients this winter and next[1]. Key elements of the plan are, as follows:

Issue	Actions
Ambulances	Every hospital and ambulance trust will have a plan in place to reduce long ambulance handover delays so they can get back on the road more quickly. Alongside, there will be improvements to the directory of services so 111 and ambulance services can direct people to the most appropriate service and ensure only those with an emergency attend A&E. The NHS will deliver on their winter plan with 4,800 call handlers in NHS 111 and 2,500 in 999 so 111 calls can be answered more quickly and ambulances can be dispatched as fast as possible. There will also be the equivalent of 7,000 more beds across the country - including 2,500 beds with remote monitoring from patients' homes, to reduce pressure on hospitals and speed up ambulance handovers.
Backlogs	Up to 160 community diagnostic centres will be up and running (92 are currently operating), to help deliver 9 million additional tests, scans and checks a year by March 2025. Trusts will continue to prioritise patients who have been waiting longest and those needing treatment most urgently, including for cancer.
Care	The Government will invest £500 million to support discharge from hospital into the community, bolster the social care workforce and free up beds for patients who need them. Ahead of this winter, the Government will also launch the next phase of the national adult social care recruitment campaign.

[1] Health and Social Care Secretary sets out plan for patients with new funding to bolster social care over winter - GOV.UK (www.gov.uk)

Issue	Actions
	Funding of £15 million this year will help increase the number of international care workers recruited. The funding will help support local areas with visa processing, accommodation and pastoral support
Doctors	An aim for all patients to see their GP within two weeks. Changes to NHS pension rules will retain more experienced NHS staff and remove the barriers to staff returning from retirement. New retirement flexibilities will include a partial retirement option for staff to draw on their pension and continue building it while working more flexibly, allowing retired staff to build more pension if returning to NHS service. The Government will address the unintended impacts of inflation, so senior clinicians are not taxed more than is necessary by amending the revaluation date in the NHS pension scheme to reduce the risk that NHS staff face annual allowance tax charges because of high inflation The Government also intend to allow retired and partially retired staff to continue to return to work or increase their working commitments, without having the payment of their pension benefits reduced or suspended. To do so, ministers will extend the temporary retire and return easements to 31 March 2025. By 2023, all Trusts will also be required to offer pensions recycling, so that employer pension contributions can be offered in cash instead of as an addition to pension funds. This is aimed at helping to retain senior staff who have reached the lifetime allowance for tax-free pension saving.
Dentists	The Government will address variation in dental care and access to dental services by working with the General Dental Council to make it easier for dentists who trained overseas to practice in the NHS and requiring practices to publicly state whether they are taking new patients. Further changes will enable those contractors that can deliver more NHS care to do so by releasing funding from contractors that consistently underdeliver.

National pay award

Julian Kelly, Chief Financial Officer at NHS England wrote to NHS Chief Executives to announce that the Government had accepted the recommendations of the Doctors' and Dentists' Remuneration Body, the 35th report of the NHS Pay Review Body, and the 44th report of the Senior Salaries Review Body. The implementation of revised pension contributions taken together with the pay rise has had a net adverse impact on a small proportion of staff. Our workforce teams are writing to the individuals affected to provide advice, help and support through these changes.

COVID-19

Cases of COVID-19 continue to fall. As a result of this, new national guidance was issued, and the trust has put in place new arrangements which entail the following:

- **Patient testing:** Only patients who have COVID-19 symptoms or who are immunocompromised need to be tested

- **Staff testing**: Staff are only required to complete lateral flow tests if they have symptoms. Staff who work in high-risk areas such as thalassemia and chemotherapy are required to continue twice-weekly lateral flow testing
- **Masks:** Staff, patients and visitors no longer need to wear a face mask in non-clinical areas of our sites. Face masks are still required in clinical areas unless the person is exempt from wearing one. Staff, patients and visitors may still choose to continue to wear a mask if they prefer

I am pleased to report that everyone member of trust staff is being encouraged to get a COVID-19 vaccine booster as part of the autumn booster campaign. While recent variants of COVID-19 have been weaker, it is still a serious virus which can be life-threatening. Getting the booster will help protect staff, their patients and colleagues and help to prevent the spread of COVID-19. The vaccine should be available next week and will be administered in the social club under the Jenner Building and at Hornsey Central.

Operational Update
Winter planning is underway working across the North Central London and other systems to ensure community, mental health, paediatric and adult pathways are optimised. Ward bed bases and winter staffing plans are being reviewed to ensure robust plans are in place this winter. We are continuing to reduce our current surge bed base, as immediate operational pressures reduce. In relation to planned care (outpatients and surgery) services are reviewing their recovery plans and focusing on productivity and transformation opportunities.

Congratulations to the Whittington diabetes team
Over 100 trusts from across England and Wales submitted data to 2020/2021 National Diabetes Audit. The Whittington team were ranked number one in, and number four in, two of the categories in type two diabetes care. I want to congratulate the diabetes team on this outcome. They have worked incredibly hard to provide high quality diabetes services through the pandemic, continuing to provide diabetes clinics in addition to inpatient work and adopting remote or blended ways of working. This commitment has clearly paid off with these excellent results for our patients.

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

Caring For Those Who Care month
As in previous years, during September, we have celebrated all the incredible staff who make up Whittington Health by holding staff focused activities and by providing a range of resources on our intranet and through other communication avenues. Each week has had a different theme and these were: cost of living, inclusivity, reflection and civility and respect.

Gold Chief Midwifery Officer award
I am proud to announce that Huda Mohamed, Female Genital Mutilation (FGM) Specialist Midwife, has received a unique and prestigious award. NHS England's Deputy Chief Midwifery Officer, Jess Read, visited our hospital and presented Huda with The Gold Chief Midwifery Officer award for her local, regional and national work and expertise in FGM and acknowledged Huda's extraordinary commitment to vulnerable women in our local community.

Michael Palin Centre
I am delighted to confirm that Whittington Health Charity has secured a US$250,000 donation in support of the Michael Palin Centre for Stammering Children. The gift comes from The Stuttering Foundation of America. Thanks to the hard work of our Charity team, working in partnership with Elaine Kelman, Head of the Centre, the donor and charity lawyers, we have managed to secure the Foundation's support via Whittington Health Charity. I am sure you will join me in celebrating this excellent news.

Chief Operating Officer
I am also delighted that Chinyama Okunuga joined Whittington Health on 26 September as our new Chief Operating Officer and extend her a warm welcome from our senior team.

Meeting title	**Trust Board – public meeting**	**Date: 30 September 2022**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 6**
Committee Chair	Naomi Fulop, Non-Executive Director	
Executive director leads	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals and Clare Dollery, Medical Director	
Report authors	Marcia Marrast-Lewis, Assistant Trust Secretary	
Executive summary	The Quality Assurance Committee met on 14 September 2022 and was able to take significant or reasonable assurance from the following items considered: • Chair's assurance report, Quality Governance Committee • Elective recovery update • Board Assurance Framework – Quality Entries • Risk Register (Quality and COVID-19 risks) • Quality Assurance Committee Effectiveness Report • Quarterly Learning from Deaths Report • Completeness of Cancer Staging Report • Pressure Ulcer Report – Supporting Staff to Prevent • Ockenden Visit Final Report • CNST & Maternity Standards of Care Bundle Report • Victoria Ward Action Plan Update • Premises Assurance Model Assessment (PAM) • Serious Incidents Following discussion, the following risks were identified to be escalated to the Trust Board: 1. **Workforce –** it was noted that the Trust continued to have ongoing challenges with safe staffing and ensuring that gaps are backfilled. 2. **Fragility of elective recovery programme –** it was recognized that much progress was needed to increase elective activity to be assured that the Trust was on track particularly with approaching winter pressures and a potential covid or influenza surge. 3. **Capital programme and the impact of operational delivery** the Committee was yet to be assured of the delivery of capital	

	programme which could impact operational delivery and patient care. Board members are also presented with the Committee Chair's assurance report for the meeting held on 13 July 2022, for which a verbal update was given at the July public Board meeting (see appendix 5).
Purpose	Noting
Recommendations	Board members are asked to note the Chair's assurance report for the meeting held on 14 September 2022
BAF	Quality strategic objective entries
Appendices	1. Q4 2021/22 Learning from deaths report 2. Q1 2022/23 Quality report 3. Premises Assurance Model assessment 4. Maternity Standards of Care/Ockenden 5. Quality Assurance Committee Chair's report for 13 July 2022 meeting

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	14 September 2022

Summary of assurance:

1. **The Committee confirms to the Trust Board that it took significant assurance in the following areas:**

Chair's report, Quality Governance Committee

The Committee received the report which detailed discussions taken at the meeting held on 28 July 2022 in which significant assurance was received on:

- Children and Young People Services ICSU Report which included commentary on the NICU environment and the improvement of which is part of maternity transformation.
- Drugs & Therapeutic Committee report actions were ongoing to ensure that fridge temperatures were measured locally. Chiller cabinets were also on the capital programme which would be discussed at the capital monitoring group imminently. It was expected that the procurement of chiller cabinets would be completed as a matter of urgency.
- Mortality Review Group
- Infection and Prevention Control Committee
- Corporate risk register which focussed on COVID-19 risks and high risks scored at 15 and above
- Quarterly Patient Safety report
- Serious Incident Report
- Quarterly Patient Experience Report
- Quarterly Quality Assurance Report
- Quarterly Learning from Deaths Report
- Quarterly Clinical Effectiveness Report
- Quality Impact Assessment of cost improvement programmes (CIPs)

The Quality Governance Committee reported limited assurance on information discussed relating to

- **Completeness of Cancer Staging Report**,

The Committee received a report on issues arising from the performance for COSD (Cancer Outcomes and Service Data) which showed that cancer staging completeness had fallen from 54% (2020/21) to 51% (2021/22). This was as a result of a disparity between different types of tumours, TNM staging and lack of consistent documentation of cancer staging. A number of mitigating actions had since been implemented. A follow up report would be submitted to the Quality Governance Committee for assurance.

The Committee noted the report.

Elective Recovery Update

The Committee was informed that for the week ending 4 September 2022:

- Total activity was 4,726 at first cut (72.8% of 19/20 activity). The week before attained 110.9% of 19/20 activity.
- Elective/Daycase Surgery – 445 cases (98% of 19/20) which included 90 high volume low complexity (HVLC) cases, the previous week hit 89%.
- Outpatients – 3,094 first appointments (105% of 19/20) and 2,369 follow ups (77% of 19/20).
- Long waiters – there were 505 patients over 52 weeks and 19 patients over 78 weeks. An increase of two 52-week waiters and a decrease of three 78 week waiters compared to last week.
- Diagnostics: Monthly diagnostics and waiting times activity DM01 performance for August 2022 was 84.2%. CT Scans and Endoscopy have plans in place to be compliant from September 2022.
- Community activity – there were 5,869 contacts for the period. There were 1,968 unoutcomed appointments for the same period.
- Community Long Waiters – 154 52-week waiters, an increase of 5 compared to last week. 97 are Children and young people (CYP) Mental Health, making up 63% of the total.
- Cancer Faster diagnosis standards (FDS) – 28 days FDS is at 61.4% for July 2022 and 63.9% for June 2022. 104+ days currently have 38 patients, 16 of these were under skin. 62+ Days currently have 152 patients waiting, 52 of these are under skin.

The Committee was assured that action plans were in place which would focus on recovery in areas that were underperforming.
The Committee noted the report.

Board Assurance Framework

Committee members were presented with the Board Assurance Framework (BAF) as at the start of quarter two. It was confirmed that the BAF was considered at the Trust Management Group where it was agreed to reduce the risk related to Quality 1 from 16 to 12 to reflect the reduction in Covid infections at the Trust. Scores on the risks to the other three quality risks remained the same. The Committee took assurance that risks to the delivery of the Trust's strategic objectives were effectively mitigated.

The Committee noted the report and agreed the scores for each BAF entry, and the reduction in the score for Quality entry 1 from 16 to 12

Trust Risk Register

The Committee received the latest iteration of the risk register which was currently undergoing an in depth review, the aim of which is to invigorate, cleanse and regularise the governance and management of risks. The Committee noted the increased risk score from 16 to 20 related to a failure to achieve cost improvement savings (CIPs) target and financial balance by Surgery and Cancer. The Committee was assured that actions were in place to mitigate the risks scored at 15+. The committee discussed the risks, related to Monopolar Diathermy and medicines storage.

	It was also agreed that the Committee would continue to review all workforce risks and receive oversight of the risk register generally. In the meantime, the recommendation to change any risk scores would be paused to complete the review of the risk register.
	Better Never Stops The Committee received a presentation from the award winning Orthodontic and Community Dental Services who provide specialist paediatric and adult dental services for patients with special needs, disabilities, or complex dental treatments. The Committee was apprised of the quality improvement initiatives taken through the development of a virtual orthodontic advice pathway, Rapid Orthodontic Advice Request (ROAR) and piloted from 13/07/21-30/04/22. The primary aim of the pathway was to reduce the waiting time and patient travelling for orthodontic advice which was provide by email referral and response. Out of the 46 patients involved in the pilot it was found that 100% of patients received virtual advice within one day of referral. All cases had adequate provision of clinical information. The Committee was assured that the pathway demonstrated a good use of innovative planning with existing resources through a virtual advice pathway. There was a tangible reduction in waiting times for orthodontic advice which enabled better patient outcomes and more timely treatment. Patients were referred to the appropriate primary or secondary orthodontic setting. **The Committee commended the team on the success of the pathway.**.
	Quarter One 2022/23 Quality Report The Committee was able to take good assurance from the quarterly Quality report and noted the following issues: • Recording of Venous thromboembolism (VTE) Risk Assessments performance had significantly improved and the 95% target had been reached for the first time in over twelve months. • No harm had been detected from clinical harm reviews for 78 week waiters which were all within Surgery and Cancer. • The Internal Audit of clinical effectiveness systems provided significant assurance across all six domains, with one improvement action in relation to including NICE guideline compliance within ICSU reporting template which has been actioned. • The National Paediatric Diabetes Audit Annual Report 2020/21 revealed that the average HbA1c had not improved since the 2019/20 report. Additional measures to support children with diabetes would be put in place. • The National GIRFT review of all the clinical claims in the last 5 years as part of a national process found that the four most frequent types of claims were in keeping with national findings: Obstetrics, Accident & Emergency, slips and trips and General Surgery. • There was a 28% rise in Friends and Family Test response rates across all areas in quarter 1. This was due to the expanded use of digital QR codes, and the outpatient FFT questions were also available in ten languages to ensure

that feedback is more representative of the population the Trust serves. However, FFT response rate remains below expected rates. Work was ongoing to improve numbers.
- Complaints remained a challenge, work was ongoing to reduce the backlog.

Committee members welcomed the comprehensive Quality report and the assurance it provided.

Quarter 4 Learning from Deaths Report

The Committee considered the report, noting the death of a patient that was evaluated to be more than 50:50 likely to be avoidable who acquired COVID-19 as an inpatient. The Committee was assured that vulnerable patients were isolated where possible, however isolation was more difficult during periods of surge.

The Committee received a briefing from the Trust Lead Medical Examiner (ME) whose role was to provide independent scrutiny of all non-coronial deaths at the Trust. The requirement to have Medical Examiners in place to review community deaths will be statutory from April 2023. In addition, the Medical Examiner was also required to carry out proportionate reviews, evaluation of any concerns raised by clinicians or family, advising the clinicians on sequencing of the cause of death and would explain the contents of the death certificate to the bereaved. The ME would often explain some of the events that took place at the end of life and give bereaved families the opportunity to ask questions. The Committee noted that a dedicated bereavement service was absent at the Trust which inevitably would add to the workload of the Medical Examiners and was potentially a strategic or resourcing issue for the Trust. It was agreed that this should be remitted to the Trust Management Committee for consideration. It was also agreed that a future report would be brought to the Committee on the future of the Medical Examiner's role at the Trust.

The Committee noted the report.

Pressure Ulcer Report & Supporting Staff to Prevent

The Committee discussed the outcome of pressure ulcer data gathered for 2021-22 and the first quarter of 2022/23. The report highlighted that the Trust did not achieve the planned target of 10% reduction of pressure ulcers but did make some progress in reducing the severity of pressure ulcers. Key themes identified related to:

- Failure or delay to correctly document/photograph pressure damage on admission
- Insufficient level of appropriate care planning
- Incorrect categorisation
- Lack of patient engagement/concordance with planned preventative strategies
- Equipment issues
- Staffing constraints

Double reporting was also cited as an issue where one episode of skin damage was recorded in hospital and then in the community.

The Committee acknowledged that further improvements were needed to ensure the continued reduction of the incidence of pressures but was assured that a

	refocus on the Trust Pressure Ulcer Improvement Plan with larger pieces of work planned would be taken forward by the Trust Pressure Ulcer Group. It was also agreed that the updated improvement plan was brought back to the Committee for assurance at a future meeting.
	Ockenden Final Visit Report The Committee welcomed the report on the outcome of an assurance visit to Whittington Health maternity service on 27thJune 2022, the final report was received from NHSE on 4th August 2022. The visit found that the Trust had demonstrated full compliance across all of the seven of the Immediate and Essential Actions outlined in the Ockenden interim report and the team was congratulated on that achievement in the report.
	Maternity Incentive Scheme – NHS Resolution The Committee was briefed on current progress against the 10 safety actions outlined in the Maternity Incentive Scheme (CNST- clinical Negligence Scheme for Trusts) for Year 4. In order to recover the Trust's contribution to the CNST maternity incentive fund, it would be required to submit a declaration by 5 January 2023, that the Trust has met all 10 safety actions. The Committee was informed that good progress had been made against the actions, compliance with carbon monoxide (CO) measurement recorded at 36 weeks (safety action 6) and multi-disciplinary training (safety action 8) were current areas of concern. All actions were being closely monitored through the maternity governance group and maternity transformation program. It was expected that all actions would be compliant in readiness for Trust Board sign off on 25 November.
	Victoria Ward Action Plan Update Report The Committee was apprised of the impact of action plans and controls put in place following concerns raised and a subsequent risk assessment of increased beds and patient safety issue on Victoria Ward, the risk was scored at 16. It was noted that while significant improvements had been made, the risk score would remain at 16 while two further incidents were investigated. Improvements were noted in visible leadership, safer staffing compliance and fire bleep response rates. Pressure ulcer management and medicines management had seen some improvement but were still areas of concern. Bed base modelling was yet to be completed and would be considered with the Trust's wider winter plans. The Committee appreciated the challenges faced amidst the improvements made and noted the report.
	Serious Incidents The Committee received an overview of Serious Incidents declared during June 2022 and July 2022 and noted the following: • Three serious incidents were declared between 01 June 2022 and 31st July 2022. • Six completed SI reports were submitted during this period of which one was a Healthcare Safety Investigation Branch (HSIB) Maternity program Investigation report.

	• There is a significant backlog of serious incident investigations which ICSUs are working through The Committee noted the aim was to have zero SI reports open more than 180 days by the end of October and agreed that feedback on progress would be brought back to the Committee meeting in November. The Committee took moderate assurance that the Serious Incident process was managed effectively at the Trust.
	Premises Assurance Model Assessment The Committee received a high-level summary overview of the NHS Premises Assurance Model (NHS PAM) assessment which was undertaken in 2021-22 by the Estates and Facilities Department in collaboration with other Teams. The objective of NHS PAM was to ensure the patient rights 'to be cared for in a clean, safe, secure and suitable environment" and establish an internal audit process to ensure regulatory and legislative compliance. The process was designed to allow NHS providers to demonstrate to stakeholders that robust systems are in place to assure that their premises and associated services are safe and fit for purpose as well as prioritise investment decisions to raise standards in patient healthcare. The Committee noted that the assessment had realised 266 actions against scorings ranging from requires minimum to moderate improvement with 2 actions against an inadequate outcome. The Committee agreed that further analysis in terms of the findings which should be aligned to the Trust's risk registers for assurance. **The Committee noted the report.**
2.	**Present:** Professor Naomi Fulop, Non-Executive Director (Committee Chair) Amanda Gibbon, Non-Executive Director (Vice Chair) Baroness Glenys Thornton, Non-Executive Director Dr Clare Dollery, Medical Director Dale-Charlotte Moor, Acting Chief Operating Officer Sarah Wilding, Chief Nurse & Director of Allied Health Professionals **In attendance:** Kat Nolan-Cullen, Compliance and Quality Improvement Manager Gillian Lewis, Head of Quality Governance David Pennington, North Central London ICS Swarnjit Singh, Joint Director Race Equality, Diversity & Inclusion/ Trust Secretary Marcia Marrast-Lewis, Assistant Trust Secretary Carolyn Stewart, Executive Assistant to the Chief Nurse Kelly Collins, Emergency and Integrated Medicine Associate Director of Nursing Iona MacDonald, Speech and Language Therapist Isabelle Cornet, Interim Director of Midwifery James Tomson, Assistant Director Community Dental Services Dr Jing Zhao, Community Dental Officer Pauline Vyse, Lead Tissue Viability Nurse Tina Jegede, Joint Director, Race, Equality, Diversity & Inclusion Dr Ilana Samson, Medical Examiner

Meeting title	**Quality Assurance Committee**	**Date: 14/09/22**
Report title	**Quarterly Learning from Deaths (LfD) Report** Q4, 1 January to 31 March 2022	**Agenda item: 4.2**
Executive director lead	Dr Clare Dollery, Executive Medical Director	
Report authors	Dr Clare Dollery, Executive Lead for Learning from Deaths. Vicki Pantelli, EA to Medical Director and Project Lead for Mortality	
Executive summary	During Quarter 4, 1 January to 31 March 2022 there were 115 adult inpatient deaths reported at Whittington Health (WH). There were also two paediatric inpatient deaths, a child and a baby. There were no neonatal deaths. 29 adult structured judgement reviews (SJRs) were requested for Quarter 4 and 20 of these have been completed and presented at department mortality meetings. There was one death this quarter evaluated to be more than 50:50 likely to be avoidable and related to a patient who acquired COVID-19 as an inpatient. Whilst the patient was in his last year of life, it was felt that his death was premature and an opportunity for him to die at home was lost. In accordance with national guidance, all definite hospital healthcare associated COVID-19 infections are subject to SJR. This quarter there were three deaths of patients with a serious mental illness; these deaths were subject to an SJR. There were also three deaths of patients with learning disabilities; these are also subject to an SJR. The Summary Hospital-level Mortality Indicator(SHMI) for the data period February 2021 to January 2022 at Whittington Health is 0.89. An overarching Mortality Review Group meeting took place on 12 May 2022. The meeting reviewed the learning from death reports and considered the mortality review process as a whole.	
Purpose:	The paper summarises the key learning points and actions identified in the mortality reviews completed for Q4, 1 January to 31 March 2022.	
Recommendation(s)	Members are invited to: • Recognise the assurances highlighted for the robust process implemented to strengthen governance and improved care around inpatient deaths and performance in reviewing inpatient deaths which make a significant positive contribution to patient safety culture at the Trust. • Be aware of the areas where further action is being taken to improve compliance data and the sharing of learning.	

Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register
Report history	Quality Governance Committee 28/7/22
Appendices	Appendix 1: NHS England Trust Mortality Dashboard

Quarterly Learning from Deaths Report
Quarter 4, 2021/22: 1 January to 31 March 2022

1. Introduction

1.1 This report summarises the key learning identified in the mortality reviews completed for Quarter 4 of 2021/22. This report describes:

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

2. Background

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

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

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

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

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

3. Mortality review Quarter 4, 2021/22

3.1 During Quarter 4, 2021/22 there were 115 adult inpatient and 2 paediatric inpatient deaths reported at Whittington Health.

3.2 During Quarter 4, 2021/22 there were 0 neonatal deaths reported at Whittington Health.

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

Table 1: *Death by Department/Team*

Department/Team	Number of deaths
Acute Admissions Unit (Mary Seacole North and South)	24
Cavell	10
Cloudesley	16
Meyrick	12
Critical Care Unit	15
Nightingale	13
Coronary Care Unit	1
Victoria	17
Coyle	6
Mercers	1
Child/neonatal/maternity	2
Total:	**115 Adults 2 Children**

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	86	24	62
Child Mortality Reviews	2	0	2
SJR	29	20	9

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)	7	0
Cavell	1	0
Cloudesley	3	1
Meyrick	3	1
Critical Care Unit	5	0
Nightingale	2	1
Coronary Care Unit	0	0
Victoria	5	4
Coyle	1	0
Mercers	0	0
Paediatrics	2	2

Table 3: *Reasons for deaths being assigned as requiring SJR during Quarter 4, 2021/22*

Criteria for SJR	Number of SJRs identified	Completed SJRs	Comments
Staff raised concerns about care	0	0	
Family raised concerns about quality of care	3	1	
Death of a patient with Serious mental illness	3	1	
Death in surgical patients	0	0	
Paediatric/maternal/neonatal/intra-uterine deaths	2	0	2 child deaths, one at 19 weeks related to a severe chromosomal abnormality and the other 12 years which is the subject of a serious incident investigation which is in progress.
Deaths referred to Coroner's office	2	2	Excludes deaths in the Emergency Department and those already in other categories
Deaths related to specific patient safety or QI work e.g. sepsis and falls	7	5	
Death of a patient with a Learning disability	3	2	
Medical Examiner concern	8	8	
Subject to serious incident investigation	1	1	Definite HCAI
Unexpected Death	0	0	
Concerns raised through audit, incident reporting or other mortality indicators	0	0	
Total including Neonatal Deaths	**29**	**20**	

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

3.7 The aim of this review process is to:

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

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

- For Q1 April to June 2021, 19 out of 23 SJRs have now been completed and returned.
- For Q2 July to September 2021, 13 out of 22 SJRs have now been completed and returned.
- For Q3 October to December 2021, 12 out of 19 SJRs have now been completed and returned.

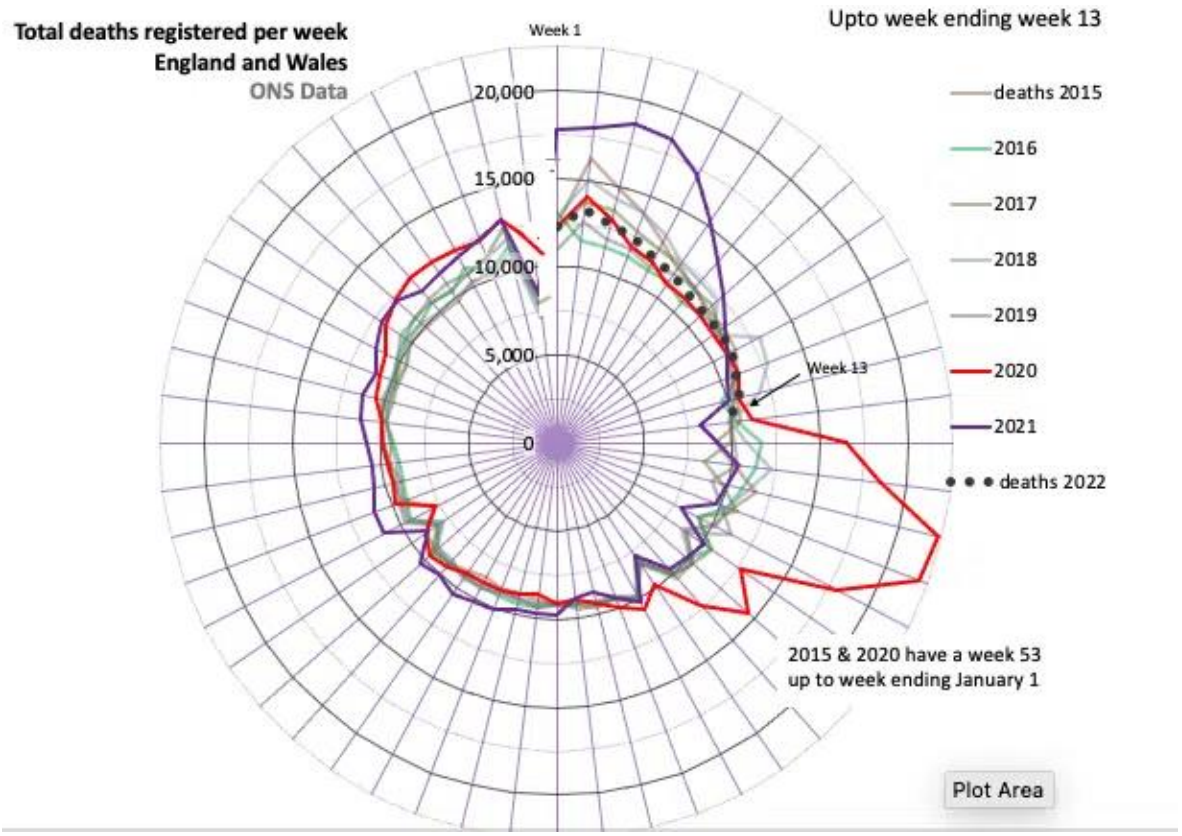
4 Mortality Dashboard

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

4.2 There were 115 inpatient adult deaths recorded in Quarter 4, 2021/22 at Whittington Health.

4.3 In week 13, ending 1 April 2022, 9,840 deaths were registered in England and Wales. This was 1.7% above the ONS 5-year average (2016 to 2019 and 2021). Of these deaths, 853 mentioned COVID-19 (8.7% of all deaths). Of the deaths involving COVID-19, 62.0% (529 deaths) had this recorded as the underlying cause of death.

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



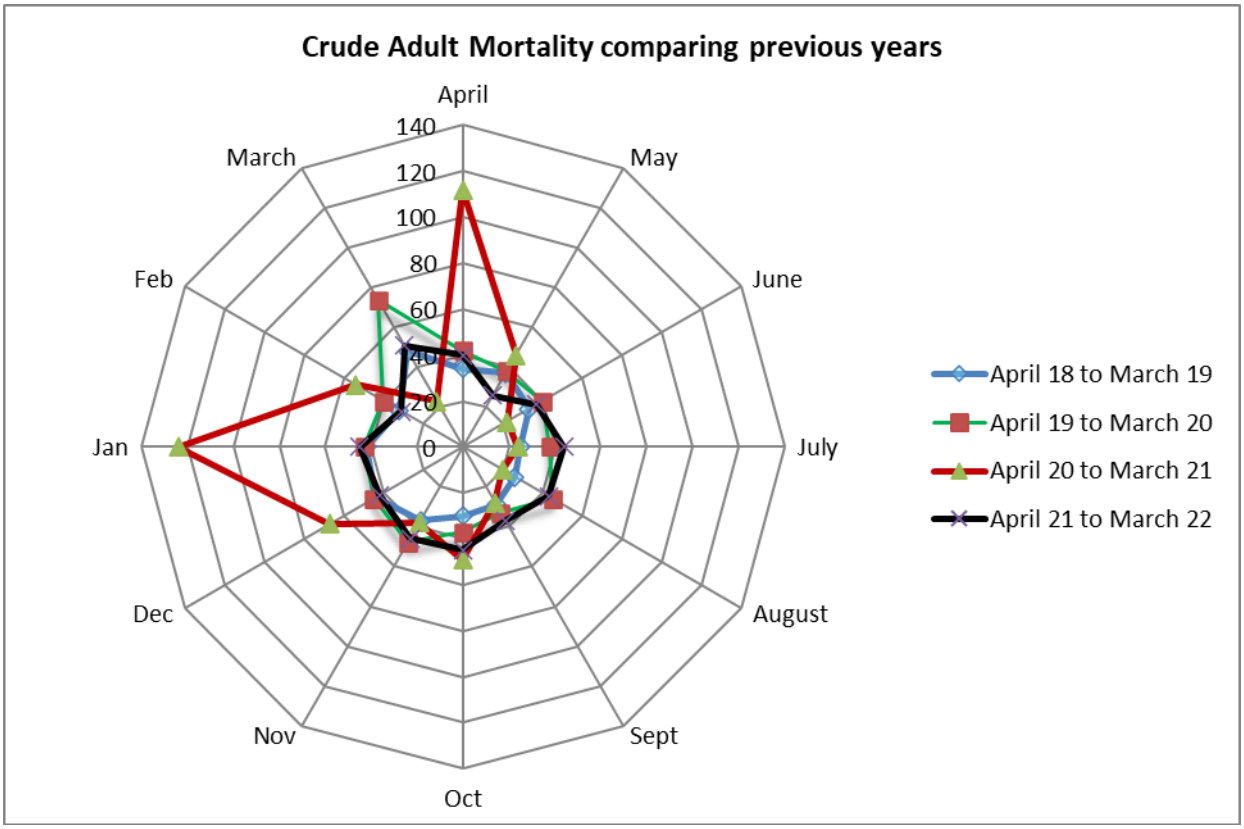
4.4 The radial graph below compares all causes of adult deaths (including ED deaths) in the Whittington hospital in 2018-19, 2019-20, 2020-21 with the year considered in this report 2021-22.

4.5 The number of deaths in Q4 2021/22 was 127 – 74 deaths less than the prior year which included the start of the second surge of COVID-19 as vaccination for COVID-19 was being rolled out.

4.6 There were 25 deaths in patients within 28 days of a positive COVID-19 test or with COVID-19 on their death certificate. This compares to 140 such deaths in Q4 2020/21. All of these deaths in Q4

2021/22 had pre-existing medical conditions. 4 were under 70 years of age and the remainder between 70 and 102. None of these patients had learning disabilities; 2 had serious mental illness and none were homeless.

Graph 2: Crude Adult Mortality comparing previous years



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

Table 4: Number of inpatient and ED deaths each month

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

5 Summary Hospital-level Mortality Indicator (SHMI)

5.1 The SHMI for the data period February 2021 to January 2022 at Whittington Health is 0.89.

6 Themes and learning from mortality reviews Quarter 4 of 2021/2022

6.1 Most mortality reviews identified excellent standards of care, with relatives expressing thanks for the care of their loved one. Early end of life care and palliative measures were taken in many cases.

6.2 A review of a case of a patient with learning disabilities showed that staff continue to use the term learning difficulties rather than the more relevant term disabilities. Some opportunities to access the patient passport were lost but it was highlighted that the learning disabilities nurse should see the patient and this review took place and continued daily during the patient's time in hospital. The patient received prompt treatment of sepsis in ED and was admitted to ICU before being stepped down. The input of the safeguarding adults lead to the SJR added important insights.

6.3 Examples of good care seen in a patient admitted with fractured neck of femur and a complex medical problem included: prompt medical consultant review, pragmatic optimisation for surgery, discussion at specialist trauma meeting and ascertainment of cognitive status. In addition, the next-of-kin was kept informed by both medical and surgical teams.

6.4 An SJR of an elderly patient with sepsis and multiple co-morbidities showed completion of 8 target actions including antibiotics within an hour. Another case in a patient with immunocompromise who was on steroids showed a lack of recognition of sepsis in ED and antibiotics within an hour not achieved – these were administered after referral to the medical team. Learning has been fed back to the ED team. A third case of sepsis on the background of severe immunocompromise showed good initial care in the first 24 hours but subsequent differences of view between the ward team and ICU about whether the patient should have active treatment – this was continued on the ward but with hindsight, a best interest meeting and a shared view would have been preferable. Pressures on time during the Covid surge were identified as contributors to the option above not being possible. A further review of a patient who died of sepsis noted that care intentionally diverged from the sepsis guidelines as the patient was identified to be dying and had all appropriate reviews and care including having family present despite this being in the height of the omicron surge.

6.5 An elderly frail unvaccinated patient was felt to be within his last year of life but his death was hastened by exposure to COVID-19 in hospital. This ultimately contributed to his death which was felt to be more than 50:50 avoidable. He was moved between wards during a 53 day stay and was exposed to COVID-19 on three occasions when other patients in the same bay tested positive during the omicron wave – two of these were temporally related to the patient time of onset of his COVID-19. Learning has centred around identifying unvaccinated patients – offering the vaccination as soon after admission as possible and isolating them in a side room where possible, understanding that this may not always be possible as demand exceeds capacity. Another immunocompromised patient with community acquired COVID-19 had all currently available treatments in a timely manner but did not recover. This showed good awareness of suitable treatments which involve frequently changing and complex pathways.

6.6 It was noted that bedside imaging is sometimes undertaken e.g., in ED – usually ultrasound or echocardiography – these tests need to be recorded in the patient's notes by the operator as they may guide further decision making.

6.7 The adverse impact of ward moves in patients with delirium was highlighted – they can increase the patient's disorientation and worsen their delirium.

7 Mortality Review Group

7.1 A Trust-wide Mortality Review Group was held on 12 May 2022. The group discussed the Q3 2021/22 Learning from Deaths report.

8 Report from Lead Medical Examiner

8.1 The Medical Examiner system is a recently established system designed to provide independent scrutiny of all non-coronial deaths occurring in England and Wales. It was initially rolled out as non-statutory in Acute Trusts only and will be statutory from April 2023. When the statutory medical examiner system commences, the intended requirement is for medical examiners to provide independent scrutiny of all deaths not taken for investigation by a coroner (see appendix 2 for letter from National ME service). As part of this statutory system, cremation forms will no longer be used and the MCCD will change to an electronic form which is a fuller description of events at the end of life and include a mandatory Medical Examiner section. This will be required for all deaths including those in which the family request the urgent paperwork out of hours.

8.2 The Lead ME was appointed in April 2020 and started scrutinising deaths in July 2020, supported by the MD and regional ME and MEO. This has progressed to a team which now consists of a Lead Medical Examiner, Medical Examiner Officer (service manager) and 5 Medical Examiners who work on a sessional basis. Deaths are currently scrutinised in hours (Monday - Friday only). Out of hours deaths are scrutinised the following working day and urgent out of hours MCCDs are issued over the weekend with retrospective scrutiny the next working day, in line with other local Trusts. The ME office reports quarterly to the national ME team. Medical Examiner scrutiny is a threefold process, involving a review of the notes, discussion with the treating senior clinician and the next of kin. The ME performs a proportionate review, evaluates for any concerns raised by clinicians or family, advises the clinicians on sequencing of the cause of death and explains the content of the death certificate to the bereaved. The ME can often explain some of the events that took place at the end of life and gives bereaved families the opportunity to ask questions about what happened or the diagnosis. In the majority of cases a brief conversation is adequate.

8.3 If significant concerns are raised by the ME or by families or clinicians, these are shared with the Trust or the responsible organisation so that they can be investigated. This is usually via the learning from deaths process, where the most common request from the ME service is to suggest that a structured judgement review (SJR) is carried out. The ME may suggest a PALS referral for a more in-depth discussion of events with the treating team, or ask the Trust to investigate via the clinical governance system for a more serious issue such as a patient safety concern. The ME may also ask that other organisations investigate issues raised by the family or hospital, such as safeguarding concerns. The ME advises if a coroner referral is required and reviews all these referrals prior to the referral being sent. At present, all coronial referrals are processed via the ME team and liaison is primarily via the MEO.

8.4 There were 130 deaths in total in the Trust for Q4 2021/22, which includes all deaths occurring in ED and out of hospital cardiac arrests which are brought to the ED. 35 of these were referred to the coroner, 19 of which were taken by the coroner for further investigation. 80% of the total deaths were reviewed by an ME, including all coroner referrals. In this quarter, all MCCDs requested urgently (for religious reasons) were achieved and the bereaved were spoken to by the ME team in 90% of cases. 17 SJRs were proposed by the ME team, based on concerns about care, falls, patients with learning disabilities or severe mental illness or patients who died post operatively.

8.5 In the next 8 months the ME service will have to double the number of deaths reviewed to include the local community deaths in Islington. This will require recruitment to the full capacity of 1.4 WTE MEOs and 0.6 WTE MEs. We will require adequate office space to facilitate the larger team and visiting junior doctors completing the MCCD under supervision of the ME and MEO. At present, the MEO shares an office with a clinician outside the service and the lead ME does not have access to a private office.

8.6 A sector wide ME GP referral form has been trialled in other local hospitals and will be trialled in the Whittington in due course. This will require extensive collaboration and work with the local GP practices. Key areas of development are timely access to GP records for community deaths, provision of out of hours ME cover (likely to be a pan-sector response) and engagement of the wider community teams in the ME process.

9 Conclusion and recommendations

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

Appendix 1: NHS England Trust Mortality Dashboard

NHS Whittington Health: Learning from Deaths Dashboard - March 2021-22

Department of Health

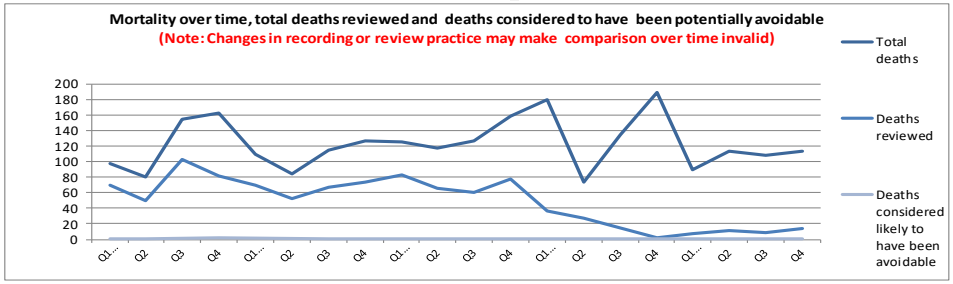
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
44	26	1	3	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
114	108	14	9	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
425	577	41	65	2	0

Time Series: Start date 2017-18 Q1 End date 2021-22 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 (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD	0	-
This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	1	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	1	1	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
5	4	2	1	0	0

Appendix 2 – Letter to all NHS organisations from National ME Service

Classification: Official

Publication reference: PAR1701

NHS England

To:
- CEOs and MDs at foundation trusts and NHS trusts
- GP practices
- Integrated care boards

cc.
- Primary care networks

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

11 July 2022

Dear colleagues,

Statutory medical examiner system

This letter sets out what local health systems need to do to prepare for the statutory medical examiner system. Ministers recently announced their intention to work towards this commencing from April 2023, recognising the need for all relevant government departments to be ready and aligned to enable successful implementation.

In June 2021 we wrote to NHS organisations asking you to work with local medical examiner offices, to enable medical examiners to start providing independent scrutiny of non-coronial deaths in all healthcare settings. When the statutory medical examiner system commences, the intended requirement is for medical examiners to provide independent scrutiny of all deaths not taken for investigation by a coroner.

Medical examiner offices have been established in all acute NHS trusts. Many have started implementing processes with other healthcare providers, but this work needs to accelerate. All NHS organisations should have processes to facilitate the work of medical examiners in place by 31 March 2023. To do this will require positive engagement across all healthcare systems to overcome practical and logistical challenges.

Acute trusts

Approximately half of deaths take place outside hospital, meaning the workload of medical examiners offices will double when all non-coronial deaths are scrutinised, compared to just those that occur in hospital. Chief executives and medical directors should ensure medical examiner offices based at their trusts have adequate workforce, and ensure they receive support to process patient records from other healthcare providers. Processes must comply with information governance/ data protection requirements, and recognise the need for medical examiner scrutiny to be independent.

Mental health trusts, community trusts, specialist trusts, and GP practices

Medical examiners provide independent scrutiny of non-coronial deaths across all healthcare settings, and carry out a proportionate review of relevant medical records. All healthcare providers need to develop and implement arrangements to share the records of deceased patients with their local medical examiner office. Many medical examiner offices have already started working with other NHS organisations within their geographical area, and regional medical examiners can provide support where required.

We have been conscious of the need to ensure information governance and data protection requirements are fulfilled. For the period before the statutory system commences, NHS England submitted an application under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2002 ('section 251 support') to process confidential information without consent. The approved application can be found on the Health Research Authority's website (ref: 21/CAG/0032).

When the statutory medical examiner system commences, we expect the provisions to add medical examiners to the list of persons with a right of access to patient records in the Access to Health Records Act 1990.

Integrated care boards

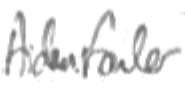
Integrated care boards will be important facilitators for implementing the statutory system. This should include facilitating efficient processes to enable medical examiners to provide independent scrutiny of the causes of death. Digital transformation leads should facilitate work between healthcare providers to share electronic patient records wherever possible.

Colleagues across the country have already made significant progress implementing the medical examiner system despite pressures arising from the coronavirus pandemic. The National Medical Examiner's report for 2021 provides more information about progress and benefits.

We are now close to facilitating independent scrutiny of all non-coronial deaths, providing significant opportunities to improve care and learning in future years.

Yours sincerely,

Dr Alan Fletcher
National Medical Examiner



Dr Aidan Fowler
NHS National Director of Patient Safety

Professor Sir Steve Powis
National Medical Director

Appendix 2

Meeting title	**Quality Assurance Committee**	**Date:14th September 2022**
Report title	**Quality Report: Q1 2022/23**	**Agenda item: 4.1**
Executive director lead	Dr Clare Dollery, Medical Director Sarah Wilding, Chief Nurse and Director of Allied Health Professionals	
Report authors	• Gillian Lewis, Associate Director of Quality Governance • Stefan Codrington, Patient Safety Information Manager • Paula Ryeland, Head of Patient Experience • Sarah Crook, Head of Clinical Effectiveness • Kat Nolan-Cullen, Compliance and QI Manager • Iona MacDonald, Quality Improvement Lead • Clarissa Murdoch, Associate Medical Director for Quality Improvement & Clinical Effectiveness • Vicki Pantelli, Project Lead for Learning from Deaths	
Executive summary	This is the regular quarterly paper to provide an overview of quality across the organisation, covering patient safety, patient experience, clinical effectiveness, quality improvement and assurance. This report will cover Q1, key highlights include: • Maternity Services had their Ockenden peer review visit on 27 June 2022. • Ongoing pressures to respond to complaints in a timely way due to backlog • Endoscopy has achieved full JAG (Joint Advisory Group) accreditation following an inspection in quarter 1, 2022	
Purpose:	Discussion and approval for Trust Board.	
Recommendation(s)	Members are asked to approve for Trust Board: • Identify key issues of good practice to highlight to the Board. • Escalate any concerns where there is insufficient assurance to the Board.	
Risk Register or Board Assurance Framework	Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.	
Report history	This report comprises elements that have been report to the Quality Governance committee in extended form	
Appendices	Appendix 1: Draft Quality account priorities report Appendix 2: Grant Thornton Internal Audit: Clinical Effectiveness	

Quality Report: Quarter 1 2022/23

1. Introduction

1.1. The Quality Governance quarterly report is designed to demonstrate Whittington Health's commitment to continuous learning and improvement. This report provides a systematic analysis of intelligence from patient experience, patient safety and clinical effectiveness, including key performance metrics, as well as themes and trends. This aggregated approach allows the Trust to proactively identify any underlying concerns and to allocate resources accordingly to drive improvement.

2. Patient Safety

Table 1 • Patient Safety Metrics from the June 2022 Board Performance Report (Q1)

Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0
HCAI C Difficile	<16	0	2	0	0	0	1	2	1	2	2		1
Actual Falls	400	30	34	27	23	21	33	40	23	31	25	28	30
Category 3 or 4 Pressure Ulcers	0	13	14	20	3	4	10	4	8	9	17	9	10
Medication Errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA Bacteraemia Incidences	0	0	0	0	0	0	0	0	0	0	0		0
Never Events	0	0	1	0	1	0	0	0	0	0	0	0	0
Serious Incidents	N/A	1	1	3	1	1	3	2	1	5	3	2	2
VTE Risk Assessment %	>95%	73.9%	76.3%	77.0%	77.8%	80.7%	84.1%	93.1%	92.0%	91.2%	95.2%	95.2%	94.9%
Mixed Sex Accomodation Breaches	0	0	0	0	2	14	7	2	4	5	4	5	0
Summary Hospital Level Mortality Indicator (SHMI)	1.14			0.88			0.89						

2.1 Exception reports

2.1.1 Pressure Ulcers

- Please see the separate Pressure Ulcer report for more detailed analysis of pressure ulcer data and an update on the improvement work previously presented to Quality Assurance Committee.

2.1.2 Venous thromboembolism (VTE) Risk Assessments

- Recording of assessments moving from ICE to Careflow as part of the electronic patient record in conjunction with ongoing quality improvement projects has significantly improved performance such that the 95% target has been reached for the first time in over twelve months.

2.2 Mortality

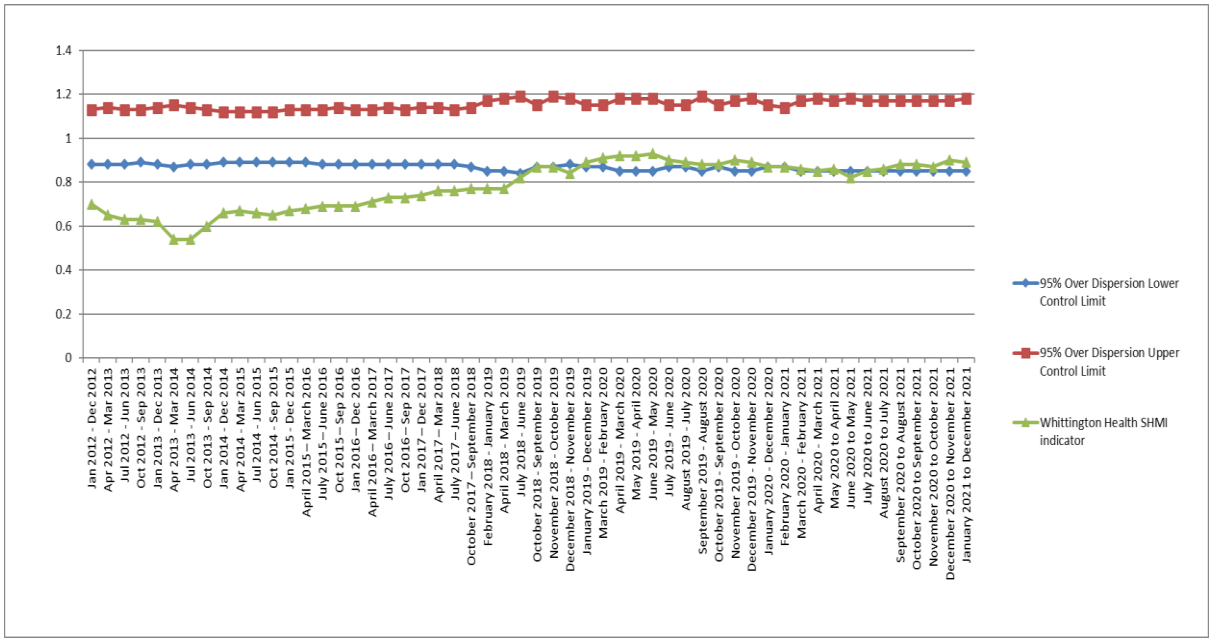
Hospital Standardised Mortality Ratio (HSMR)

- The Hospital Standardised Mortality Ratio (HSMR) is calculated by looking at performance in the NHS and adjusting the mortality risk in a spell of patient care for risk factors such as their age, gender and health conditions. The HSMR uses risk models to provide the number of 'expected deaths' per Trust per month, compared with the number of actual deaths at the Trust.
- The 12-month measurement of HSMR for the Trust shows a significantly low relative risk of 85.5, which outperforms London as a whole. The Trust figure is slightly up in the prior period of 84.6. At rolling 12-month level, the Trust have a low HSMR for the last four years of data. There are no statistically significantly high mortality risk diagnosis groups for Whittington in the last 12 months of data. Weekday HSMR for Whittington for these admissions is significantly low mortality risk, with a HSMR of 80.8 with 234 deaths observed versus 289.7 expected according to the HSMR methodology. Weekend emergency admissions has a 'within expected range' HSMR, of 98.5, which is very close to the NHS benchmark of 100.

Summary Hospital-level Mortality Indicators (SHMI)

- The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. It covers all deaths reported of patients who were admitted to non-specialist acute Trusts in England and either die while in hospital or within 30 days of discharge. COVID-19 deaths are excluded from the SHMI.
- As of July 2020, publication of COVID-19 activity has been excluded from the SHMI. The SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included.
- The SHMI for the data period February 2021 to January 2022 at Whittington Health is 0.89.

Graph 1: Whittington Health SHMI from February 2021 to January 2022



2.3 Safety Alerts

- The Trust received two new National Patient Safety Alerts in Quarter 1.

Table 2: Patient Safety Alerts published in Q1 2022/23

Reference	Title	Issued	Status
NatPSA/2022/ 004/MHRA	NovoRapid PumpCart in the Roche Accu-Chek Inight insulin pump: risk of insulin leakage causing hyperglycaemia and diabetic ketoacidosis	26 May 2022	Alert distributed to relevant leads. Deadline 26 November 2022.
NatPSA/2022/ 002/MHRA	Philips Health Systems V60, V60 Plus and V680 ventilators – potential unexpected shut-down leading to complete loss of ventilation	Re-issued 25 May 2022	This is an update to the alert previously issued in 2021. This alert provided the outcome from Philips Health Systems on the decision regarding replacement/ repair of the previously identified devices. Mitigation of this alert is in progress with a programme of replacement and compensation by Philips which is being coordinated by Whittington Health through the Medical Device Team and

			Respiratory Physiology. This is expected to take 6 – 9 months. The Trusts has been loaned alternative units from the Royal Free London group.

EFA/2017/002	Anti-Barricade Devices: risk of ineffectivity in certain circumstances	19/02/2018	The works arising from this alert are on the Trust's Risk Register (ID 919). Essential Secure Solutions has completed assessment of various areas in the Trust; Simmons House assessment completed and work needed to replace doors which is outstanding, the Northern Health Centre assessment completed and action list to be produced by end of September; assessments of Ifor Ward and ED to be completed by end of September. Remaining assessments and action lists to be completed by the end of August 2022.
EFA/2020/001	Allergens Issues - Food Safety In The NHS	12/02/2021	The Trust awaits approval of the Food Policy at the Environmental and Food Hygiene Group after which this alert can be closed. The policy has been circulated to all group members for final consultation and will be approved by chair's action by end of September. The alert can then be closed.

Two estates alerts remain overdue, which have been escalated to the Director of Finance (responsible for Estates) to support closure with expected completion dates before next quarterly report.

2.4 Maternity Safety Dashboard

2.4.1 The Maternity Safety Dashboard provides and overview of key safety issues. Following Ockenden, there is a recognition that focusing on targets alone, c-section rates, can be misleading and potentially harmful. There is therefore no longer a target rating for c-section or instrumental delivery rates, however the numbers are still reviewed to monitor safety in the context of the wider clinical care delivered.

Table 3: Maternity Dashboard Q1 2022/23

Measure	Goal	Red flag	April	May	June
Induction of labour rate	< 32.1%	>41.2%	**27.0%**	**35%**	**33.6%**
C section rate	N/A		**40.5%**	**40.0%**	**36.5%**
Overall Instrumental Vaginal Delivery Rate (Ventouse or Forceps)	<12.3%	>15.5%	**15.2%**	**17.3%**	**17.0%**
Failed instrumental delivery rate	N/A	N/A	**7.7%**	**2.4%**	**4.7%**
Stillbirth rate	<3.93per 1000births after 23+6 weeks	> 4.8 per 1000 births after 23+6 weeks	**3.8 (one baby)**	**4.1 (one baby)**	**3.8 (one baby)**
Neonatal death rate	<1.71per 1000 live births	>1.81per 1000 live births	**0**	**0**	**0**
Term admissions to NICU	N/A		**7.6%**	**6.6%**	**5.0%**

2.4.2 Maternity Dashboard overview

- The maternity team is working in collaboration with the informatic analyst team to change the way that caesarean section metrics are reported on the local maternity dashboard as well as at the NCL maternal dashboard. The metrics for

caesarean section will be reported using the Robson classification. This will help to:

- Identify and analyse the groups of women which contribute most and least to overall caesarean section rates.
- Compare practice in these groups of women with other units who have more desirable results and consider changes in practice.
- Assess the effectiveness of strategies or interventions targeted at optimizing the use of caesarean section.
- Assess the quality of care and of clinical management practices by analysing outcomes by groups of women.

- Induction of Labour Rate for May and June 2022 is Amber. The overall induction of labour rate has increased since last year – this may be attributed to induction of labour for preterm premature rupture of membranes as well as for premature rupture of membranes not being included on the maternity dashboard for the previous year. The analysis of the NCL maternity dashboard for Quarter 1 also demonstrates that all other maternity units within the sector also saw an increase in their overall induction of labour rate. Our figures are in line with the ones from NCL. To better understand the overall increase of the induction of labour rate an audit needs to be completed. This needs to be a regular quarterly audit to identify the root causes.
- In May 2022, one term baby was stillborn out of 244 total registerable births. This equates to a stillbirth rate of 4.1 per 1000 births. For April and June there was also one stillbirth in each month. However, this figure appeared within the ceiling on the maternity dashboard as for those months the total number of births was higher.
- All stillbirths have been subjected to a systematic, multidisciplinary, review of the circumstances and care leading up and surrounding each stillbirth. This is in line with the perinatal mortality review tool programme. No care and or service delivery problems were identified.

2.4.3 Healthcare Safety Investigation Branch (HSIB)

- The Healthcare Safety Investigation Branch (HSIB) replace the Trust's investigations for all incidents that fit the criteria of the Each Baby Counts programme and any maternal deaths within 42 days of birth.
- The Trust has one active investigation being undertaken by HSIB at present and there were no changes recommended at the HSIB Quarterly Review Meeting (QRM) on 17 June 2022 following the last QRM in March.

2.5 Clinical Harm Reviews

- Since April 2022, the NCL guidelines for harm reviews have changed to patients who have breached 78 weeks. There were six 78-week breaches, and all had clinical harm reviews completed; no harm has been identified.

Table 4: 78-week breaches for Q1 2022 – Patients on admitting pathways only

Speciality Pathway	How many 78w breaches Q1 2022 Patients on admitting pathways only	How many harm reviews were completed	Number outstanding	How many resulted in harm to the patient	What level of Harm (Please insert number)		Action taken
General Surgery	7	7	0	0	No harm	7	
					Minor harm		
					Moderate harm		
					Severe/ Catastrophic/ Death		

- 104-day cancer breach data from Q1 to Q4 below, shows a total of 18 patients breaching across tumour groups in Q4. No harm has been identified from the completed reviews.

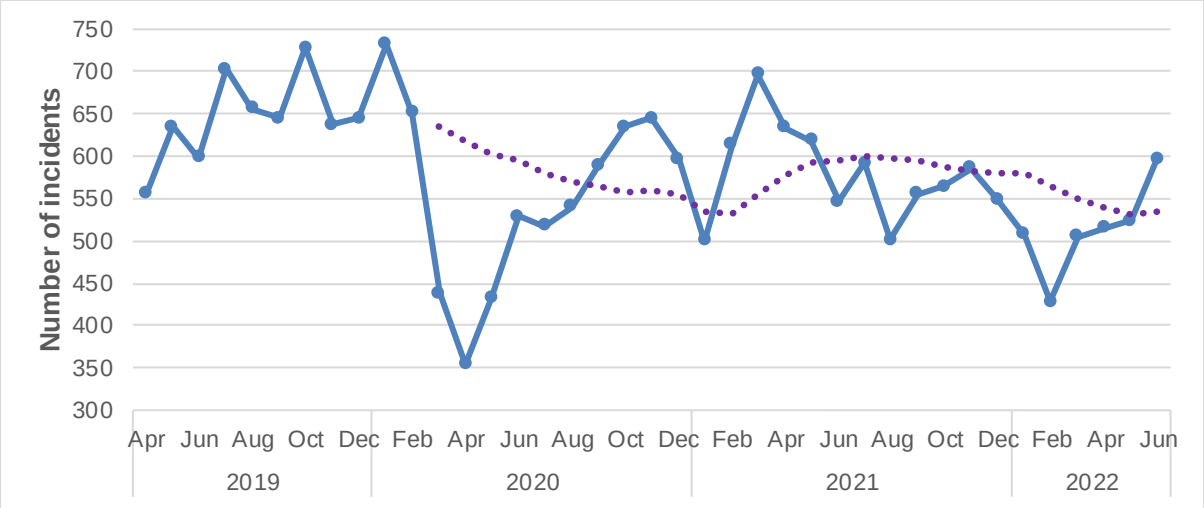
Table 5 • 104-day cancer breaches

Tumour group	Q1	Q2	Q3	Q4
Breast	0	4	0	1
Colorectal	0	1	2	1
Gynaecology	0	0	2	3
Haematology	0	0	0	0
Lung	1	0	0	1
Skin	0	0	1	1
Upper GI	0	1	3	3
Urology	3	3	10	8
TOTAL	4	9	18	18

- The harm reviews are currently outstanding for urology for Q4 this has been escalated to the Clinical Director for Surgery and Cancer. The urology team currently has significant staffing difficulties related to staff sickness and the team have been asked to consider where others can support in completing the reviews.

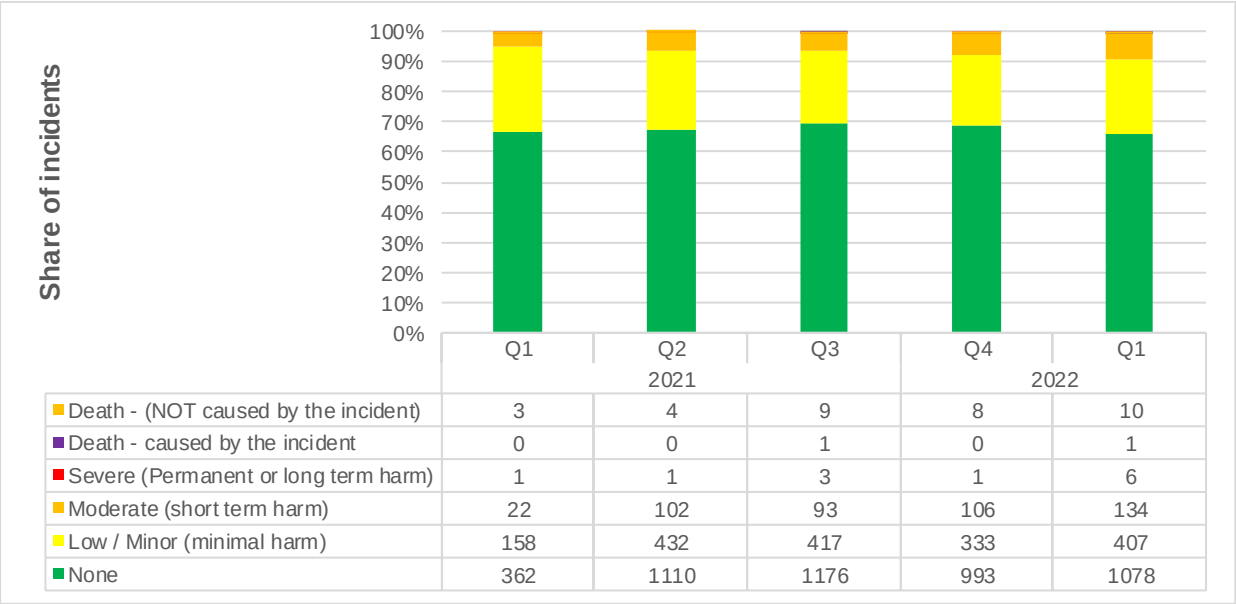
2.6 Learning from Incidents

Graph 2 • Patient Safety incidents from April 2019 to June 2022 by month reported



- The number of incidents reported in Q1 were slightly below the moving average but have trended upward since February 2022. The Quality Governance team continues to support staff increased reporting through Datix training and sessions modelled on the Essentials of Patient Safety from the National Patient Safety Syllabus.
- The severity of these incidents is shown below in graph 3, illustrating little variation in the proportion of incidents causing significant harm (i.e. moderate harm, severe harm or death) compared with those causing no harm or low harm.

Graph 3 – Severity of incidents by Quarter 2021 vs 2022



	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
Death - (NOT caused by the incident)	3	4	9	8	10
Death - caused by the incident	0	0	1	0	1
Severe (Permanent or long term harm)	1	1	3	1	6
Moderate (short term harm)	22	102	93	106	134
Low / Minor (minimal harm)	158	432	417	333	407
None	362	1110	1176	993	1078

- The first three of the top five categories of most frequently reported incidents remain largely unchanged from 2021/22, making up around 40% of all incidents each quarter. The next top areas vary slightly quarter on quarter, but not a statistically significant difference; this quarter labour and delivery, replaced 'Accident that may result in personal injury' (the incident category that includes patient falls) as the fifth most frequently reported incident category. Incidents of 'abusive, violent, disruptive or self-harming behaviour' as a proportion of all incidents, have dropped since Quarter 3, but this continues to be monitored by the Managing Challenging Behaviour Group. New training has been developed with NHS England funding, using Whittington scenarios for community staff facing challenging behaviour in patients' homes. This is following feedback that incidents were being under reported in the community and that the existing training was not relevant to the unique challenges of delivering care in a patients' home and lone working.

Table 6 – Incidents by Category

Category	Number of incidents	Share of incidents in Q4 2021/22
Pressure Ulcer / Moisture-associated Skin Damage	294	18.0%
Security	224	13.7%
Access, Appointment, Admission, Transfer, Discharge	191	11.7%
Medication	139	8.50%
Labour/Delivery	132	8.1%

  - For learning from Serious Incident investigation reports see the bi-monthly Serious Incident report. Key learning from other investigation tools used included review of two medication incidents in which GPs misunderstood the dose of a drug to be prescribed from patients' discharge summaries; the cause was prescribers had not selected the most appropriate strength of drug from the drop-down menu on the electronic prescribing system (JAC).

  - It was identified that these incidents happened with JAC but could also occur with the new CMM prescribing system, and it is not yet possible to make a system change so that the correct preparation strength is automatically selected for a given dose, which would completely avoid risk of human error.

  - Therefore, the Medication Safety Pharmacist has highlighted this to the e-prescribing team and notified teams that, when using the discharge summary, GPs and district nurses who transcribe medication administration record (MAR) charts that they should use the dose rather than the

preparation strength stated on the discharge summary to ensure that patients receive the right doses.

- Duty of Candour: There were 128 eligible incidents which met the criteria for Duty of Candour in Q1 2022/23. 51% were achieved within the recommended 10 working days (verbal apology and written letter), with a further 18% completed after 10 days; forty incidents (31%) remained outstanding as of 22 August.
- Of the duty of candour outstanding 40% (16 incidents) relate to pressure ulcers and this work is incorporated into the Pressure Ulcer Improvement Plan with regard to timely reviewing of DATIX incidents. This primarily relates to the challenge of cross-referencing pressure ulcers noted on admission to Emergency Department and with district nursing services, to identify if these were acquired while within Whittington community care. Additional support was identified and put in place by Emergency and Integrated Medicine ICSU to review pressure ulcers, and the success of the role is now being reviewed. All other outstanding duty of candour incidents are being actively reviewed by the ICSU risk managers and are visible on the dashboard for ICSU leadership review.

3 Clinical Effectiveness

3.1 National and Local Audit

- Grant Thornton undertook an Internal Audit of Clinical Effectiveness systems which provided significant assurance across all six domains, with one improvement action in relation to including NICE guideline compliance within ICSU reporting template. This has now been actioned and will be monitored by the Clinical Effectiveness Group to ensure it is embedded. Full audit report included as Appendix 2

- 11 national clinical audit reports were published in Q1 and work is under consideration to make the report review and action planning process multi-disciplinary as currently it is undertaken by individual medical consultants.

- Outlier status as been identified for the National Early Inflammatory Arthritis Audit. This was expected and primarily due to resource issues, with work ongoing to resolve.

- **The National Paediatric Diabetes Audit Annual Report 2020/21** has identified the following:

- The median HbA1c has not improved since the 2019/20 report. 61.0 mmol/mol was the national median HbA1c for children and young people with Type 1 Diabetes, down from 62.0 in 2020. Whittington Health achieved 68.0 (8.4%) in 2020/21 compared with 61.0 (7.7%) that was achieved nationally. The Department are continuing to work and improve upon the impact of previously identified actions:

- Continue to focus on education in clinic and patient empowerment – downloading and reviewing data at home.
- Low threshold for elective patient admission.
- Low threshold for social services referral.
- Participation in Peer Review is now postponed to Jan 2023.

- **NCEPOD: Healthcare Inequalities - A review 2022.** This report from NCEPOD examines how data captured by their studies supports the identification of healthcare inequalities. The nature of the NCEPOD method means that studies were never explicitly designed to expose healthcare inequalities. However, this report retrospectively highlights where inequalities have been identified. It also includes data from the ongoing Transition study. The findings of this work have been incorporated into the work being undertaken by the Deputy Director of Strategy and NCL on improving population health. As well as being shared with Children and Young people's services for learning on transition to adult care.

- **National data opt-out:** The deadline for health and care organisations to comply has been extended to 31 July 2022. NELA study exemption from the National Data Opt-Out, was confirmed by the Confidentiality Advisory Group.

- The Tendable ward app project (previously called Perfect Ward) continues, it is designed to support regular ward-led audits to allow for real-time monitoring and targeted improvements. Tendable will be live across community services from the end of September 2022.

- A format for standardised reporting on Tendable audits is currently being developed which will be incorporated into the monthly ICSU Board reports, and a high-level graph will be included in the six-monthly report to Quality Governance Committee.

3.2 NICE Guidance

- A total of 60 documents were published in Quarter 1; NICE clinical guidelines (13), with responses on compliance and implementation expected in Quarter 2 2022/23. No significant barriers to implementation have been identified.

- Of the 11 NICE guidelines published in Quarter 4, 3 have been subsequently republished and superseded by updated guidance. One remains outstanding for review; the Integrated health and social care for people experiencing homelessness guideline, which due to its complexity requires a longer timeframe for review and is expected by November.

3.3 GIRFT (Getting It Right First Time)

- In December 2021 an external NHS contractor was employed to undertake a review of all the clinical claims in the last 5 years as part of the National GIRFT litigation review cycle. The final report was presented to the Trust in Quarter 4, 2021/22. The four most frequent types of claim were in keeping with national findings: Obstetrics, Accident & Emergency, slips and trips and General Surgery. Of note Obstetrics and ED are the two clinical specialities that increase a Trust's annual premium as they are acknowledged to be areas of high-risk litigation.

- Actions following the report have been ongoing in Quarter 1;
    - Women's Health to review learning from all open cases to expedite learning from claims (claims may remain open for a longer period due to damages being paid but final settlement not possible as care needs maybe lifelong and not yet determined): The NHS Resolution Head of Patient Safety for the South East attended the Trust to meet with maternity, neonatal and legal teams to provide greater insight on the findings and key learning from the data.
    - Detailed review of 20 surgical cases: This was completed and shared with Surgery and Cancer ICSU, no common themes were identified.
    - The report also highlighted the difficulty in analysing common themes from litigation due to the lead time between the underlying incident and the date of claim. To mitigate this, the legal team work closely with patient safety team and ICSU risk managers to relate the claim to any associated safety investigation or complaints. A revised pathway for learning from claims has been put in place, whereby the actions from any related SIs or complaints are checked for completion, and a data search is completed to identify if there have been any similar incidents since the underlying claims case which would indicate the actions have not been effective and require further mitigation.

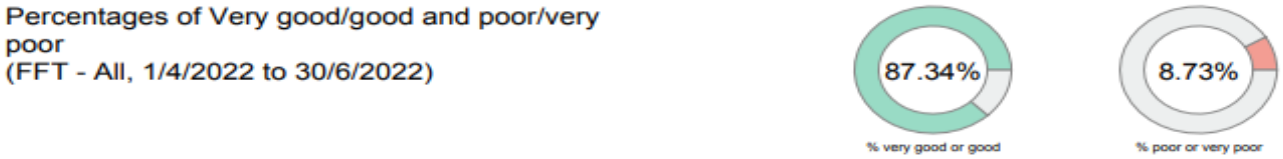
4 Patient Experience

4.1 Friends and Family Test (FFT)

- There has been a 28% rise in response rates across all areas in quarter 1. This is in part due to the expanded use of digital QR codes, with the Patient Experience Manager continuing to support services to promote QR usage to increase uptake further. In addition, the outpatient FFT questions are now available in ten languages to ensure that feedback is more representative of the population the Trust serves.
- However, FFT response rate remains below expected rates (Table 7 below shows the expected FFT rates for the Trust). Work is ongoing to improve this, led by the Patient Experience Manager including;
    - Streamlining the FFT process to minimise use of paper cards which create an administrative burden. However, ensuring paper cards are still available for those for whom digital feedback in inaccessible
    - Ensuring forms are suitable for children, patients with learning disabilities and available in multiple languages
    - Working with Communications Team to promote FFT on social media, website, screen savers and posters, as well as regular league tables sent to ICSUs
    - Training on use of IQVIA, the software which collates FFT results
    - A cohort of volunteers directly support with gathering feedback in targeted areas as needed
    - Patient Experience Manager is working with ICSUs to create meaningful actions and 'You said, we did' boards to demonstrate how FFT feedback is used to drive improvement.
    - Targeted support in maternity services
    - Patients from ED receive a text message once they have attended to complete an FFT questionnaire.
    - The Patient Experience Team will provide further support to the ED team to trial different ideas to improve FFT collection in ED.

- 9th June 2022 was '"What Matters to Me Day" and so to mark this, staff from across ICSUs spoke to patients across the Trust. They were asked three questions- what matters to them when they are here; what they were pleased with and then whether anything had disappointed them during their visit/ admission. The results showed some themes in different areas and these have been analysed and fed back to the areas to work on.
    - One example was on two wards, there was a theme about call bells not being answered- and this was fed back to the ward managers to take immediate action

Graph 4: FFT data for Quarter 1



Graph 5: FFT Surveys Completed by Month

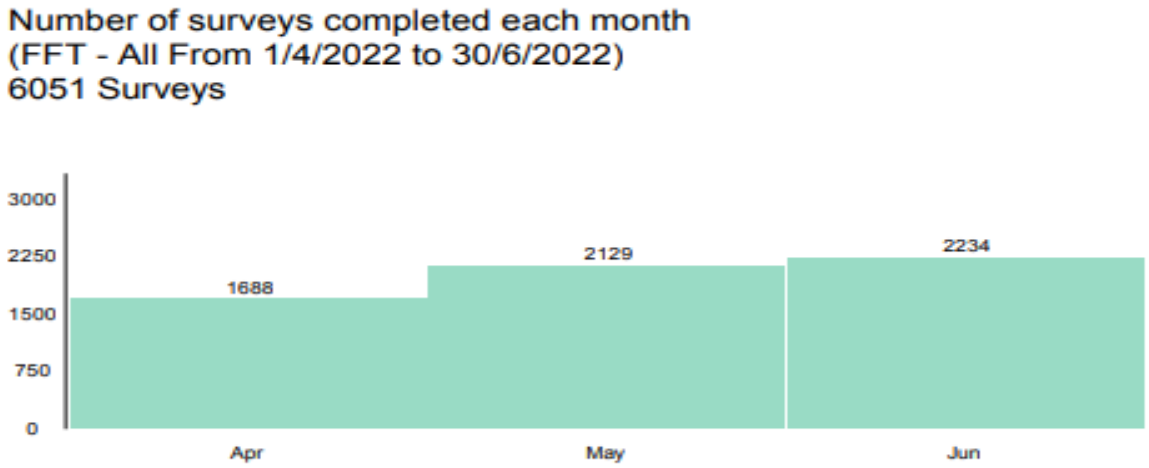
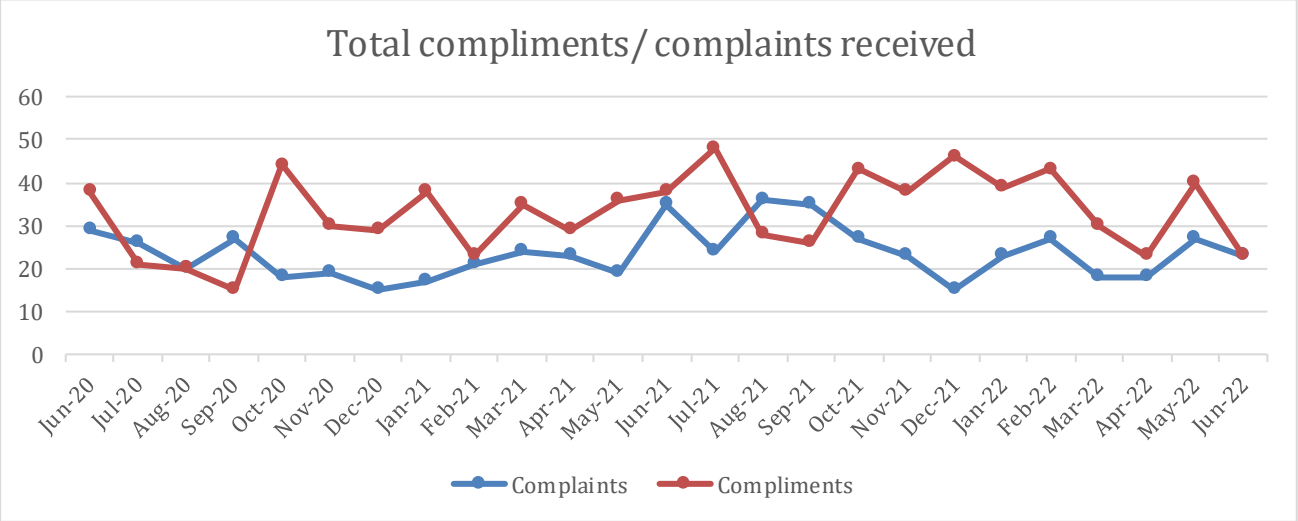


Table 7: Board performance report 'Caring', July 2022

Indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	2022-2023
ED - FFT % Positive	>90%	75.5%	77.8%	77.7%	78.0%	74.7%	77.1%	82.2%	79.2%	72.4%	79.1%	75.3%	74.6%	76.2%
ED - FFT Response Rate	>15%	11.0%	11.5%	10.6%	10.6%	10.5%	11.3%	11.5%	10.8%	10.0%	10.6%	11.3%	12.4%	11.4%
Inpatients - FFT % Positive	>90%	95.9%	96.4%	94.1%	94.7%	95.9%	96.5%	96.3%	96.4%	96.8%	94.2%	93.2%	93.3%	93.5%
Inpatients - FFT Response Rate	>25%	16.6%	13.8%	18.8%	18.1%	23.9%	16.0%	18.7%	17.2%	14.9%	16.5%	19.1%	29.1%	20.7%
Maternity - FFT % Positive	>90%	100.0%	100.0%		99.0%	94.9%	97.8%	96.5%	100.0%	77.8%	80.0%	100.0%	100.0%	87.5%
Maternity - FFT Response Rate	>15%	24.6%	2.2%	0.0%	16.1%	20.1%	8.4%	9.6%	1.6%	0.9%	1.0%	0.4%	0.2%	0.5%
Outpatients - FFT % Positive	>90%	97.5%	97.7%	96.3%	75.0%	88.9%	90.0%	98.1%	93.3%	89.5%	75.0%	87.9%	90.0%	89.1%
Outpatients - FFT Responses	400	40	43	27	20	54	60	54	60	76	4	33	100	137
Community - FFT % Positive	>90%	97.1%	97.0%	95.1%	96.5%	98.0%	98.2%	99.2%	99.4%	99.1%	97.2%	99.2%	97.3%	98.0%
Community - FFT Responses	1500	383	367	509	567	611	547	486	462	572	470	627	672	1769

4.2 Complaints and compliments

Graph 6: Total Received Compliments and Complaints per month since June 2020

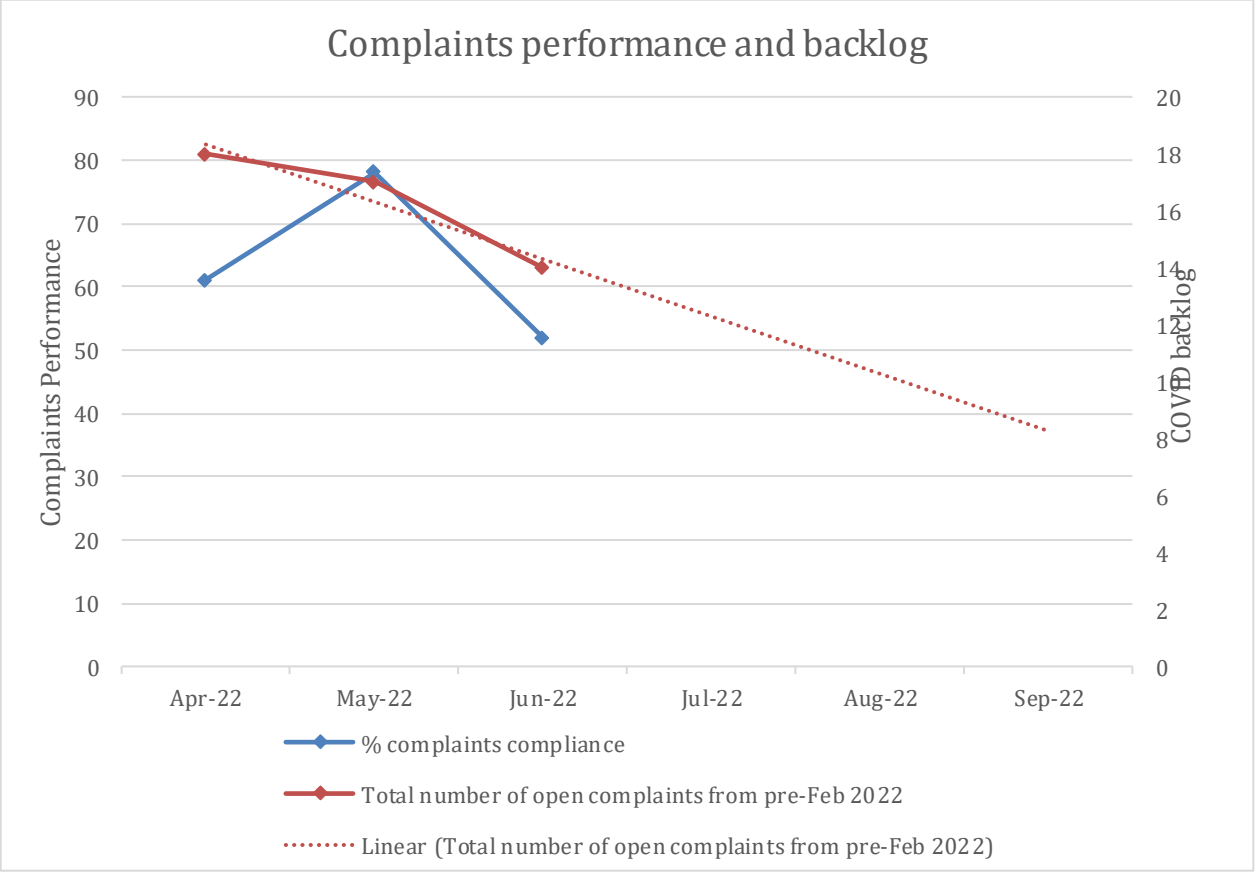


- Due to staffing and clinical pressures, complaint responses were paused from December 2021- February 2022, while the number of new complaints has remained relatively constant, leading to an inevitable backlog.
- Graph 7 below illustrates the gradual decline of the historic backlog, alongside monthly completion rates for new complaints. The quarter 1 performance was 65% of complaints responded to within timeframe, against a target of 80%, and backlog pre-February 2022 was at 14 complaints, due to ongoing staffing pressures in both ICSUs and the complaints team.
- Actions to address introduced in quarter 2 include;
    - Redeployment of staff member from Quality Governance team to support directly with backlog of complaint investigations within Surgery and Cancer ICSU
    - Review of complaint templates to improve quality
    - Revision of duties between complaints team and ICSU investigators to improve quality and timeliness of responses. This includes the complaints team now offering to draft the formal response once the ICSU have investigated the complaint and offering to meet with investigators to ascertain the terms of reference to be addressed in each complaint
    - Ongoing focus on early discussion with the complainant to address concerns promptly and de-escalate complaint (9 complaints deescalated in Q1)
    - ICSUs provided with personalised weekly graphs, showing total number of open complaints, those open still in time and their backlog. This will help show the backlog decreasing and provide visibility

Graph 7 below shows the number of complaints responded to within timeframe (% complaints compliance) and the backlog. There is also a trendline for reducing the backlog, illustrating the trajectory to close historic complaints (red line), which is

being done in conjunction with ongoing work to return to the target of responding to at least 80% of complaints within agreed timeframes.

Graph 7: Complaints performance and Backlog Apr – Jun 2022



4.3 Patient Surveys

Picker 2021 Inpatient Survey Results (Results embargoed until October 2022)

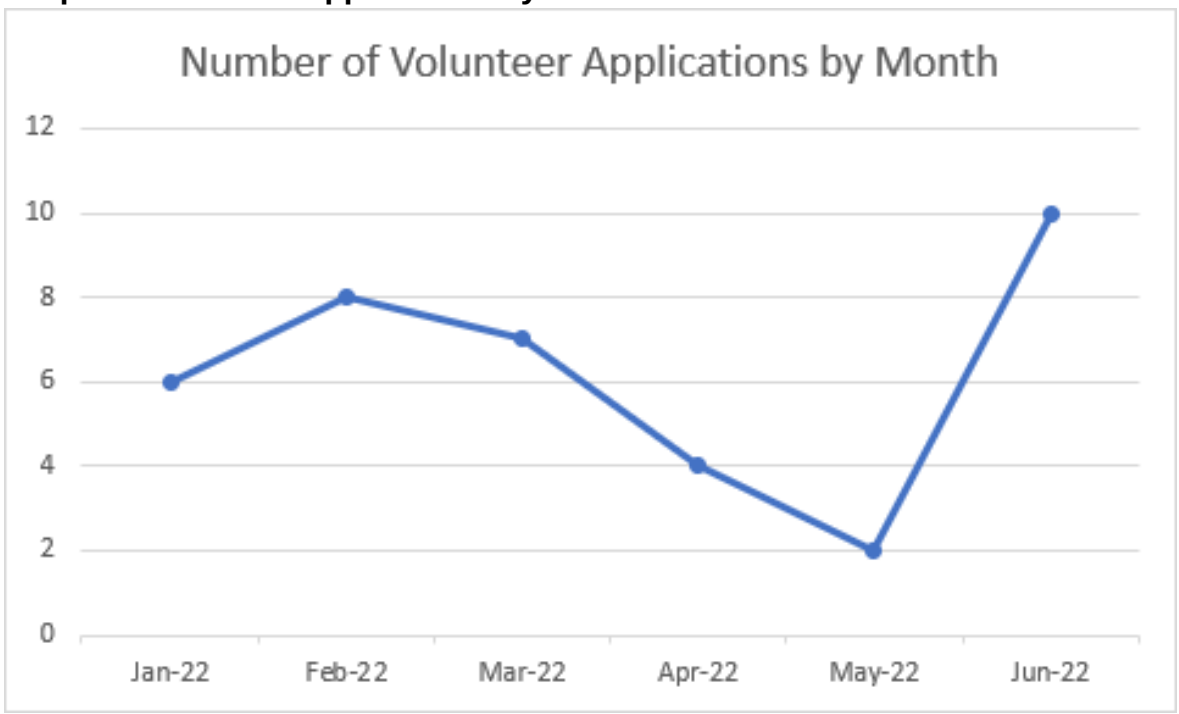
There will be a verbal update on the results given to the committee.

4.4 Volunteer Service

- The volunteer and patient experience coordinator role was recruited to in May 2022, meaning the pause of volunteer recruitment has been lifted.
- 29 new volunteers were recruited in May and June, including processing a backlog of applications following the pause
- Volunteer roles are supporting in administrative roles across a number of services including rheumatology, maternity, cariology, cancer services, and a new role with the overseas patients department, as well as prioritising the Welcome guide roles, which are now in place 5 days per week. Ward based roles have been re-introduced but these have been harder to maintain due to varying Covid restrictions; volunteer support in the chemotherapy unit has continued throughout the pandemic and two volunteers have recently been recruited to support the Dementia Clinical Nurse Specialist.

- In Quarter 2, we hope to welcome volunteers on to the care of the older people's wards as part of a 'tea and chat' initiative.
- There has been an increase in demand for volunteers to support in areas due to staffing shortages, and the volunteer team continue to work hard to ensure that volunteer roles find the balance between providing valuable learning opportunities for volunteers while also supporting patients and the work of the Trust.
- There has been a slight decline in new volunteer applications with 16 received in Q1 2022/23, due to a pause in recruiting volunteers. This ended in May 22. 21 were received in Q4 2021/22. The volunteer managers are working with the communications team to advertise volunteer opportunities more widely through social media platforms. This has already helped to increase applications so far in Q2 2022/23 to 25. Please see graph 8 for further information.
- The team is also working to increase representation of different community groups within the volunteer cohort. Future plans to do this are by working with different sixth form colleges and universities to offer placements for students interesting in working in the Health Care sector; approaching the local faith groups with a view to advertising opportunities with them; advertising opportunities with local community groups; continuing to work with Ambitious about Autism and Care Trade and offer placements for these students
- This academic year, the volunteering team has worked closely with 'Ambitious about Autism' and provided a placement for a student. The Trust also has provided placements for Health and Social Care students from Westminster and Kingsway college and is currently working to establish the same placements for students from Regents College which run for the academic year.

Graph 8: Volunteer Applications by Month



4.5 Patient Information and Interpreting

- The gradual shift towards face-to-face interpreting has continued, after the focus on virtual and telephone interpreting during the pandemic. These continue to be predominantly managed in-house however 10% of these are outsourced to Big Word due to the lack of availability of inhouse interpreters. Communication with services continues to outline the criteria for face-to-face interpreting and ensure virtual and telephone interpreted are used when appropriate.
- Tender of Out of Hours/ Unplanned interpreting provision across five Trusts is remains ongoing with delays due to the number of trusts involved in the procurement process
- The implementation of the new interpreting booking system remains ongoing which will help with current problems of reduced capacity and lack of resource issues. This will mean a change of current processes for the whole Trust but will allow clinics/services to book online and check their own bookings.

4.6 Legal Services

- There has been an increase in inquests in quarter 1, alongside more detailed information requests from the Coroner's office, which has put additional pressure on clinical teams. The Legal Services office is supporting with inquest briefings for clinical teams as needed to provide additional support
- 10 inquests were closed in Q1 and no Prevention of Future Death orders issued.
- The number of claims received remains steady this quarter.

4.7 Patient Experience Strategy 2022-25

At present, the new Patient Experience strategy is being developed with key stakeholders. In a series of meetings with stakeholders, themes and issues were discussed which has driven the proposal of three overarching commitments:

  - enable our patients and carers to join us in improving patient experience
  - support our staff to improve patient experience
  - work alongside our local partners to improve patient experience

This strategy will run from Jan 2023- December 2025.

5 Better Never Stops: From Good to Outstanding

5.1 Quality Improvement Programme

The Trust Quality Improvement Programme is focused on 5 key priorities, which were identified as part of the Quality Account consultation. The details on progress

against the Quality Account commitments can be found in Appendix 1. Key headlines include;

- Baseline data for Next of Kin (NoK) project showed 85% of sample non-elective admissions in May 2022 had NoK data recorded, and identified missed opportunities to update records. Contact with Next of Kin, when appropriate appeared in the majority of cases.
- Dear Patient letter initiative: Spot check audit showed that practice is well embedded in Care of Older People and Pain management teams, but significant variance across other services. Targeted work in surgical specialties planned in Q2.
- Blood transfusion training continues to increase across the Trust, most noticeable for operating department practitioners (ODP) and midwifery disciplines
- National Patient Safety Syllabus training added to Elev8, with communication and delivery plans ongoing for Q2 and Q3.
- More focused support will be provided to support the three work streams related to reducing deconditioning in Q2

In addition to the commitments made in the Quality Account, the QI Lead monitors the QI registration database to identify any projects, which correlate with these priorities in order to provide support and share learning. This helps maintain the balance between top down and bottom-up quality improvement, current project examples include;

Deconditioning:

- Improving Recognition and Documentation of Delirium in ITU
- Remote monitoring project
- Community Trial Without Catheter (TWOC) project
- ICAT Frailty
- Stop falls!
- Completion and Accuracy of Clinical Frailty Scores in the Emergency Department
- Optimising Hydration in a Care Home

Health Inequalities:

- Interpreter on wheels service
- Improving the experience of patients with Sickle Cell Disorder attending the Emergency Department

5.2 Encouraging, Empowering and Embedding Quality Improvement

An annual QI Celebration event was held in June 2022. Projects presented at the afternoon represented a cross section of ICSUs and multiple disciplines

(Admissions, Dentistry, Emergency Department, General Medicine, General Surgery, Maternity and Women's Health, Occupational Therapy, Pharmacy, Physiotherapy, Radiology, Rheumatology, Speech and Language Therapy, Trauma and Orthopaedics).

- ***Best Project Winner:*** "Reaching our goals together" which developed an upper limb programme for stroke survivors using a co-design model, involving clients in the development of the programme. The project resulted in reduced waiting times, increased multidisciplinary working, and improved wellbeing and quality of life for clients.
- ***People's Choice Winner:*** "A quality improvement collaboration of orthodontic and community dental services" which introduced a new pathway (ROAR - Rapid Orthodontic Advice Request) to digitally connect community dental services with orthodontic specialist advice. This resulted in local multidisciplinary integrated care reduction of waiting time for orthodontic advice from 6-8 months to within 1 day.

Training and support:

- A QI training workshop was delivered 23rd May (16 attendees)
- Ad-hoc specific training groups planned for Q2 for OD, junior doctors, and Nursing and AHP preceptorship programme
- QI drop-in support provided to AHP Leadership Fellowship
- Virtual QI support clinics set up, providing 30-minute slots (8 per week) for those seeking QI support/mentoring, advertised via the Noticeboard

Whittington Improvement Faculty

- Held in May 2022 with the theme "Building a team and developing an effective team culture", identified top 5 pieces of advice:
    - *Treat each person how they want to be treated, not how you want to be treated. There is no right or wrong way*
    - *Work on difficult relationships and good behaviours to enable communication and a good environment for other improvements*
    - *Most conflicts are due to lack of role clarity or communication*
    - *Team leaders should consider asking the OD team (Organisational Development) about what support their team might need to work most effectively*
    - *Ensure there are clear explanations and expectations of each role, so individuals know what they and others do*

5.3 Adopting and Acknowledging QI

Table 8 QI Projects presented at national and international conferences:

Project Title	Project Lead & Workers	Outcome

Reducing fatigue and improving facilities: a QI project	Liam Healey, Becs Sullivan, Julie Andrews, Cecil Douglas, Steven Packer, Graeme Muir, Paula Ryeland	Presented project internationally
Feedback Provision in Autism Diagnostic Observation Schedule	Debbie Levene, Nicola Horwitz	Project presented at the BACCH conference
Improving the delivery of Venous Thromboembolism (VTE) prophylaxis for ambulatory patients requiring lower limb immobilisation in the emergency department	Harry Carter; Lucy Parker; Vanessa Georgoulas	Poster presented at the Welsh Orthopaedic Society Conference
Admission weight and Malnutrition screening in the Acute Admissions Unit	Darmiga ThayabaranMehar Chawla, Roobini Basra, Tomisin Ademiju, Dorothy Ip	Poster presented at the Society of acute medicine conference, Liverpool 2020
Assessment of suitability of Patient-Student phonecalls for medical education	Nicola Marks, Naomi Rasmussen, Menna Yakoub, Felix Simpson-Orlebar	Abstract presented at the British Thoracic Society Winter Conference 2021
Midwife led referrals for physiological jaundice into hospital@home & Management of Neonatal Jaundice in the Community	Janine Younis, Zoe Tribble, Delores D'Souza	Project features in the Atlas of Shared Learning and was shortlisted for an RCN award. Project has gone 'viral' and been the inspiration for several other H@H teams who have now set up home based Phototherapy services across the UK. Additional project to an international audience last month which stemmed from this QI project
Young Persons Rounds	Janine Younis; Colette Datt; Rhys Johnson; Madeline Ioannou; Sarah Otley; James Connell	Presented at RCPCH

5.4 CQC and External Reviews

- Maternity Services had their Ockenden peer review visit on 27 June 2022, an item detailing the report is being discussed at this meeting.
- Grant Thornton Internal Audit of CQC Action Plan in quarter 1 provided significant assurance with some improvement actions, which have been added to the existing CQC action plan, and are being monitored via ICSU reporting structure with oversight from Better Never Stops meeting and Quality Governance Committee

- Human Tissue Authority (HTA) conducted a visit in June 2022 of the laboratory, mortuary and maternity services. Informal feedback highlighted the caring attitude of staff. The written report has highlighted six major areas to address in the subsequent action plan and one minor; these relate to risk assessment being completed regularly and monitored (with reference to fridge storage), premises are clean and well maintained (body store and most mortem room), facilities for the storage of bodies and human tissue (fridge storage capacity, specialist storage for bariatric bodies, and working condition of fridge/freezer units), equipment in good condition, and demarcation of clean/dirty/transition areas of the mortuary. The report was recently received and is due to be presented at Quality Governance Committee. Actions are ongoing to address these issues.
- Endoscopy has achieved full JAG (Joint Advisory Group) accreditation following an inspection in quarter 1, 2022.
- The CQC Engagement meeting focused on Outpatients and Diagnostic services, with positive assurance noted by the CQC

5.5 Peer Reviews/ Mock CQC Inspections

- In quarter 1, two paper-based peer reviews were undertaken in Holloway Health Centre and Hornsey Central Health Centre. This was part of the trial to move community services onto the Tendable app for regular audits.
- In line with the new CQC inspection process and the introduction of Tendable, Whittington has adopted a risk-based approach to mock CQC inspections with larger, multi-disciplinary reviews triggered by <70% Tendable outcomes as well as other intelligence, such as patient safety incidents and patient feedback.

6 Recommendations

6.1 The Quality Assurance Committee is asked to note the three key quality messages from the Q1 Quality report:

- Positive feedback from Ockenden visit to maternity services
- Annual Quality Improvement Celebration Event in June 2022 highlighted a number of positive achievements across the Trust
- Ongoing challenges exist in responding to complaint responses within national timeframes with actions in place to improve

Appendix 3

Meeting title	**Quality Assurance Committee**	**Date: 14/09/2022**
Report title	**Premises Assurance Model (PAM) Assessment 2021/22**	**Agenda item: 4.9**
Executive Director lead	Ahmed Hassan, Director of Estates and Facilities	
Report author	Vera Drenska, Compliance Officer (in collaboration with the Estates & Facilities Department)	
Executive summary	The Premises Assurance Model (PAM) is a self-assessment tool originally developed by the Department of Health in 2013 and subsequently updated on a regular basis. It provides a nationally consistent approach to evaluate the current position of Estates and Facilities performance against a set of common indicators. The objective of NHS PAM is to support the patient rights 'to be cared for in a clean, safe, secure and suitable environment" set out in the NHS Constitution and essentially establishes an internal audit to ensure regulatory and legislative compliance. The completion of the current version of the NHS PAM is now a mandatory exercise as the model is now included within the NHS Standard Contract. This report provides a high-level summary overview of the NHS Premises Assurance Model (NHS PAM) process, which was undertaken in 2021-22 by the Estates and Facilities Department in collaboration with other Teams. It details the results of the self-assessment exercise. As a live working document, the PAM assessment and its findings will be subject to regular reviews in 2022-23. The Director of Estates and Facilities is the Senior Responsible Officer for the Estates and Facilities function and is responsible for the Premises Assurance Model delivery.	
Purpose:	The Trust Board is asked to review and approve this document by 5th September 2022. The submission deadline is 9th September 2022.	
Recommendation(s)	The Trust Board is requested to acknowledge the 2021/22 PAM assessment findings.	
Risk Register or Board Assurance Framework		
Report history	PAM Working Group	
Appendices	Appendix 1 PAM Assessment 2021/22 Presentation	

Introduction

The NHS operates over 1,200 hospitals as well as nearly 3,000 other treatment facilities, many of which operate 24/7, every day of the year. The occupied floor area of the NHS is 24.3 million m^2 which is the equivalent of 3,400 football pitches.

The estate and its related services are integral to the delivery of high-quality clinical care. Therefore, it is essential that the NHS provides a safe, high quality and efficient estate. It is critical that none of these three elements are delivered at the expense of the other two. The objective is to deliver a financially sustainable NHS that takes quality and safety as its organising principle.

As part of this, assurance is needed that appropriate actions and investment are taking place.

The main benefits of the NHS Premises Assurance Model (PAM) are to:

- Allow NHS funded providers of healthcare (NHS providers) to demonstrate to their patients, commissioners and regulators that robust systems are in place to assure that their premises and associated services are safe.
- Provide a consistent basis to measure compliance against legislation and guidance, across the whole NHS.
- Prioritise investment decisions to raise standards in the most advantageous way.

The Director of Estates and Facilities is the Senior Responsible Officer for the Estates and Facilities function and is responsible for the Premises Assurance Model delivery.

The PAM assessment was originally a voluntary annual return to NHSE/I but is now a mandatory annual return as part of the NHS Standard Contract. Last year 85% of Trusts completed the annual return and this year NHSE/I expect to receive 100%.

It essentially constitutes an internal audit of the elements that would be inspected by the CQC to ensure regulatory and legislative compliance and safety fulfilling the 'rights of patients' to be treated in a safe and suitably maintained environment.

The PAM assessment for the Whittington Health Estate took place through a series of meetings held with key stakeholders, including consultation with Authorising Engineers (AEs) and external assessors.

Domains and Scoring

The Pam Assessment Tool is split into 5 Domains to evaluate the way our organization manages its Estate and Facilities. The 5 Domains are:

- Safety Hard & Safety 'Soft' – The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical and social outcomes.
- Patient Experience - The organisation provides assurance that its premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
- Efficiency - The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.

- Effectiveness - The organisation provides assurance that its premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
- Governance - The organisation's Board of Directors deliver strategic leadership and effective scrutiny of the organisation's Estates and Facilities operations. It analysis how the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

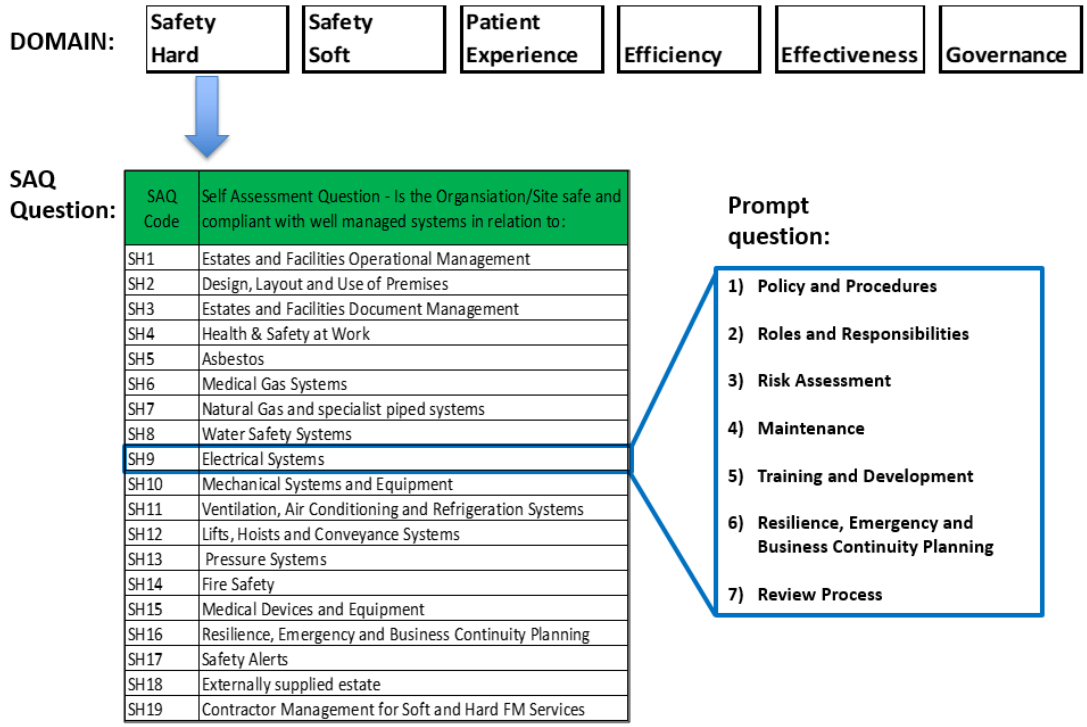
Each Domain contains specific Self-Assessment questions (SAQs), that are then broken down into further questions known as 'Prompt' questions.

Domain	Total number of SAQs	Total number of Prompt questions
Safety Hard (Combined Hard and Soft FM)	29	230
Patient Experience	6	27
Efficiency	5	29
Effectiveness	4	25
Governance	3	26
Total	**47**	**337**

There are six possible responses for a prompt question which are illustrated in the table below:

Outstanding
Compliant with no action plus evidence of high-quality services and innovation.
Good
Compliant no action required.
Requires minimal improvement
The impact on people who use services, visitors or staff is low.
Require moderate improvement
The impact on people who use services, visitors or staff is medium.
Inadequate
Action is required quickly - the impact on people who use services, visitors or staff is high.
Not Applicable
The prompt question does not apply to our organisation/site or is not applicable by virtue of the responses given in the other prompt questions e.g. there is no need to prepare an action plan where full compliance has been identified.

PAM Process – Structure

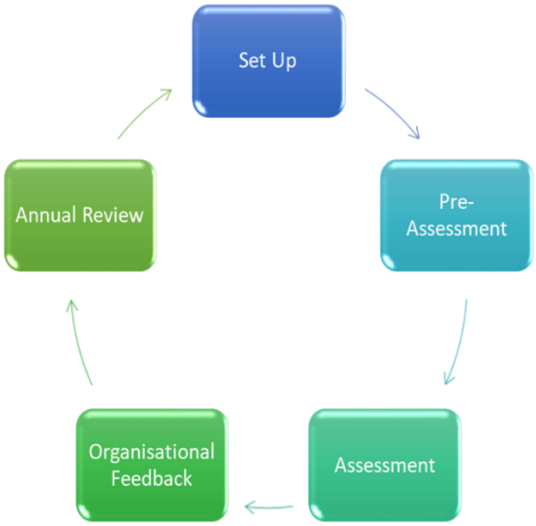


The aim is to demonstrate safe and compliant processes with well managed systems in relation to the topic areas.

1. Policy & Procedures	Current, approved policy and an underpinning set of procedures that comply with relevant legislation and published
2. Roles and responsibilities	Qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?
3. Risk assessment	Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?
4. Maintenance	Are assets, equipment and plant adequately maintained?
5. Training and development	Up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?
6. Resilience, emergency and business continuity planning	Have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?
7. Review process	Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?
8. Costed action plans	If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance?

The scores/rating on individual prompt questions are averaged to provide a rating for the Self-Assessment Question (SAQ) and in turn the SAQ ratings are averaged to produce a rating for the Domain. The ratings provided by the NHS PAM cannot be considered to be a definitive indication that a service/organisation/site is safe and meets all their legal obligations but provides a structured basis for greater transparency and discussion of the organisations own view of compliance.

Assessment Process
The assessment process has been based on a 5-step process which has proven to be effective.



Set-Up
The set-up process included reviewing the submission template and identifying the most appropriate Leads/Subject Matter Experts for each SAQ.

PAM Pre-Assessments
The pre-assessment stage included a review of Leads/Subject Matter Expert to ensure we had the most appropriate members of the teams involved in the assessment process.

PAM Assessments
During the assessment session, individual Leads met within Sub-Groups to assign an adequate score, gather relative evidence and discuss any further actions.

The information gathered from each Sub-Group was then collated and shared with the PAM Assessment Group, which saw Lead taking a collaborative approach to provide ideas and identify any additional actions. The assessment panels included:

- Deputy Director of Estates & Facilities
- Head of Estates
- Head of Facilities
- Head of Capital Projects
- Health & Safety Advisor
- Deputy Head of Financial Services
- Clinical Engineering & Medical Physics Manager
- Decontamination Manager and Trust Advisor
- Assistant Director of Strategy
- Estates Development Lead Strategy
- Fire Safety Manager
- Emergency Planning Officer
- Energy and Estates Systems Manager
- M&E Supervisor

- Compliance Officer
- Property Consultant

Additional support, guidance and advice was also provided by:

- Quality Governance & Risk Management and Compliance Team
- PALS Office
- Patient Experience Team
- Finance Team
- IT Team
- Communications Team
- Authorised Engineers for Hard FM
- Estates Managers/Officers (Hard FM)
- Facilities Managers/Supervisors (Soft FM)
- Project Team
- Bed Site Management Leads
- Energy & Process Improvement Consultant

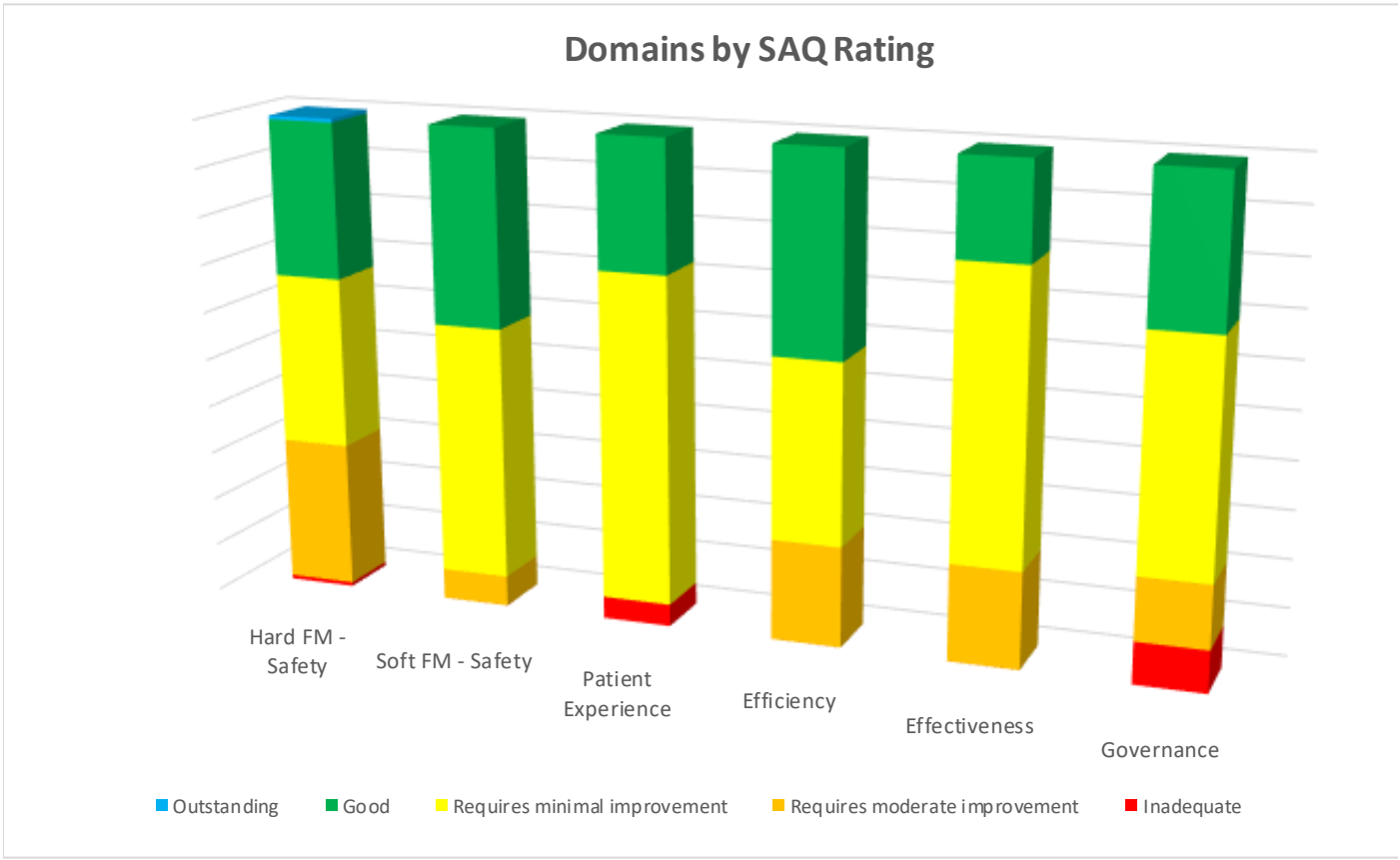
Supporting documents for the PAM scoring have been saved in I:\Facilities Directorate\2. ESTATES\19. PAM (Premises Assurance Model) 2021-2022\Evidence 2021-22 for future reference.

Organisational Feedback
The outcome of the assessment will be shared with Estates and Facilities Director for comment prior to being shared with the Board for information and assurance.

Any SAQs with an outcome of inadequate or requires moderate improvement will be reviewed with the Leads/Subject Matter Experts to assist with completing any gaps identified.

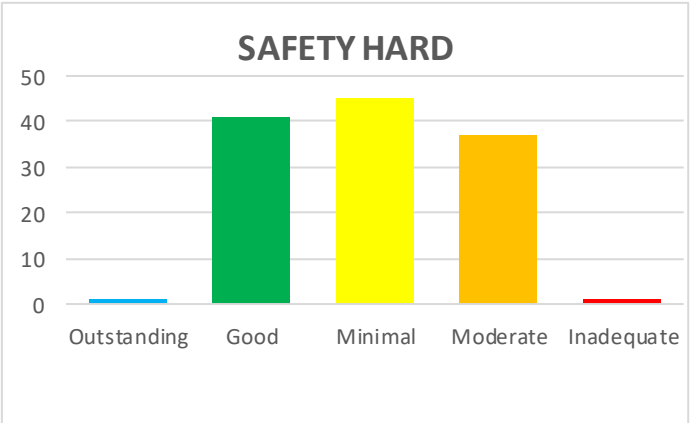
Annual Review
In 2022/23, RFLPS will be working closely with Whittington Health to provide leadership and stewardship to the Estates and Facilities team. Annual reviews will be conducted to continue the review cycle of the PAM Assessment.

Whittington Health PAM Results 2021/22



Safety Hard Results

SAQ No.	Self-Assessment Question (SAQ) Subject
SH1	Estates and Facilities Operational Management
SH2	Design, Layout and Use of Premises
SH3	Estates and Facilities Document Management
SH4	Health & Safety at Work
SH5	Asbestos
SH6	Medical Gas Systems
SH7	Natural Gas and specialist piped systems
SH8	Water Safety Systems
SH9	Electrical Systems
SH10	Mechanical Systems and Equipment
SH11	Ventilation, Air Conditioning and Refrigeration Systems
SH12	Lifts, Hoists and Conveyance Systems
SH13	Pressure Systems
SH14	Fire Safety
SH15	Medical Devices and Equipment
SH16	Resilience, Emergency and Business Continuity Planning
SH17	Safety Alerts
SH18	Externally supplied estate

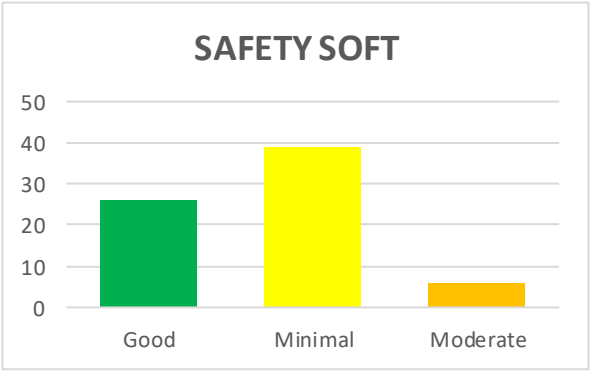


Safety Hard	
Outstanding	1
Good	41
Minimal	45
Moderate	37
Inadequate	1
Total	**126**

SH19	Contractor Management for Soft and Hard FM services

Safety Soft Results

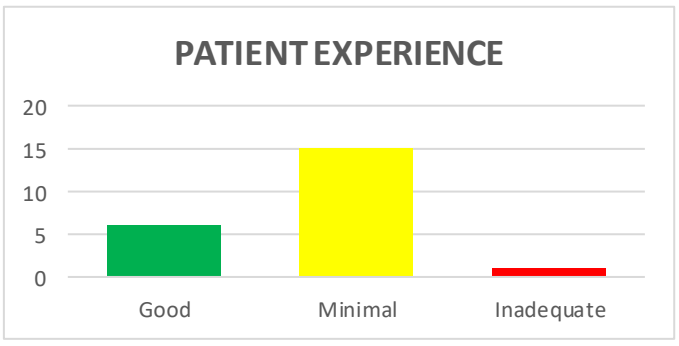
SAQ No.	Self-Assessment Question (SAQ) Subject
SS1	Catering services
SS2	Decontamination process
SS3	Waste and Recycling Management
SS4	Cleanliness and Infection Control
SS5	Laundry and Linen Services
SS6	Security Management
SS7	Transport Services
SS8	Pest control
SS9	Portering services
SS10	Telephony and switchboard services



Safety Soft	
Outstanding	0
Good	26
Minimal	39
Moderate	6
Inadequate	0
Total	**71**

Patient Experience Results

SAQ No.	Self-Assessment Question (SAQ) Subject
P1	Engagement and involvement
P2	Condition, appearance, maintenance and privacy and dignity perception

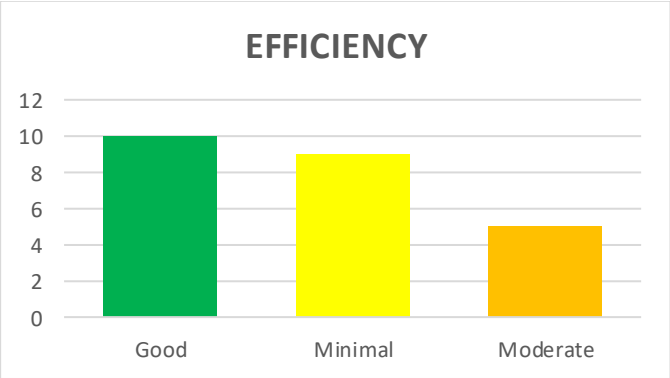


P3	Cleanliness
P4	Access and Car Parking
P5	Grounds and Gardens
P6	Catering services

Patient Experience	
Outstanding	0
Good	6
Minimal	15
Moderate	0
Inadequate	1
Total	**22**

Efficiency Results

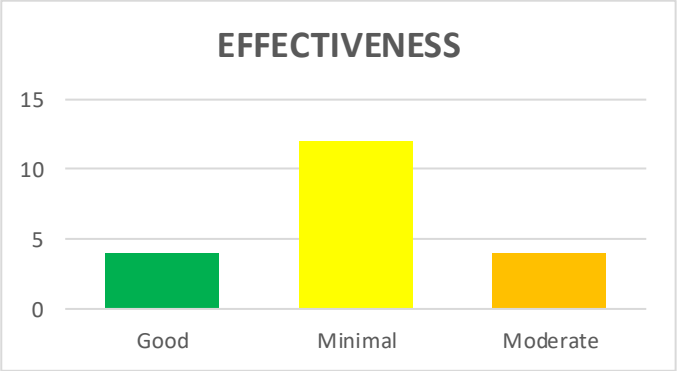
SAQ No.	Self-Assessment Question (SAQ) Subject
F1	Performance management
F2	Improving efficiency - running
F3	Improving efficiency - capital
F4	Financial controls
F5	Continuous improvement



Efficiency	
Outstanding	0
Good	10
Minimal	9
Moderate	5
Inadequate	0
Total	**24**

Effectiveness Results

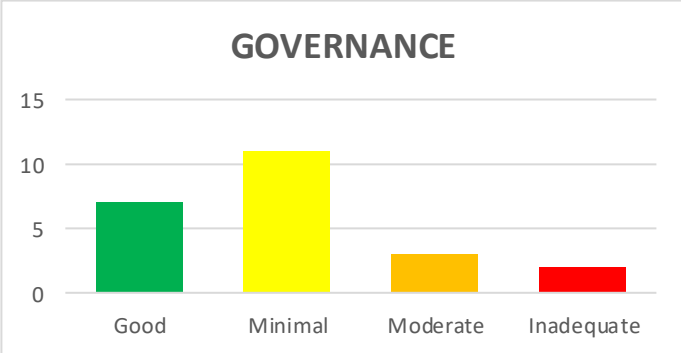
SAQ No.	Self-Assessment Question (SAQ) Subject
E1	Vision and strategy
E2	Town planning
E3	Land and Property management
E4	Sustainability



Effectiveness	
Outstanding	0
Good	4
Minimal	12
Moderate	4
Inadequate	0
Total	**20**

Governance Results

SAQ No.	Self Assessment Question (SAQ) Subject
G1	Governance process
G2	Leadership and culture
G3	Professional advice



Governance	
Outstanding	0
Good	7
Minimal	11
Moderate	3
Inadequate	2
Total	**23**

Total Actions

Actions Identified	Total
Actions identified against a scoring of 'Requires Minimum Improvement'	171
Actions identified against a scoring of 'Requires Moderate Improvement'	90
Actions identified against a scoring of 'Inadequate'	5
Total Actions for 2021-2022	**266**

Actions Scored as Inadequate

SAQ	Prompt Question	2021-22 Score	Action Identified
SH9 - Electrical Systems	Training	Inadequate	Identify Electrical AP/CPs. Carry out a recruitment drive.
P5 - Grounds & Gardens	Other Assessments	Inadequate	Implement an audit plan for Grounds and Gardens
G1- Governance Process	Partners	Inadequate	Resume Landlords' meeting
G1- Governance Process	Partners	Inadequate	Create a compliance tracker for community sites
G1- Governance Process	Audit	Inadequate	Develop surveillance programme & audit programme

Conclusions

The NHS PAM tool provides evidence and assurance of the current position of the Estates and Facilities Department and direction of travel with regard to future improvement and development of the overall domain standards.

Where gaps have been identified, action plans are generated to ensure that non-conformances with PAM standards are recorded and appropriately managed to demonstrate continuing and targeted improvement.

The actions identified during the 2021-22 PAM Assessment will be discussed and evidenced at the relevant committees (e.g. Medical Gas Safety Group, Water Safety Group, Asbestos Management Group etc.) Updates will be provided to the Compliance Group meetings to provide assurance and feed into the PAM assessment for 2022/23.

Recommendations

The Trust Board is requested to acknowledge the 2021/22 PAM assessment findings.

Whittington Health
NHS Trust

Premises Assurance Model (PAM) Assessment 2021/22

31st August 2022

What is PAM?

The Premises Assurance Model (PAM) is a self-assessment tool originally developed by the Department of Health in 2013 and subsequently updated on a regular basis. It provides a nationally consistent approach to evaluate the current position of Estates and Facilities performance against a set of common indicators.

The objective of NHS PAM is to support the patient rights ‘to be cared for in a clean, safe, secure and suitable environment” set out in the NHS Constitution and essentially establishes an internal audit to ensure regulatory and legislative compliance.

The main benefits of the NHS PAM are to:

- Demonstrate to our patients, commissioners and regulators that robust systems are in place to assure that our premises and associated services are safe;
- Provide a consistent basis to measure compliance against legislation and guidance, across the whole NHS,
- Prioritise investment decisions to raise standards in the most advantageous way.

Premises Assurance Model (PAM) Assessment

The Director of Estates and Facilities is the Senior Responsible Officer for the Estates and Facilities function and is responsible for the Premises Assurance Model delivery.

The PAM assessment was originally a voluntary annual return to NHSE/I but is now a mandatory annual return as part of the NHS Standard Contract

The PAM assessment for the Whittington Health Estate took place through a series of meetings held with key stakeholders, including consultation with Authorising Engineers (AEs) and external assessors.

Action Required

The Trust Board is asked to review and approve this document by 5th September 2022. The submission deadline is 9th September 2022.

Domains & Scoring

The Pam Self-Assessment Questions are split into 5 Domains to evaluate the way our organisation/site manages its estate and facilities. Each SAQ contains several prompt questions. There are six possible responses for a prompt question which are: Not applicable, Outstanding, Good, Requires minimal improvement, Requires moderate improvement and Inadequate.

Domain	Total number of Self Assessment Questions (SAQs)	Total number of Prompt questions
Safety Hard (Combined Hard and Soft FM)	29	230
Patient Experience	6	27
Efficiency	5	29
Effectiveness	4	25
Governance	3	26
Total	**47**	**337**

Outstanding
Compliant with no action plus evidence of high quality services and innovation.
Good
Compliant no action required.
Requires minimal improvement
The impact on people who use services, visitors or staff is low.
Require moderate improvement
The impact on people who use services, visitors or staff is medium.
Inadequate
Action is required quickly - the impact on people who use services, visitors or staff is high.

The 5 point scale provides the outcome for the structure below.

PAM Process – Structure

DOMAIN:

- **Safety Hard**
- **Safety Soft**
- **Patient Experience**
- **Efficiency**
- **Effectiveness**
- **Governance**

SAQ Question:

SAQ Code	Self Assessment Question - Is the Organsiation/Site safe and compliant with well managed systems in relation to:
SH1	Estates and Facilities Operational Management
SH2	Design, Layout and Use of Premises
SH3	Estates and Facilities Document Management
SH4	Health & Safety at Work
SH5	Asbestos
SH6	Medical Gas Systems
SH7	Natural Gas and specialist piped systems
SH8	Water Safety Systems
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SH10	Mechanical Systems and Equipment
SH11	Ventilation, Air Conditioning and Refrigeration Systems
SH12	Lifts, Hoists and Conveyance Systems
SH13	Pressure Systems
SH14	Fire Safety
SH15	Medical Devices and Equipment
SH16	Resilience, Emergency and Business Continuity Planning
SH17	Safety Alerts
SH18	Externally supplied estate
SH19	Contractor Management for Soft and Hard FM Services

Prompt question:

1) **Policy and Procedures**
2) **Roles and Responsibilities**
3) **Risk Assessment**
4) **Maintenance**
5) **Training and Development**
6) **Resilience, Emergency and Business Continuity Planning**
7) **Review Process**

The aim is to demonstrate safe and compliant processes with well managed systems in relation to the topic areas.

1. Policy & Procedures	Current, approved policy and an underpinning set of procedures that comply with relevant legislation and published
2. Roles and responsibilities	Qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?
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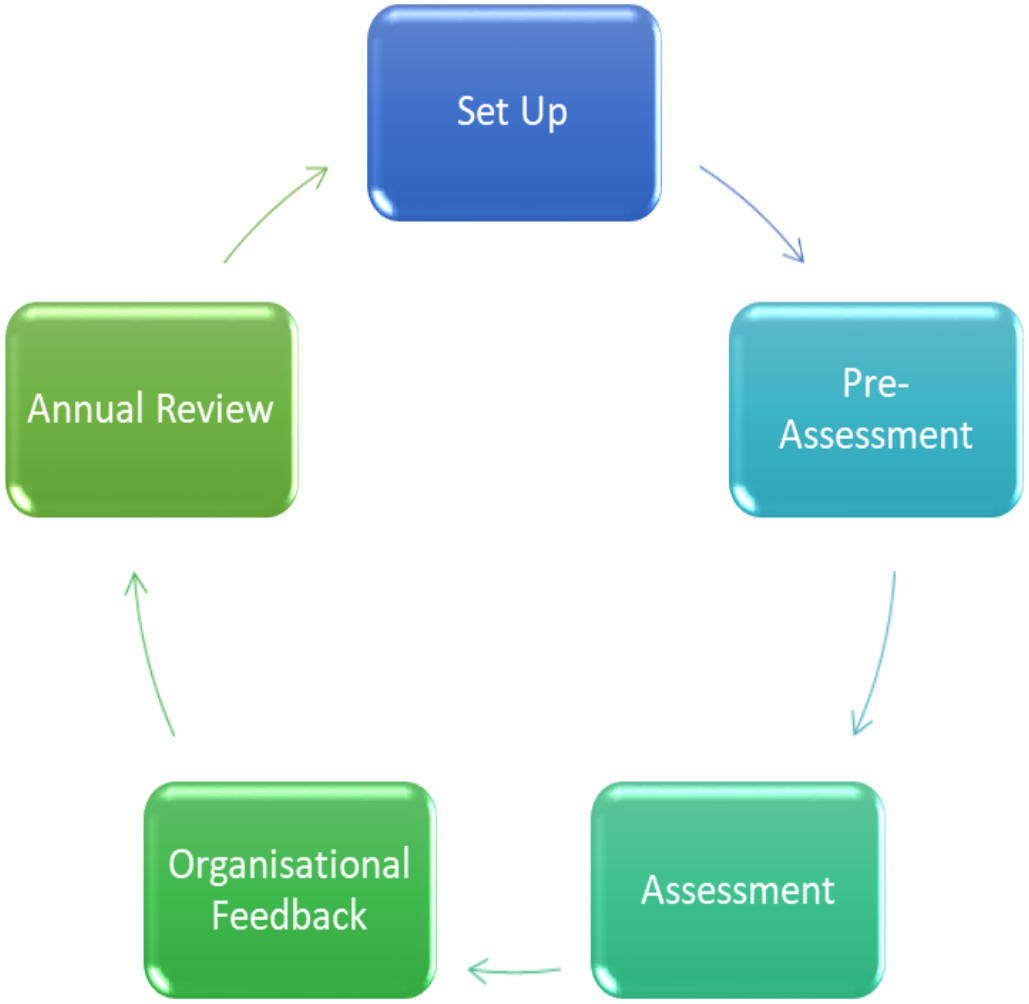
4. Maintenance	Are assets, equipment and plant adequately maintained?
5. Training and development	Up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?
6. Resilience, emergency and business continuity planning	Have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?
7. Review process	Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?
8. Costed action plans	If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance?

Assessment Review Process



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- Clinical Engineering & Medical Physics Manager
- Decontamination Manager and Trust Advisor
- Assistant Director of Strategy
- Estates Development Lead Strategy
- Fire Safety Manager
- Emergency Planning Officer
- Energy and Estates Systems Manager
- M&E Supervisor
- Compliance Officer
- Property Consultant

PAM Assessments (Continued)

Additional support, guidance and advice was also provided by:

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- PALS Office
- Patient Experience Team
- Finance Team
- IT Team
- Communications Team
- Authorised Engineers for Hard FM
- Estates Managers/Officers (Hard FM)
- Facilities Managers/Supervisors (Soft FM)
- Project Team
- Bed Site Management Leads
- Energy & Process Improvement Consultant

Whittington Health PAM Results 2021/22

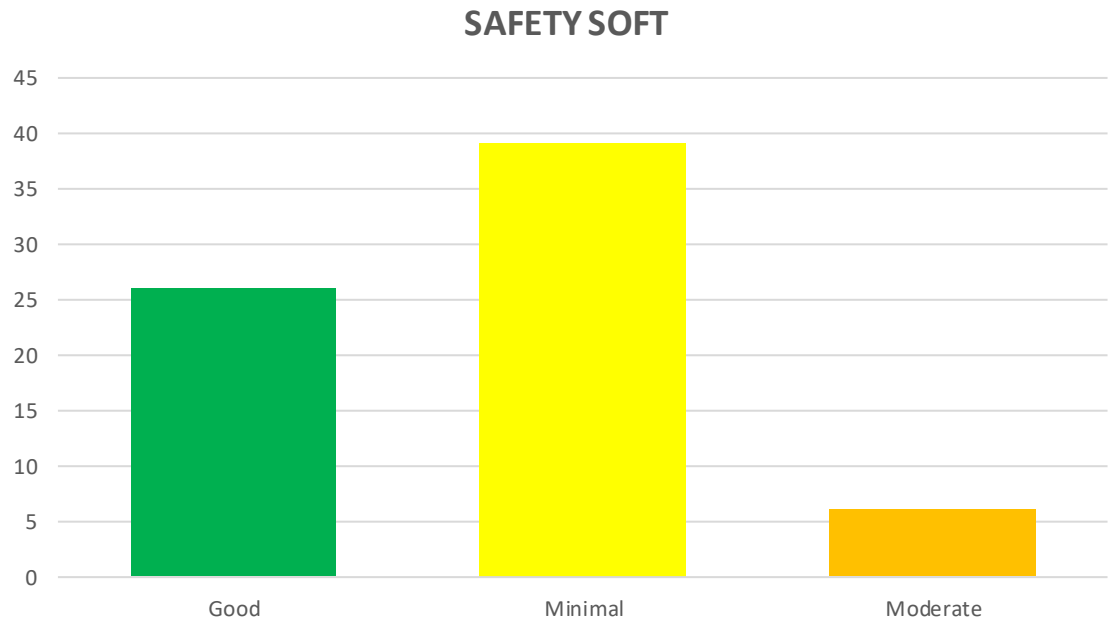
Safety Hard Results

SAQ No.	Self-Assessment Question (SAQ) Subject
SH1	Estates and Facilities Operational Management
SH2	Design, Layout and Use of Premises
SH3	Estates and Facilities Document Management
SH4	Health & Safety at Work
SH5	Asbestos
SH6	Medical Gas Systems
SH7	Natural Gas and specialist piped systems
SH8	Water Safety Systems
SH9	Electrical Systems
SH10	Mechanical Systems and Equipment
SH11	Ventilation, Air Conditioning and Refrigeration Systems
SH12	Lifts, Hoists and Conveyance Systems
SH13	Pressure Systems
SH14	Fire Safety
SH15	Medical Devices and Equipment
SH16	Resilience, Emergency and Business Continuity Planning
SH17	Safety Alerts
SH18	Externally supplied estate
SH19	Contractor Management for Soft and Hard FM services

Safety Hard	
Outstanding	1
Good	41
Minimal	45
Moderate	37
Inadequate	1
Total	**126**

Safety Soft Results

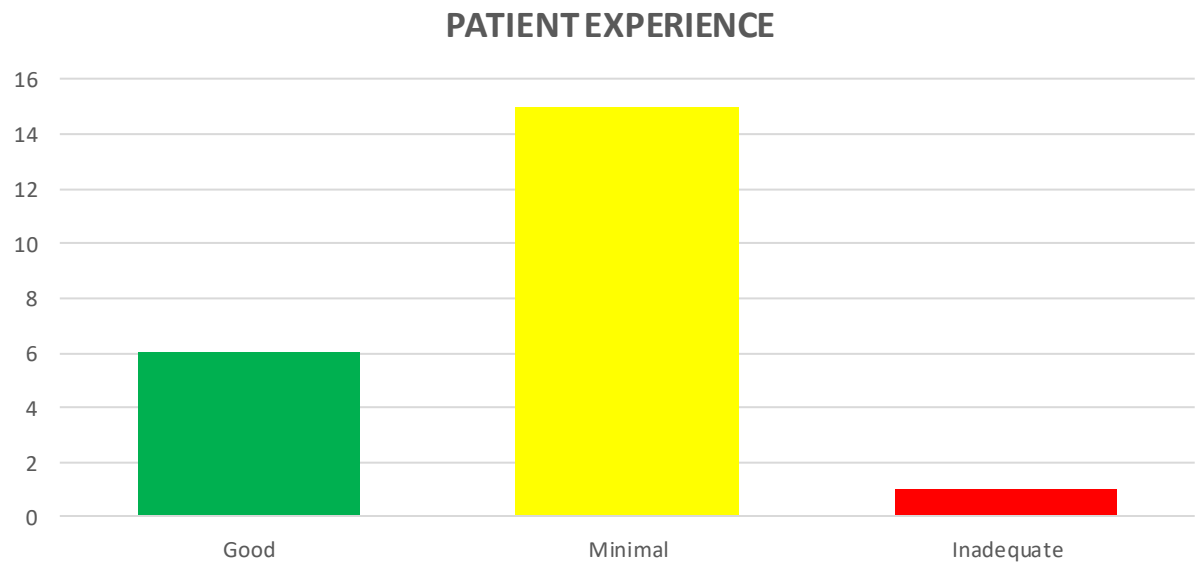
SAQ No.	Self-Assessment Question (SAQ) Subject
SS1	Catering services
SS2	Decontamination process
SS3	Waste and Recycling Management
SS4	Cleanliness and Infection Control
SS5	Laundry and Linen Services
SS6	Security Management
SS7	Transport Services
SS8	Pest control
SS9	Portering services
SS10	Telephony and switchboard services



Safety Soft	
Outstanding	0
Good	26
Minimal	39
Moderate	6
Inadequate	0
Total	**71**

Patient Experience Results

SAQ No.	Self-Assessment Question (SAQ) Subject
P1	Engagement and involvement
P2	Condition, appearance, maintenance and privacy and dignity perception
P3	Cleanliness
P4	Access and Car Parking
P5	Grounds and Gardens
P6	Catering services



Patient Experience	
Outstanding	0
Good	6
Minimal	15
Moderate	0
Inadequate	1
Total	**22**

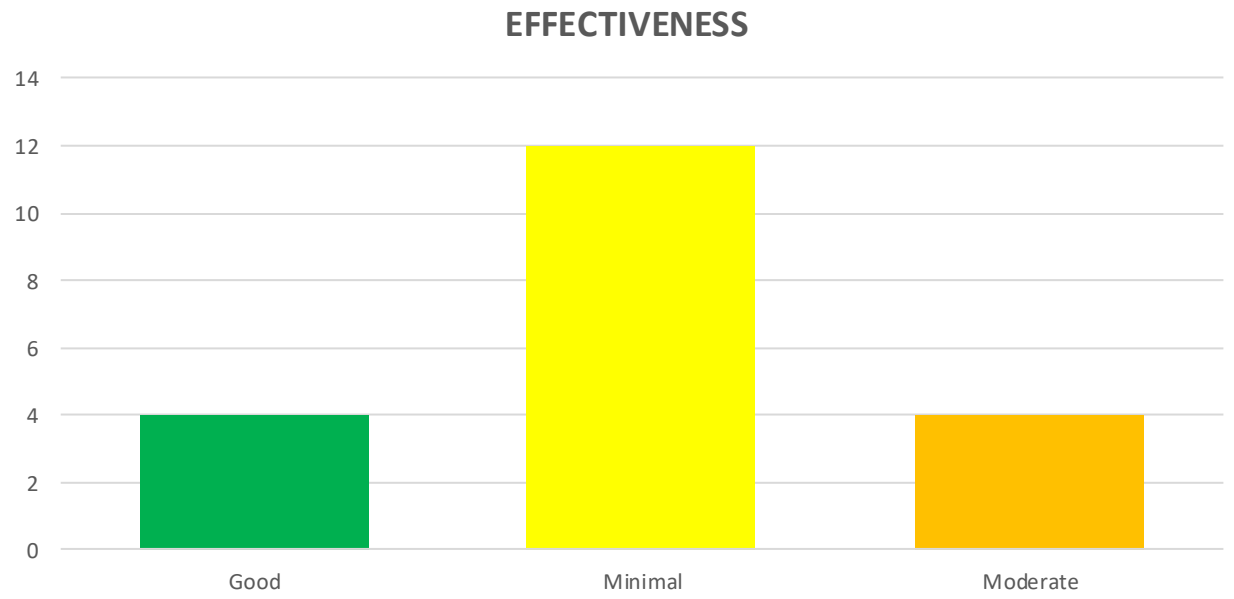
Efficiency Results

SAQ No.	Self-Assessment Question (SAQ) Subject
F1	Performance management
F2	Improving efficiency - running
F3	Improving efficiency - capital
F4	Financial controls
F5	Continuous improvement

Efficiency	
Outstanding	0
Good	10
Minimal	9
Moderate	5
Inadequate	0
Total	**24**

Effectiveness Results

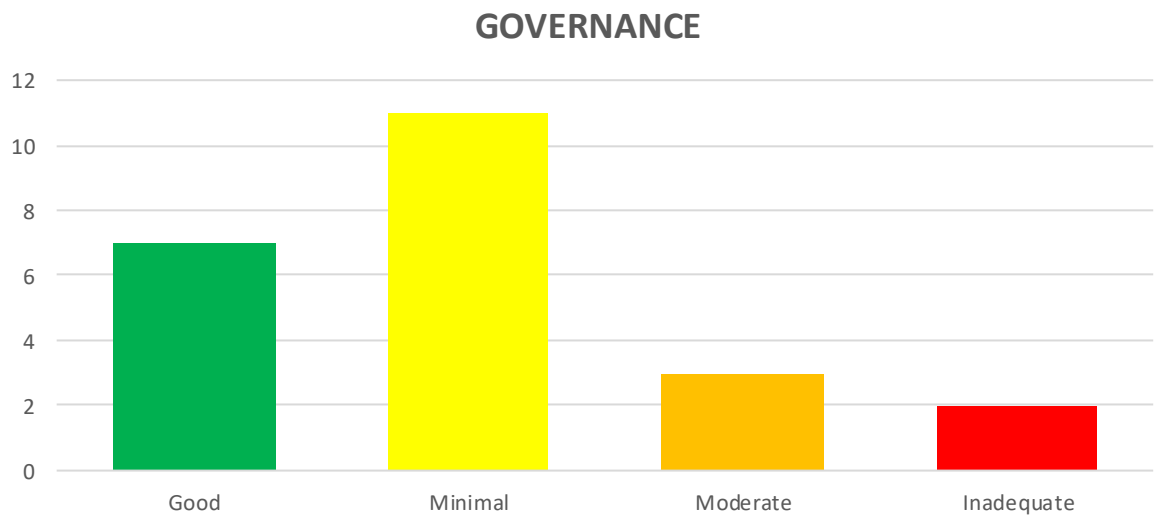
SAQ No.	Self-Assessment Question (SAQ) Subject
E1	Vision and strategy
E2	Town planning
E3	Land and Property management
E4	Sustainability



Effectiveness	
Outstanding	0
Good	4
Minimal	12
Moderate	4
Inadequate	0
Total	**20**

Governance Results

SAQ No.	Self Assessment Question (SAQ) Subject
G1	Governance process
G2	Leadership and culture
G3	Professional advice



Governance	
Outstanding	0
Good	7
Minimal	11
Moderate	3
Inadequate	2
Total	**23**

Total Actions

Actions Identified	Total
Actions identified against a scoring of 'Requires Minimum Improvement'	171
Actions identified against a scoring of 'Requires Moderate Improvement'	90
Actions identified against a scoring of 'Inadequate'	5
Total Actions for 2021-2022	**266**

Actions scored as inadequate

SAQ	Prompt Question	2021-22 Score	Action Identified
SH9 - Electrical Systems	Training	Inadequate	Identify Electrical AP/CPs. Carry out a recruitment drive.
P5 - Grounds & Gardens	Other Assessments	Inadequate	Implement an audit plan for Grounds and Gardens
G1- Governance Process	Partners	Inadequate	Resume Landlords' meeting
G1- Governance Process	Partners	Inadequate	Create a compliance tracker for community sites
G1- Governance Process	Audit	Inadequate	Develop surveillance programme & audit programme

Conclusions

The NHS PAM tool provides evidence and assurance of the current position of the Estates and Facilities Department and direction of travel with regard to future improvement and development of the overall domain standards.

Where gaps have been identified, action plans are generated to ensure that non-conformances with PAM standards are recorded and appropriately managed to demonstrate continuing and targeted improvement.

The actions identified during the 2021-22 PAM Assessment will be discussed and evidenced at the relevant committees (e.g. Medical Gas Safety Group, Water Safety Group, Asbestos Management Group etc.) Updates will be provided to the Compliance Group meetings to provide assurance and feed into the PAM assessment for 2022/23.

Recommendations

The Trust Board is requested to acknowledge the 2021/22 PAM assessment findings.

Whittington Health NHS Trust

Maternity Services – Overview findings of Regional Ockenden Assurance Visit

Date: 27th June 2022

Purpose

An assurance visit to Whittington Health maternity service was completed on 27th June 2022.

The purpose of the visit was to provide assurance against the 7 immediate and essential actions from the interim Ockenden report (December 2020). The assurance visit team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice.

Conversations were held with a number of members of the board, maternity senior leadership team, front line staff and students in a range of job roles. Emerging themes from conversations were organised under the immediate and essential actions.

1. Enhanced Safety
2. Listening to Women & Families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Well-Being
7. Informed Consent
8. Workforce Planning and Guidelines

Visit team members

Regional maternity team

Kate Brintworth Regional Chief Midwife, NHS England

Nina Khazaezadeh Deputy Regional Chief Midwife, NHS England

Olivia Houihan Regional Transformation Lead Midwife

Sarah Espenhahn Maternity Service User Voice Lead for London

Peer reviewers

Angie Velinor Head of Maternity Commissioning Programme Director, NHS North Central London CCG

Clare Baker Head of Midwifery, King's College Hospital NHS Foundation Trust

Clare Maher Director of Programmes, Midwifery and Lead Midwife for Education, Middlesex University

Caroline Moren Maternity Programme Manager, NHS North Central London Clinical Commissioning Group

Freya El Baz Chair for Royal Free London Maternity Voices Partnership

Louise Webster Co-Clinical Director, London Maternity Clinical Network (within NHS England), Consultant Obstetrician Specialising in Maternal Medicine at Chelsea and Westminster Hospitals NHS Foundation Trust

Natasha Singh Clinical Director for Obstetrics, Chelsea and Westminster Hospitals NHS Foundation Trust

Manjit Roseghini Deputy Chief Nurse and Director of Midwifery, Croydon Health Services NHS Trust

Key headlines

- The team enjoyed the visits to the Whittington Health maternity services and were grateful for the warm welcome and the time and effort that went into arranging the day.
- A comprehensive summary of the achievements and aspirations, was presented by an enthusiastic Multi-Disciplinary Team (MDT), including the MVP, demonstrating that the service's is committed to partnership working and strives to be responsive to the needs of service-users.
- The Trust Board were knowledgeable and invested in all aspects of its maternity service with a clear understanding of the issues affecting the maternity workforce and a desire to be part of the solution.
- The MVP chairs are respected, listened to, and embedded within the maternity service. The Chairs' presence at MDT during the Ockenden Awareness week and their attendance at Governance meetings is evidence of this.
- The Trust is invested in improving the environment and has made progress in relation to signage, however, more work is needed to improve signage further with input from the MVP because service users still find it confusing, and this confusion can lead to sense of alienation and feeling that their 'user' experience has not been adequately considered.
- Information provision on birth choices should be reviewed and interpretation services optimised to ensure all women and birthing people have equal access, ensuring the service meets the needs of the diverse community and reduces variations in outcomes. This is crucial to ensure that women and birthing people are able to make informed decisions.
- The maternity service is working to improve the culture of MDT working through role modelling working relationships between midwives and obstetricians: The Consultant Obstetric Lead and Director of Midwifery share an office. Whilst some staff described maternity as supportive '*a learning unit', with "great teamwork*", and gave examples of how everyone looks after each other, more work needs to be done to improve MDT relationships in the labour ward. There is no specific rest room for doctors. The resource room used for teaching and hand over in the day time is used for breaks if they occur, while midwives have a dedicated rest period and use the kitchen.
- Their service is committed to supporting and developing its staff, demonstrated through the creation of new roles, for example, Head of Midwifery, flow coordinator, new consultant obstetrician posts.
- The same level of attention is apportioned to the student midwives as their future workforce, by introducing innovative projects, e.g., "student buddy systems". The majority of students indicated their plans to seek employment and start their preceptorship at Whittington, which is a credit to the maternity team, particularly the Clinical Practice Facilitators (CPF).
- It was acknowledged that the outcome of the internal investigation into the whistleblowing letter received on 11 December 2021 did not call for further action and the outcome had been shared with staff via email. However, the message doesn't appear to have reached all staff, and wider engagement is needed to communicate the outcome, restore the relationship with those affected, and ensure staff feel valued.
- The Trust recognised the impact of the pandemic on staff, was responsive to creating a number of opportunities to support staff health and wellbeing and was the first Trust to pilot the "project Wingman" which has been recognised nationally.
- Since March 2022, the Trust has demonstrated full compliance across all of the seven Immediate and Essential Actions outlined in the Ockenden interim report and is congratulated on that achievement.
- The visiting team would like to extend their thanks to all the staff who, on the day of the visit, gave time to the team to share their thoughts, experiences and aspirations for their services.
- The effective collaborative working relationships between midwives and obstetricians promote respectful care and a psychologically safe culture for effective clinical escalation.

IEA1: Enhanced safety

- There is a robust governance process in place with a multidisciplinary approach to investigations however; the changes in professional groups mean more effort is required to ensure all disciplines, e.g., anaesthetic colleagues, are included to contribute.
- The governance team were described by staff as being supportive. The clinical governance team consists of one Band 8B midwifery lead covering maternity and gynaecology, a risk manager (1 WTE), and an obstetric risk lead (1PA). There is no dedicated admin support. The team is hoping to utilise the Ockenden funding to increase the medical teams' PA.
- There is an open culture around raising clinical concerns as staff expressed that they know how to escalate clinical concerns and feel confident in doing so. However, some expressed a lack of acknowledgement or response from the maternity leaders when raising their concerns.
- Staff are encouraged to attend Serious Incident (SI) review meetings which promotes respectful shared learning. Clinical staff expressed a desire to attend but felt unable to do so due to clinical commitments. The learning is shared mainly via emails, and a recent incident folder has been introduced in the ward areas to create more opportunities for staff to access information.
- There is a good understanding of the incident reporting process. Lessons from SIs are disseminated at the Friday meeting "Learning from risk". All trainees attend this meeting.
- The risk team supports the junior doctors and midwives if they are involved in a serious incident, and they are invited to attend the round table in advance. Staff reported that they would feel confident going through the SI processes in the future. Equally, the students involved in an incident felt well supported by the team and the CPF.
- The DOM is leaving the Trust due to promotion. Some staff are finding the constant transition in leadership unsettling and demoralising as they have had a number of changes in the senior leadership team over the last few years.
- The Triumvirate attends the fortnightly Trust Management Group and feels well connected and supported by the Board.
- The Trust safety champion and the NED have a sound understanding of issues, are very engaged and remain visible. One midwife described: *"The safety champion removing potential barriers and invested in supporting staff. She attended labour and was cleaning and mopping".!!*
- Staff described the culture of the unit to be hardworking. There is a sense of community with a warm atmosphere, and many look forward to seeing their colleagues.
- The senior maternity team described the Trust Level Speak Up Guardian as having a strong presence throughout all departments, including maternity.

IEA1	RAG
Q1 - Dashboards	
Q2 – External review of SIs	
Q3 – SIs to Board/LMNS	
Q4 - PMRT	
Q5 - MSDS	
Q6 - HSIB	
Q7 - PCQSM	
Q8 – SIs to Board/LMNS	

IEA2: Listening to women and families

- The NED was appointed during the pandemic and has not met the MVP and whilst she is invested in maternity, she expressed a wish to engage more with the team. It would be particularly helpful to meet the MVP to hear about the experiences of women and birthing people from diverse backgrounds, virtually or face to face.
- The NED joins the monthly clinical governance meeting on a fortnightly basis, so she has an awareness of current safety issues within the department and also sits on the quality assurance and workforce assurance committees.
- The Board level safety champion is to be congratulated on her engagement with the maternity team. She is invested in maternity, offers a great deal of support and is well known to all staff.
- The MVP chairs are invited to all safety champion meeting and feel able to contact the safety champions directly if needed.
- The MVP is embedded into how the maternity service operates. There are well-established meetings where MVP chairs engage with the Director of Midwifery, and it was clear that many staff know them personally. It is exemplary that the chairs have passes so that they can walk around the unit unaccompanied.
- There were examples of regular service user engagement and feedback is welcomed, although the service users who joined the pre-visit discussion were unaware of how they could have given feedback, nor that they could access a birth debrief.
- The MVP chairs are involved and consulted on numerous initiatives, including the MVP induction of labour workshop, and Whittington's response to national guidance on Covid 19 visitors' restriction. The Partner Policy developed during the pandemic was described as humanistic. Coproduction could be strengthened by working with the MVP from the beginning of a project, but this would need increased resource.
- Very positive reports from women about students.
- The senior team is committed to addressing the health inequalities agenda and are proud of their initiative "*See Me First*", and Civility and Safety Workstream in response to this agenda. Staff are well engaged with this initiative.

IEA2	RAG
Q9 – Advocate role	N/A
Q10 – Advocate role	N/A
Q11 – NED	
Q12 - PMRT	
Q13 – Service user feedback	
Q14 – Bimonthly safety champ meetings	
Q15 – Service user feedback	
Q16 – NED	

IEA3: Staff training and working together

- Regular Multi-Disciplinary Team (MDT) meetings and teaching sessions are taking place for midwives, obstetricians and students. However, facilities to host the training/PROMPT remain challenging, (as face-to-face training is resumed, due to a reduction in the facilities available at the education centre). The senior leadership team are aware and are working to find solutions.
- The education team are very supportive and provide clinical cover to enable staff to access PMA support and training was valued by staff and described as supportive and good.
- Twice daily consultant ward rounds is a well-established aspect of care and visible to staff.
- Fetal wellbeing training, which includes intermittent auscultation, is multidisciplinary and conducted weekly via MS teams to ensure accessibility and meet staff's needs.
- The junior doctors described the consultant body as supportive and approachable, especially out of hours. The team heard examples of the consultant on-call attending the unit to help with complex cases. They reported good dissemination of information and alerts via email concerning complex care.
- The Capital Midwife preceptorship programme is embedded in the service and highly regarded. The service has introduced a buddy system for midwives who recently passed their preceptorship programme.
- Staff reported a culture of bullying and undermining behaviours in the senior midwifery team. This was described as having created damaging effects in the team. The trust should seek to support and develop a positive culture in the team and across teams.

IEA3	RAG
Q17 – MDT Training	
Q18 – Cons. Ward Rounds	
Q19 – Ring-Fenced Funding	
Q20 – workforce planning	
Q21 – 90% MDT Training	
Q22 – Cons Ward Rounds	
Q23 – MDT Training Schedule	

IEA4: Managing complex pregnancy

- The Maternal Medicine (MM) service is established as part of North Central London (NCL) Network, and well-described pathways exist. There is a collaborative working with UCLH as the designated MM centre for the NCL network. There is one designated midwife for the maternal medicine network who will be working with local midwives.
- There is a daily fetal medicine clinic run by the local team. The obstetric medicine clinics are held weekly and attended by both an obstetric consultant and either an obstetric physician or a haematologist, depending on the type of clinic. The Whittington is a tertiary level unit for haemoglobinopathies and can offer exchange transfusions. The Fetal Medicine Unit (FMU) has close links with FMU at University College Hospital and runs daily clinics by fetal medicine subspeciality-trained Consultants and two scanning midwives. There is a monthly visiting specialist obstetric physician covering obstetric medicine.
- MDT meetings between the hub and spoke are newly established. The lead for obstetric medicine discusses cases at the regional MDT for meetings. The cases are then presented at the local perinatal meeting, and the visiting team heard that all obstetricians are not able to attend due to lack of time. The visiting team also heard that the lead consultant for fetal monitoring does not attend the SI panels due to competing work commitments, relies on feedback from other consultant colleagues, and is perceived as a missed opportunity for sharing key information.
- Other specialist support offered includes preconception care in collaboration with a local GP and an MDT-delivered diabetic service, which has been a longstanding feature of care provided.
- There is 1 wte bereavement midwife post which three midwives share. The PMRT sits within this portfolio and the bereavement midwives support women/birthing people. There are no dedicated bereavement rooms, and families attend the labour ward, which impacts on their experience. One woman shared that when she came in to give birth, she had conflicting information and was sent to a number of different wards and left alone for hours, until she finally was cared for by the bereavement midwife, who was “an angel”. Staff reported awareness of the need to improve the bereavement support for women and pregnant women and birthing people using gynae services and need support and investment in order to address this.
- In response to reducing health inequalities, the maternity service has appointed a 0.4WTE perinatal mental health specialist midwife. There is now an MDT perinatal mental health team consisting of a psychiatrist, named lead consultant and involvement from the MVP. New referral pathways and guidelines have been developed, including a risk assessment at booking and a 32 weeks birth planning conversation with the woman/birthing person. The training for midwives includes a 20 min slot for perinatal mental health and safeguarding and staff expressed a need to increase the allocated time to cover these important issues.

IEA4	RAG
Q24 – MMC Criteria	
Q25 – Named Consultant	
Q26 – Complex Pregnancies	
Q27 – SBLCBv2	
Q28 – Named Cons/Audit	
Q29 – MMC	

IEA5: Risk assessment throughout pregnancy

- Risk assessment processes are embedded in the maternity patient information system (Medway).
- The trust has invested in maternity IT equipment, including 26 computers on wheels and 40 laptops and mobile phones. Maternity uses a blended approach of Medway IT system and paper notes for intrapartum care. The visiting team heard from a different group of staff that there are 12-15 and also 42 different digital platforms that midwives need to access, which is inefficient and time-consuming and detracts from care delivery. Staff reported using Medway plus paper in all areas and expressed dissatisfaction with the process as this created duplication. In addition, the key information was not found in both places. The Medway IT system was viewed as "*not fully fit for purpose*" as it was time-consuming to complete, so staff resorted to paper.
- Referral pathways for designated consultant obstetric link to a midwifery team changed to a centralised system of screening and triaging referrals during the pandemic in response to the workforce pressures. Consequently, midwifery teams do not have a designated consultant and have requested to reinstate the pre-pandemic referral system. The senior management is aware but waiting to expand the consultant workforce to create capacity.
- There is a lack of communication between the senior leadership team and the junior staff concerning the Birmingham Symptom-specific Obstetric Triage System (BSOTS). Staff believed that BSOTS had commenced but was not fully implemented due to staffing challenges, whereas the senior leadership perception was that the BSOTS was yet to start.
- Staff raised concerns in relation to the triage service capacity (9 beds during the day reduced to 3 overnight), which moves to the antenatal ward overnight, and staff mentioned both inadequate staffing and inappropriate skill mix, particularly for the junior medical team resulting in a delay in care and assessment. There is no dedicated maternity helpline and women/birthing people use triage as a helpline which adds to a pressured workload.

IEA5	RAG
Q30 – Risk assessment	
Q31 – Place of Birth RA	
Q32 – SBLCBv2	
Q33 – RA recorded with PCSP	

IEA6: Monitoring fetal well-being

- There are close working relationships across the MDT, and a number of training opportunities have been created to meet the staff needs, for example, fortnightly interdisciplinary medical and midwifery student fetal monitoring training, fetal monitoring study days and a fetal monitoring notice board.
- The fetal monitoring leads are in post, 1 WTE midwife and 1PA for the obstetric lead. However, the fetal monitoring midwife is also part of the PDM team and the lack of clarity in expectations made it challenging to establish the role. This issue has been escalated to the Head of Midwifery (HoM), who has been very supportive in setting clear expectations and supporting the midwife; however, further review is needed to ensure the role of fetal monitoring midwife is separated in order to fulfil the function.
- The 1 PA for fetal monitoring consultant is split among three consultants (0.5, 0.25 and 0.25). One of the leads is also a HSIB inspector and attends the quality review meetings and feeds back to the team on lessons to be learnt. The lead consultant is also engaged with relevant forums both within in sector and regionally. The fetal monitoring consultants, however, do not attend the SI panels and are not part of the round table discussions for the panels due to external work commitment. Instead, they liaise with other consultant colleagues to keep abreast of the information.
- The fetal monitoring training package has been reviewed and updated to include human factors and learning from the risk themes.
- Staff found the fetal monitoring midwife and the PDM team to be very supportive, and the visiting team heard examples of the clinical support they received to improve their clinical skills.
- The labour ward co-ordinator is generally supernumerary, but staff mentioned that it had become more challenging to maintain the labour ward co-ordinator supernumerary status.
- Midwives articulated an open culture that enables them to voice their concerns. However, some staff would have liked to receive an acknowledgement from the senior leadership team when they raise concerns, and to be engaged in the improvement efforts. Establishing a consistent and robust ‘feedback loop’ with midwives would be advisable so that staff are clear on the impact /results of concerns raised. The ‘you said, we did’ adage needs to apply to staff to foster a culture of openness and improvement.
- Continuous CTG monitoring is captured via a centralised monitoring system.

IEA6	RAG
Q34 – Leads in post	
Q35 – Leads expertise	
Q36 – SBLCBv2	
Q37 – 90% MDT Training	
Q38 – Leads in post	

IEA7: Informed consent

- The maternity website is easy to navigate and has the functionality to adjust for accessibility and translate the information to other languages, although depending on the device used this may not always be obvious.
- Generally, website information is clear, although more detail would be welcome in some areas e.g., pain relief, and it is not always easy to find the required information. Some information is inconsistent e.g., the Covid 19 page stating that home birth is suspended, but the home birth and FAQ pages implying it is available.
- There is some excellent co produced information, such as the MVP caesarean leaflet and poster. There are plenty of contact details throughout, including for the MVP and the DOM, and there is a summary page of the Ockenden key issues. Leaflets need to be provided in multiple languages as they will not be automatically translated e.g., induction of labour leaflet.
- Service users expressed that their information needs hadn't always been met, so they had visited other websites such as NHS, or scientific journals to help them understand their personal risks e.g. "There need to be more facts. I had to look at scientific journals to assess my risk for a post partum haemorrhage". It should be noted that this information is equally available to all service users, and barriers to access include language, and digital poverty, so other sources of clear, nuanced information need to be available alongside the website. The new app was reported as being helpful in some cases, although this depended on the staff.
- There is a well-established pathway, led by the consultant midwife and the birth centre manager to ensure good information and facilitate women's/birthing people's choices that fall outside the guidelines to ensure safe and personalised care. "I had a good experience – I was given various opinions on pain relief and the pros and cons of each." However, in the discussion group it was reported that joining this pathway was at times dependent on bumping into the consultant midwife.
- In contrast, other service users reported not receiving enough information, particularly around induction of labour, or having different information provided by doctors and midwives, and a sense of opposition between the two teams. Some services users felt that the information presented wasn't nuanced enough (e.g., quantifying risk) leading to an inability to make full use of the information as a result. These factors made informed decision making and choice challenging, and resulted in women feeling confused and ignored, or even that they had to "fight" for their preferred care. "I felt I had to prove myself" "I felt things were happening and felt they didn't believe me."
- The maternity website is easy to navigate and has the functionality to translate the information to other languages. There is a summary page of the Ockenden key issues and contact details of Whittington MVP, and contact details for the DOM.
- The visiting team heard that the home birth service is often suspended due to staffing shortages. This limits birth options for women and birthing people and creates unsatisfactory work experience for staff as offering real choice for local women and birthing people is vital in the maternity strategy. This issue requires an urgent review.

IEA7	RAG
Q39 – Accessible Information, Place of Birth	
Q40 – Accessible Information, All Care	
Q41 – Decision making and Informed Consent	
Q42 – Women's Choices Respected	
Q43 – Service User Feedback	
Q44 - Website	

Workforce Planning and guidelines

- There is 1 WTE Clinical Practice Facilitator (CPF) and one clinical support midwife (0.4 WTE) funded from the Education budget. The CPF is very proactive in engaging and supporting student midwives. The CPF office is located on Labour Ward, which increased her clinical visibility and was described as beneficial by the student midwives, who also found both the CPF and the clinical support midwife visible and accessible.
- Students felt safe working in the Trust and received excellent support from all midwives. There is a robust process in place to ensure they are able to complete their assessment documents and they expressed a strong desire to work at the Trust post qualification and referred to Whittington as "my home", which is a credit to the clinical team and demonstrates Trust commitment to supporting the future workforce.
- The preceptorship programme is well established and has the Capital Midwife kite mark. All preceptors work in an integrated model covering community and hospital settings. In addition, they are allocated a preceptor and a buddy as they complete their preceptorship programme and continue their journey as early career midwives. This is a unique opportunity; if evaluated, the learning could be shared as a best practice example pan London.
- The senior leadership is invested in the Maternity Support Worker (MSW) development programme as such, all MSWs are now a band 3, demonstrating excellent support, developmental opportunity and commitment to develop the workforce.
- There is a staffing shortage (4 WTE) within the anaesthetic workforce. They take part in elective recovery and obstetrics duties, and the team has prioritised obstetrics to the detriment of surgical cases. The senior leadership is aware of the challenges and is reviewing the demand with the view to developing a business case to support workforce expansion and require further integration into the maternity governance process, particularly SIs.

Workforce planning & guidelines	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

Workforce planning and guidelines

- A clinical fellow has been at the Whittington for three years now. The junior doctors and trainees described the unit's culture as friendly and supportive, with a positive working relationship with all staff. However, they expressed a desire to have information on formal contact details for specialist teams, for example, how to contact specialist diabetic team rather than “the midwife X” as they often have to rely on their informal networks for signposting and referrals.
- The visiting team heard about challenges with the medical workforce working pattern, part-time work was perceived as putting a strain on managing rotas within the medical workforce. There are plans to appoint six new consultant obstetricians that will significantly improve the running of the unit as a whole which creates an opportunity to review rotas and PAs to ensure safety and support a work-life balance.
- Neonatal services are in a different management group within the Trust, which is reported to pose some challenges to joined-up working.
- The visiting team heard that there is pressure from the senior leadership team to manage all staff issues via formal HR processes, which was perceived to impact staff negatively, leaves little room for personalisation and is counterproductive to creating a supportive environment. There is a need to support managers to balance the need for operational safety whilst supporting staff and for staff to view the HR processes as facilitative and supportive rather than punitive.
- There are 11 PMAs in post, one lead PMA who has 15 hours' dedicated time and ten sessional PMAs. One of the new PMAs in training is a band six midwife. The PMAs were found to be passionate and proactive in supporting staff.

WFP & Guidelines	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

Other points of note

- The maternity service supports two midwives to participate in the Capital Midwife fellowship programme and the midwife has recently secured a promotion.
- There is a strong culture of co-production, and service users' involvement in continuous improvement projects, recruitment and innovative services was noticeable.
- The maternity service nurtures and values the student midwives as their future workforce and is piloting an innovative "Peer to Peer teaching" programme between 3rd and 1st-year student midwives. The programme is well received and has scope for wider sharing across London once the pilot has been completed. Third-year students reported how this initiative has helped them develop their leadership through imparting their knowledge and teaching. They felt empowered and found this to be a valuable experience as they continued their journey as early career midwives. The first years reported finding this system supportive, improving psychologist safety, and supporting their learning.
- The HIV service and infectious disease service was given as an example of service improvement by providing continuity of carer with guidelines and digitally-enabled documentation and a combined clinic with input from the MDT, e.g., infectious disease and HIV specialists. The wrap-around service has reduced the non-attendance.
- The leadership team has been responsive to meet the needs of the staff and from December 2021 to the end of March 2022 –the maternity service employed an external PMA to support all staff. This was at a time when the unit was particularly challenged owing to staff sickness and shortages. The external PMA met with 80-90 members of staff during that time and also offered a birth reflection. The project was well received and considered a success; as such additional funding has been secured to continue the support offer for another two weeks.
- The MVP identified improvements needed in signage around the maternity unit. However, this still needs improvement, including clearly saying “Antenatal (Murray) Ward” rather than using the name only. Colour coding can help too
- There was some information around the unit about access to interpretation but this needs to be large and clearly displayed throughout.

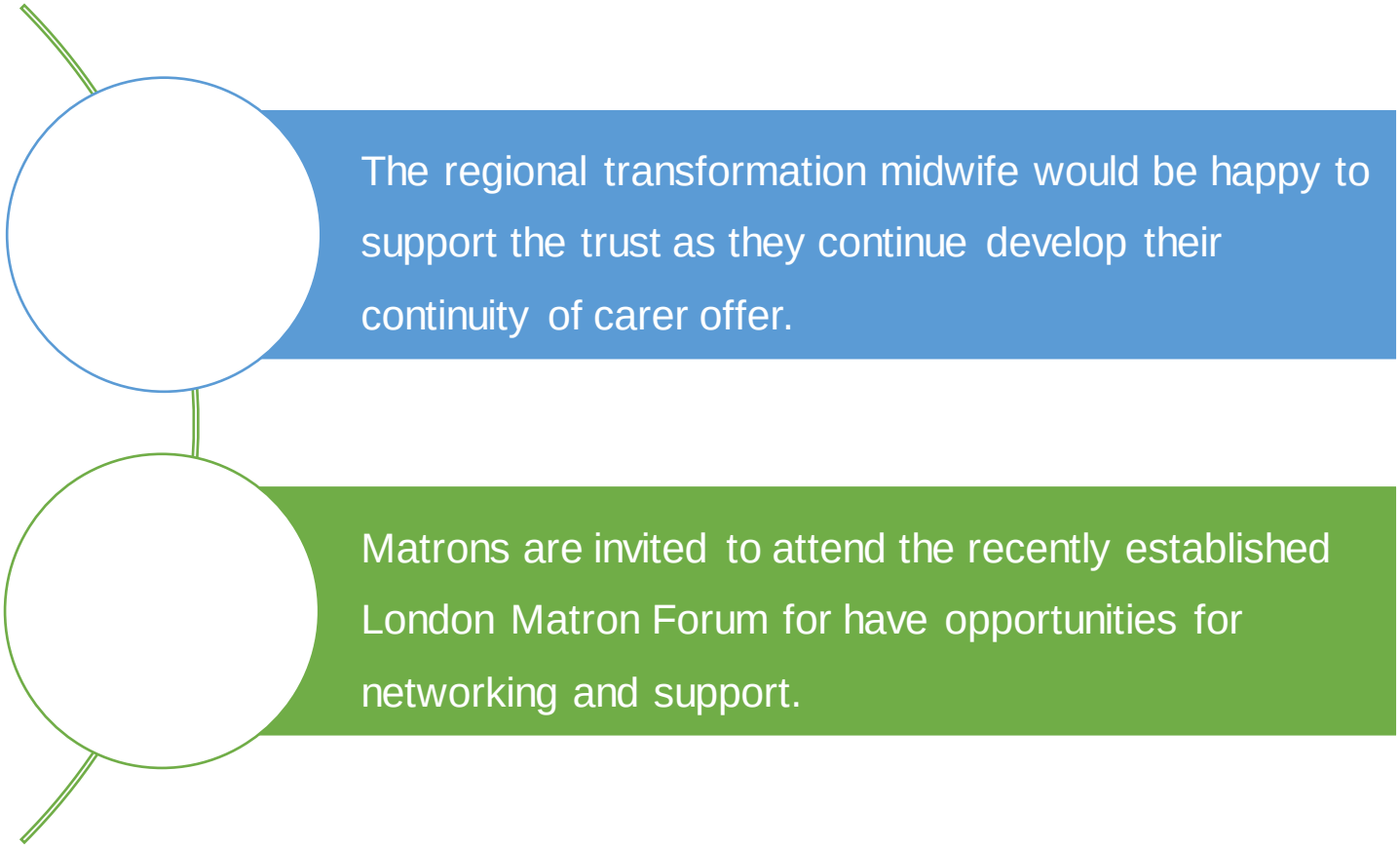
Recommendations / points for consideration

- It was acknowledged that the MVP's involvement in maternity had improved the signage. However, service users still find the signage confusing, e.g., Murray ward instead of an antenatal ward. The service users called for further clarity around signage, for example, using colour coding and having more information on choice and interpreting options in the maternity areas.
- Service users' feedback illustrated excellent provision of information, choice, and personalised care when supported by the consultant midwife. This positive experience was not consistent across all service user groups. Some didn't receive relevant information and had to seek information through external sources, whilst others expressed a feeling of being coerced into interventions, e.g., induction. The senior leadership is aware that the induction pathway needs reviewing and must prioritise this to address the imbalance and facilitate choice by providing evidence-based information that is accessible to meet the needs of all women/birthing people to facilitate informed decision-making. Additionally, an urgent review is required to mitigate staffing challenges and reduce the impact on women's choices ,e.g., home-birth.
- Staff reported that sharing the learning from SIs, HSIB and Datixes heavily rely on email communication. Consideration could be given to strengthening the dissemination of learning using other modalities ,e.g., sharing hot topics at staff safety huddles. There are opportunities for learning from the other Trusts.
- Risk and SI meetings are open to all staff, and despite the clinical staff's awareness and desire to participate, clinical commitment and staffing pressures are barriers to staff participation. Staff would welcome alternative ways of communication, the senior leadership has created a folder for each clinical area in maternity to share the learning. There is an opportunity to explore other strategies to support further access to information, e.g., open meetings for clinical staff and a rotational allocation on the rota to support attendance by clinical staff.
- Capacity for the bereavement team and lack of facilities for the bereaved families is a challenge. There is a 1 WTE (job-share) bereavement midwife post responsible for PMRT providing support for women with pregnancy loss from 18 weeks' gestation. There is a lack of support for early pregnancy loss. There is no designated bereavement room, and bereaved families use a delivery room on the labour ward. There is an urgent need to review the team's capacity and include a bereavement suite as part of the modular approach to improving estate and facilities. Although the regional team was subsequently informed that there is a plan to increase the bereavement midwife post to 1.8 wte.

Recommendations / points for consideration

- The staff raised that the changes in senior midwifery leadership over the last few years resulted in some instability but acknowledged that the service is transitioning to a better place. There were variations in staff perception of the maternity leadership's support and level of engagement. Some described senior midwifery leadership as engaged and visible, while others reported undermining behaviour and bullying. Urgent attention and support must be given to both staff and the maternity leadership to enable them to restore and repair relationships, build trust, improve team working and create a feeling of being seen, heard and supported.
- The labour ward coordinator often carries a caseload and cannot remain supernumerary. This needs an urgent review to ensure the midwife can fulfil her function as the labour ward coordinator.
- The maternity unit did not successfully obtain Baby Friendly Initiative (BFI) accreditation last year. Lack of resources was perceived by staff as a key factor in this: currently, 1 WTE infant feeding post is shared between a band 7 and a band 6 midwife. The senior leadership shared their plans to appoint nursery nurses to improve infant feeding support. Whilst this is a welcomed initiative, there is a need to have additional midwifery resources to obtain the BFI accreditation, a recommendation outlined in the NHS Long-term Plan and critical in offering information and support for women/birthing people.
- MDT working was reported to be good within midwifery and obstetrics but strengthening the MDT and collaborative partnership across all disciplines, particularly the anaesthetics involved in maternity, should remain a priority. Innovations such as Ockenden Café were well received by staff and provided an excellent platform to support this effort.
- It is encouraging to see the investment in the senior obstetric team, however, there needs to be a review of their working pattern to ensure an equitable working pattern whilst ensuring consistent operational cover. Equally, there needs to be a focus on the midwifery workforce as there is a high turnover of senior staff with some relatively inexperienced midwives in senior leadership teams. They will need support to grow into their roles to ensure the ongoing success of all their improvement work.
- It is acknowledged that Triage is on the maternity risk register; however, it requires an urgent review on, (1) its capacity and relocation overnight, (2) the feasibility of staff having the ability to support a helpline as well as Triage, (3) implementation of BSOTS, and (4) ensuring an appropriate skill mix of staff.
- The maternity team need to review choice in relation to place of birth especially given the reported challenges in maintaining the home birth service when there are staffing shortages.
- Consideration should be given to placing concerns relating to the Maternity Data System/ paper documentation on the risk register with clear plans and mitigations to address the issues, particularly in terms of clinicians not having documentation completed by colleagues accessible to them whilst making clinical decisions.

Offers of support to the Trust



The regional transformation midwife would be happy to support the trust as they continue develop their continuity of carer offer.

Matrons are invited to attend the recently established London Matron Forum for have opportunities for networking and support.

Appendix 1:

15 Steps-style survey

For background please see the full 15 Steps for Maternity Toolkit: https://www.england.nhs.uk/publication/the-fifteen-steps-for-maternity-quality-from-the-perspective-of-people-who-use-maternity-services/

Where to focus:

For the assurance visits, we aim to visit the first 3 areas listed below, which tie in with the Ockenden priorities, and possibly more, depending on time and the layout of the unit:

1. triage waiting area
2. the antenatal clinic waiting room
3. postnatal ward
4. scanning waiting area
5. day assessment unit (or equivalent) waiting area

If there is time, you could visit other areas as well.

Aim to spend a maximum of 20-30 minutes in each area, depending on the overall time available, and observe what is happening (rather than talking to service users, or discussing with staff other than to say hello and why you're here).

All participants can take notes on paper/electronically, and then share so that both the MVP chair(s) on the assurance team and the local MVP chair(s) can use this information.

Use the following in the "Observed?" column:

Key:	✓✓✓	✓✓	✓	0	N/O	NA
	excellent/ always	good/ mostly	Could be better/ occasionally	poor/ never	Not observed	Not relevant

Alongside the overall impression, where possible make specific notes on what is working well and could be shared eg "excellent wall display with up to date information and showing a diverse group of service users", as well as specific things that could be improved.

Antenatal Clinic

Element	Observed?	Notes
Welcome		
How long did I have to wait to enter?	NA	
Are reception staff welcoming and kind?	✓	
Does the space feel welcoming?	✓	
Is the atmosphere calm and peaceful?	✓✓	
Are there enough seats? Are they comfortable	✓✓	
Do appointments seem to be on time?		
Is water available to drink?	✓✓	
Safety		
Does the area feel safe? (Why/ why not?)	✓	
Is hand gel/hand washing available?	✓	
Are masks available?		
Staff		
Are staff calm and friendly in general?	✓	
Are staff calm and friendly when calling someone for an appointment?		
Do staff introduce themselves?		
Do staff seem caring of each other?		
Are staff kind (to service users and each other)?		
Is there information about who the staff in the area are?	✓	In scanning waiting area, listing receptionist, MSW and plebotomist
Do staff communicate waiting times etc?		
Cleanliness & accessibility		
Is the area clean?	✓✓	
How accessible is the area for people with varying needs eg physical, mental or learning disabilities?		
Is there access to translation/ interpretation services?	✓	Staff report using interpretating services but only small signs using Turkish, Spanish & Italian – would be good to see info in more languages and easy to see.
Are cultural needs taken into account or acknowledged?		
Are the toilets clean?	✓✓	Toilets are shared
Are the toilets accessible?	0	
Toilets for partners/support people too?	✓	
Are baby change facilities available?	0	

Antenatal Clinic

Element	Observed? (see key)	Notes
Information		
Is the signage clear and well placed?	No	No sign for antenatal clinic – had to choose between Antenatal Ward and Maternity Scanning, although the antenatal clinic is listed on the sign by the lift.
How useful are noticeboards, posters (visual information)? Including • in places where service users can read them? • Well laid out • Up to date • Inclusive of different groups (eg ethnicities, LGBTQ, people with disabilities etc)		Some information is well placed on walls opposite chairs in the waiting room, or screens (seem to alternate information and ads), though some is behind water cups etc. And some are well laid out. Mostly up to date. Other information more targeted to staff – doesn't feel helpful for women and families Not noticeably inclusive (not translated, or linked to translations; no reference to additional needs or LGBTQ etc)
Does the information available encourage/ support choice? Specifically choice about: • place of birth • different ways of giving birth (mode of birth) • coping strategies • personalising birth space • infant feeding • birth supporters	 ✓✓ ✓✓	 Info on screening tests, but nothing on choice or personalization, coping strategies etc Display on close & loving relationships, baby stomach size, responsive feeding and brain development
Is there information available about personalised care? For example: • using personalised care & support plans • use of birth preferences/plans • postnatal care plans • birth reflections services		
Is there information about: • visiting times/policies • classes • staff • Trust values • Support • Birth reflections/afterthoughts service • How to give feedback (including PALS for complaints) • MVP	 ✓ ✓	 Virtual BF workshop QR code poster outside lift. Surprising long ad for Gentle Birth Method classes, which don't seem to be evidence-based, on screen in waiting room on antenatal ward. MVP poster and info on PALS in 2nd waiting room

Antenatal Clinic

Element	Observed? (see key)	Notes
Information		
Is there safety information? For example: • who to contact if you need help • covid restrictions • domestic violence • safe sleep information • skin to skin time with baby	 ✓ ✓ ✓	CO monitoring in waiting room on antenatal ward Domestic violence information focuses on men; also forced marriage, FGM. Not in most toilets as shared.

ANY OTHER OBSERVATIONS?
NB Ockenden themes: Safety, information, personalised care & decision making, feedback, coproduction

The antenatal clinic seems to be spread across the areas labelled “Maternity Scanning” and the Antenatal (Murray) Ward, a couple of waiting areas as well as chairs in the corridor near the lift. The second room (on the antenatal ward) seemed quite tucked away and we heard that sometimes women & birthing people felt forgotten there.

QR codes sometimes low down on posters which make it harder to access.

Triage

Element	Observed? (	Notes
Welcome		
How long did I have to wait to enter?	NA	
Are reception staff welcoming and kind?	NA	
Does the space feel welcoming?	0	Wide open space, not well decorated
Is the atmosphere calm and peaceful?	✓✓	
Are there enough seats? Are they comfortable	✓	Not enough
Do appointments seem to be on time?		
Is water available to drink?	✓✓	And tea, coffee & biscuits
Safety		
Does the area feel safe? (Why/ why not?)		Feels exposed
Is hand gel/hand washing available?	✓	
Are masks available?		
Staff		
Are staff calm and friendly in general?	✓✓	
Are staff calm and friendly when calling someone for an appointment?		
Do staff introduce themselves?		
Do staff seem caring of each other?		
Are staff kind (to service users and each other)?		
Is there information about who the staff in the area are?		
Do staff communicate waiting times etc?		
Cleanliness & accessibility		
Is the area clean?	✓✓	
How accessible is the area for people with varying needs eg physical, mental or learning disabilities?		
Is there access to translation/ interpretation services?		
Are cultural needs taken into account or acknowledged?		
Are the toilets clean?	✓✓	But some way from the waiting room
Are the toilets accessible?	0	
Toilets for partners/support people too?	0	
Are baby change facilities available?	0	

Triage

Element	Observed? (see key)	Notes
Information		
Is the signage clear and well placed?		No, layout confusing
How useful are noticeboards, posters (visual information)? Including • in places where service users can read them? • Well laid out • Up to date • Inclusive of different groups (eg ethnicities, LGBTQ, people with disabilities etc)		A couple of noticeboards. Video screen which probably becomes quite annoying if waiting some time. Plus a screen not in use.
Does the information available encourage/ support choice? Specifically choice about: • place of birth • different ways of giving birth (mode of birth) • coping strategies • personalising birth space • infant feeding • birth supporters		
Is there information available about personalised care? For example: • using personalised care & support plans • use of birth preferences/plans • postnatal care plans • birth reflections services		
Is there information about: • visiting times/policies • classes • staff • Trust values • Support • Birth reflections/afterthoughts service • How to give feedback (including PALS for complaints) • MVP		

Triage

Element	Observed? (see key)	Notes
Information		
Is there safety information? For example: • who to contact if you need help • covid restrictions • domestic violence • safe sleep information • skin to skin time with baby	 ✓	

ANY OTHER OBSERVATIONS?
NB Ockenden themes: Safety, information, personalised care & decision making, feedback, coproduction

Early diagnostic clinic and triage waiting rooms are partially separated by a wall, but essentially part of the same space, with people walking through, with water & biscuits for both in one place.
We didn't see night triage space.

Missed opportunity to share information on a variety of topics with those waiting.

Postnatal (Cellier) ward

Element	Observed?	Notes
Welcome		
How long did I have to wait to enter?	NA	
Are reception staff welcoming and kind?	✓	
Does the space feel welcoming?		
Is the atmosphere calm and peaceful?	✓✓	
Are there enough seats? Are they comfortable	✓	Most bays have a couple of seats
Do appointments seem to be on time?		
Is water available to drink?	✓✓	Also tea/coffee. No kitchen, but parents' fridge. Food reported as good.
Safety		
Does the area feel safe? (Why/ why not?)		
Is hand gel/hand washing available?		
Are masks available?		
Staff		
Are staff calm and friendly in general?		
Are staff calm and friendly when calling someone for an appointment?		
Do staff introduce themselves?		
Do staff seem caring of each other?		
Are staff kind (to service users and each other)?		
Is there information about who the staff in the area are?	✓✓	(Also ward manager and safety champions) Infant feeding support, but only there Monday and Friday this week
Do staff communicate waiting times etc?		
Cleanliness & accessibility		
Is the area clean?		
How accessible is the area for people with varying needs eg physical, mental or learning disabilities?		
Is there access to translation/ interpretation services?		
Are cultural needs taken into account or acknowledged?		Shabbos room, funded by local charity.
Are the toilets clean?	✓✓	
Are the toilets accessible?	✓	
Toilets for partners/support people too?	✓	
Are baby change facilities available?		

Postnatal (Cellier) ward

Element	Observed? (see key)	Notes
Information		
Is the signage clear and well placed?		No, would be clearer to say Postnatal Ward or "Postnatal (Cellier) Ward". Colour coding would help navigation
How useful are noticeboards, posters (visual information)? Including • in places where service users can read them? • Well laid out • Up to date • Inclusive of different groups (eg ethnicities, LGBTQ, people with disabilities etc)		Posters and information mixed. Some information targeted to staff rather than service users.
Does the information available encourage/ support choice? Specifically choice about: • place of birth • different ways of giving birth (mode of birth) • coping strategies • personalising birth space • infant feeding • birth supporters	✓	BF helpline
Is there information available about personalised care? For example: • using personalised care & support plans • use of birth preferences/plans • postnatal care plans • birth reflections services		
Is there information about: • visiting times/policies • classes • staff • Trust values • Support • Birth reflections/afterthoughts service • How to give feedback (including PALS for complaints) • MVP	✓	Out of date

Postnatal (Cellier) ward

Element	Observed? (see key)	Notes
Information		
Is there safety information? For example: • who to contact if you need help • covid restrictions • domestic violence • safe sleep information • skin to skin time with baby		
ANY OTHER OBSERVATIONS? **NB Ockenden themes: Safety, information, personalised care & decision making, feedback, coproduction** Women are in large bays, which they don't tend to leave		

Appendix 5

Meeting title	**Trust Board – public meeting**	**Date: 30 September 2022**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 6**
Committee Chair	Naomi Fulop, Non-Executive Director	
Executive director leads	Clare Dollery, Medical Director, Carol Gillen, Chief Operating Officer, and Varda Lassman, Acting Deputy Chief Nurse	
Report authors	Swarnjit Singh, Joint Director of Inclusion and Trust Secretary	
Executive summary	The Quality Assurance Committee met on 13 July 2022 and was able to take significant or reasonable assurance from the following items considered: • Internal audit review – Care Quality Commission action plan • 2021/22 Quality Account publication • Bi-annual adult and children's safeguarding report • Adult community services - Quality improvement projects • 2021/22 Complaints, compliments and patient advice and liaison service annual report • Chair's assurance report, Quality Governance Committee • Board Assurance Framework – Quality entries • Risk register • Safer staffing nursing and midwifery interim report • Victoria ward action plan • Serious Incidents There are no items for which the Committee is reporting limited assurance to the Board. The Committee agreed that the workforce challenges remained the paramount risk for the Trust. The following key areas of risk are reported to the July Board meeting: • The most significant risk was the adverse impact of the current coronavirus surge on staffing capacity across all professional groups. The volatility of the present position was recognised along with the actions being taken to support staffing capacity, such as the use of professional development nursing staff on wards • Several actions were in place to respond to the internal incident and included a daily review of staffing across hospital and community settings	

	• In order to achieve safe staffing and midwifery levels, extensive mitigations were required daily
Purpose	Noting
Recommendations	Board members are asked to note the Chair's assurance report for the meeting held on 13 July 2022.
BAF	Quality strategic objective entries
Appendices	None

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	13 July 2022

Summary of assurance:

1. The Committee confirms to the Trust Board that it took significant assurance in the following areas:

Internal audit review – Care Quality Commission action plan

The internal audit team had reviewed the processes and controls in place for the development and, ongoing monitoring of the delivery of the action plan in response to the areas for improvement highlighted in the last Care Quality Commission inspection report for Whittington Health. The review team visited Committee members thanked the Quality and compliance manager and the integrated clinical service units for the positive outcome of *significant assurance with some improvement required* following the review by Grant Thornton.

2021/22 Quality Account publication

Committee members noted that, following the Board's approval at its May meeting for delegated authority for the Acting Chief Executive and Chief Nurse to approve the final version of the Quality Account, this has been published on the Trust's external webpages by the 30 June 2022 deadline. The Committee thanked all colleagues who had been involved in its production and noted that a summary version was being produced by the Communications team.

Bi-annual adult and children's safeguarding report

The Committee took good assurance from the report presented by the Adult Safeguarding Lead. The report covered the period from September 2021 to April 2022. It was assured that there were systems in place to protect children and vulnerable adults from abuse and neglect whilst in our care and that Whittington Health continued to fulfil its role as a statutory partner in safeguarding children and adults at risk in the wider community and health and care economy.

During discussion, Committee members were apprised of developments which included the following:

- A continued increase in both numbers and complexity of safeguarding adult concerns referred, in part reflecting domestic abuse and neglect which had taken place during the coronavirus pandemic
- The delivery of training by the Tissue Viability Nurse to over 100 social care, care agency and care home staff as the numbers of pressure ulcers reported as safeguarding adult concerns had increased in the previous two quarters
- There was good compliance with training requirements for both adult and children's safeguarding
- The work taking place to prepare for the implementation of the new Liberty Protection Safeguards (LPS) to replace the Deprivation of Liberty Standards
- The Adult Safeguarding Lead was a member of both the national and London LPS Clinical Review Groups and was able to influence both

regional and national responses to the LPS consultation which ended on 14 July

Adult Community Services - quality improvement projects

The Committee considered updated on two quality improvement projects. First, it received an informative presentation from the Advanced Physiotherapy Practitioner who demonstrated the improvements made through the establishment of multidisciplinary teams between the rheumatology and musculoskeletal clinical assessment and treatment services. The Committee took good assurance from the reported improvements in patient care pathways through actions such as upskilling advanced physiotherapy practitioners and the management of patients without rheumatological conditions through community care.

Secondly, Committee members learnt about a project for stroke patients. This work involved the creation of an upper limb group programme for stroke patients in the London Borough of Haringey, an increase in the intensity and quality of multidisciplinary evidence-based assessments and interventions, and the establishment of a platform for patients to share experiences, and to support and motivate each other. This project had resulted in improved patient access and outcomes, including improved patient wellbeing and increased confidence with rehabilitation exercises.

2021/22 Complaints, Compliments and Patient Advice and Liaison Service (PALS) annual report

Committee members reviewed and took assurance from the annual report which covered a period when staff faced several pandemic surges. Feedback from the Committee covered the need to show trend and demographic data. They noted the following points:

- 2021/22 saw a 56% increase in formal complaints compared with the previous year, reflecting a return to pre-pandemic levels
- 97% of complaints were acknowledged within the stipulated three working days against a 90% target
- The Trust received eight requests from the Health Service Ombudsman
- 442 compliments were received – an increase from 345 in 2020/21
- A total of 3,165 PALs contacts took place with patients and GP practices. This was an increase from the 2,617 PALs contacts in 2020/21

Chair's assurance report, Quality Governance Committee

The Committee noted the report which highlighted items discussed at the meeting held on 14 June 2022. Clare Dollery drew the following areas to the Committee's attention:

- The estates and facilities team were thanked for the good progress achieved with the fire door remediation works
- The interim safer nursing and midwifery staffing interim report showed improvements in some areas. Assurance was provided that teams worked on a daily basis to maintain safe staffing levels in the face of significant capacity challenges
- The Pharmacy and Information Technology teams were thanked for their exceptional support during the successful upgrade of its e-prescribing and

medication administration and pharmacy stock control JAC medicines management system on 21 June 2022
- The Clinical Effectiveness Group reported on the notable good practice identified from a Getting It Right First Time Deep Dive into dermatology services

During discussion on the interim safer staffing report, assurance was provided to Amanda Gibbon that the appropriate safer staffing tools were being used, that the skill mix on wards was regularly reviewed and that the key risk remained with staffing capacity pressures caused by increased absence due to the pandemic and not recruiting to vacant positions. Naomi Fulop noted that pressure ulcers remained an area of concern and a report was due to be considered at the Committee's next meeting in September. The good work on venous thromboembolism risk assessments was also noted alongside a fall in family and friend's test responses.

Board Assurance Framework – Quality entries
The Committee noted the increased score for the Quality 1 entry to 16 as a result of the significant operational and staffing pressures across the NHS and their impact on sustainability. The current increased internal incident level was discussed and whether this should impact on a higher likelihood rating for the Quality 1 entry. It was noted that this matter would be reviewed by the executive team prior to next week's meeting of the Trust Board.

Trust Risk Register
The Committee noted the key changes to the risk register since it was last considered by the Committee in May 2022. The Committee discussed a new risk which related to workforce resilience and health and wellbeing in the Emergency and Integrated Medicine integrated clinical service unit. Assurance was provided that controls were in place to help mitigate this risk and included new ways of working, support from NHS Elect, team awaydays and additional management support.

Committee members acknowledged the sustained pressure which emergency and urgent care pathways had been under and that this had been exacerbated further by the current coronavirus pandemic surge and also by high temperatures. They welcomed the fact that a number of risks had been closed and others downgraded through successful controls and mitigations. Assurance was provided that business continuity reviews took place for all areas, including mortuary stores. Committee members were also informed that a contract review was taking place with Camden and Islington Foundation Trust for the provision of psychologist support for haematology services.

Safer staffing nursing and midwifery interim report
The Committee was apprised of the challenges in completing the bi-annual staffing review in a timely manner due to staffing pressures and the remedial actions in place covering staff engagement, improved communication and training so that there was reliable and accurate data available for the review. Assurance was provided that a timely staffing review took place in response to clinical activity setting changes such the opening of escalation beds, and that workforce planning, and redeployment decisions were taken to ensure safe staffing levels. The Committee noted the interim report's recommendations, including the review of the three healthcare assistant posts in the children's ambulatory care unit and the use of the Birthrate Plus assessment tool to review staffing in maternity services. The Committee looked forward to reviewing the bi-annual staffing report at its next meeting in September.

Victoria ward action plan
Fiona Long presented the report which had been discussed at the Quality Governance Committee and at a partnership meeting with the Care Quality Commission. The report showed progress with the implementation of actions and continued to be monitored closely. Challenges included nurse staffing and recruitment exercises had been successful in identifying four new nurses who would start on the ward in the next two months. The Committee agreed that further trajectory information on pressures ulcers, serious incidents and complaints and compliments would be helpful to help evidence improvements. Assurance was provided to the Committee that no new complaints specific to the ward had been received and that pressure ulcer data showed no deterioration in the improvement trajectory.

Serious Incidents
The Committee received an overview of Serious Incidents declared during May and June 2022. It noted the following:

- Five new serious incidents were declared during this period. The cases covered a baby born in poor condition who required admission to the neo-natal intensive care unit and transfer to a tertiary unit for therapeutic cooling, two intrauterine deaths when pregnant mothers presented with reduced fetal movements, a case of testicular torsion which required an orchidectomy to be performed, and a patient had an unwitnessed fall whist getting up from the toilet which resulted in the patient sustaining a left intertrochanteric fracture of the neck femur
- The Trust had implemented its obligations under the statutory duty of candour for each serious incident recorded in April and in May 2022
- Lessons had been shared widely through a range of methods on the six serious incidents declared in April and in May 2022

The Committee discussed concerns regarding the timescales for the completion of serious incident investigations and the issue of duty of candour letters where required. It noted that the publication of patient safety criteria was awaited from the national Healthcare Safety Investigation Branch and the current operational pressures and agreed that a plan would be discussed at the next Committee meeting in September, including the performance metrics to be used.

2.	**Present:** Professor Naomi Fulop, Non-Executive Director (Committee Chair) Amanda Gibbon, Non-Executive Director (Vice Chair) Baroness Glenys Thornton, Non-Executive Director Dr Clare Dollery, Medical Director Carol Gillen, Chief Operating Officer Varda Lassman, Acting Deputy Chief Nurse **In attendance:** Kat Nolan-Cullen, Compliance and Quality Improvement Manager Gillian Lewis, Associate Director, Quality Governance Fiona Long, Deputy to the Associate Director of Nursing – Emergency & Integrated medicine Nadine Jeal, Director of Operations – Adult Community Health Services Tina Jegede, Joint Director of Race, Equality, Diversity & Inclusion Carolyn McGirr NHS North Central London ICS Nicolas Nicolaou, Advanced Physiotherapy Practitioner David Pennington, Deputy Director Quality, North Central London ICS Theresa Renwick, Adult Safeguarding Lead Clara St Jean, Occupational Therapist Swarnjit Singh, Joint Director of Inclusion and Trust Secretary Carolyn Stewart, Executive Assistant to the Chief Nurse and Director of Allied Health Professionals

Meeting title	**Trust Board – public meeting**	**Date: 30 September 2022**
Report title	**Audit & Risk Committee Chair's Assurance report**	**Agenda item: 7**
Committee Chair	Rob Vincent, Non-Executive Director	
Executive director lead	Kevin Curnow, Chief Finance Officer	
Report author	Swarnjit Singh, Joint Director of Inclusion and Trust Secretary	
Executive summary	This report details areas of assurance from the items considered at the Audit and Risk Committee meetings held on 18 July and 20 September 2022. **Areas of significant assurance:** • 2022/23 Internal audit plan • Internal audit reviews – public engagement and clinical effectiveness • Quarter three Board Assurance Framework • Counter Fraud progress report **Areas of moderate assurance:** • Internal audit reviews – Consultant job planning • Internal audit progress report and recommendations' tracker • Trust Risk Register The Committee also discussed reports covering losses and special payments, NHS and non-NHS debtors and the committee's forward work plan. In addition, the Committee received an oral update from KPMG on work taking place for the 2022/23 external audit plan.	
Purpose	Noting	
Recommendations	Board members are invited to note the Chair's assurance report for the Audit and Risk Committee meetings held on 18 July and 20 September 2022.	
BAF reference	All entries	
Report history	Board meetings following each Committee meeting	
Appendices	None	

Committee Chair's Assurance report

Committee name	Audit and Risk Committee
Date of meetings	18 July 2022

Summary of assurance:

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

2022/27 Internal audit strategy including 2022/23 internal audit plan
Committee members considered an updated internal audit plan which had been widely consulted on with executive directors. They agreed that the comprehensive plan was rationally structured and linked to key organisational risks. The Committee Chair welcomed the plan's emphasis on data quality, culture and communication. Assurance was provided that, while the plan was ambitious, it was achievable, particularly with the early engagement of respective executive leads. The Committee Chair fed back the need to review staff appraisals and statutory and mandatory training earlier than set out for the following year in the draft plan.

Internal audit reviews – public engagement and clinical effectiveness
Committee members took significant assurance from the two successful outcomes of internal auditors' reviews. They welcomed the revies' conclusions and assessments which have both areas an assessment of s*ignificant level of assurance with some improvement required*. They noted the examples of good practice highlighted in both reviews and noted that the areas highlighted for improvement were being taken forward.

2. The Committee can report moderate assurance to the Trust Board in the following areas:

Internal audit review – Consultant job planning
The Committee Chair noted that a fuller discussion would be held at the Committee's September meeting on this review with the Medical Director. The Committee noted the review's assessment of *partial assurance with improvement required* and the two high level and seven medium level recommendations suggested to help improve. These recommendations covered the updating of the job planning toolkit in line with best practice, a higher rate of job plans being completed and ensuring that all private practice was declared and recorded on the Allocate system.

Internal audit progress report and recommendations' tracker
The Committee discussed the recommendations tracker and welcomed the progress achieved. However, the Committee also noted that recommendations were overdue for implementation in the areas of medicines management and temporary staffing and that these were being discussed and progressed with respective management leads.

3.	**Other reports** Committee members welcomed a helpful update on cyber security developments from RSM and agreed that this be circulated widely to relevant colleagues. In addition, the Committee carried out its annual review of its terms of reference and effectiveness.
4.	**18 July 2022 meeting attendance:** **Present:** Rob Vincent, Non-Executive Director (Committee Chair) Amanda Gibbon, Non-Executive Director Glenys Thornton, Non-Executive Director **In attendance:** Raphael Atoyebi, Auditor, Grant Thornton LLP Vivien Bucke, Business Support Manager Andy Conlan, Grant Thornton LLP Kevin Curnow, Chief Finance Officer John Elbake, Senior Manager, RSM Martin Linton Assistant Director of Financial Services Jerry Francine, Operational Director of Finance Ciaran McLaughlin, Director, Public Assurance, Grant Thornton LLP Clive Makombera, Partner, RSM Fleur Nieboer, Director, KPMG LLP Swarnjit Singh, Trust Secretary **Apologies:** Clare Dollery, Medical Director Jonathan Gardner, Director of Strategy and Corporate Affairs James Shortall, Local Counter Fraud Specialist, BDO

Committee name	Audit and Risk Committee
Date of meetings	20 September 2022

Summary of assurance:

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

Quarter three Board Assurance Framework

The Committee reviewed the Board Assurance Framework (BAF) for quarter three. Committee members were apprised of the decision by the Quality Assurance Committee earlier this month to agree to a reduction in the score for BAF entry Quality 1 from 16 to 12 to reflect the lower prevalence of Covid-19 positive inpatients at the Trust. Committee members also noted the decision by the Trust Management Group to maintain the present scores for both Integration entries and to keep these under review.

Counter Fraud progress report

The Committee welcomed an update on counter fraud activity since its last meeting and took assurance from the progress achieved. In particular, the Committee was updated on three investigations which covered intelligence on the targeting of NHS trusts in a series of phishing and mandate fraud attempts, a WhatsApp message from a fake account in the name of the Chief Executive requesting unusual expenditure and a fraudulent attempt to change bank details. The Committee received assurance that no financial loss was incurred through any of these attempts to breach Whittington Health's financial systems and controls and that, in each instance, the staff member who identified the fraud attempt, took the correct course of action by escalating the matter to their respective line managers.

2. The Committee can report moderate assurance to the Trust Board in the following areas:

Internal audit review – Consultant job planning

The Committee Chair welcomed the Medical Director and the Associate Medical Director, Workforce, for the discussion on the review of Consultants' job planning arrangements. Committee members were informed of the progress achieved with 67% of job plans fully completed and signed off and others under review with clinical leads and of plans to review and update the job planning toolkit in time for the next job planning round which commenced in October 2022. During discussion of concerns about the completion of declarations of interest, the Committee was informed that an audit of all Consultant declarations of interest would take place at the end of the current job planning cycle and received assurance of mitigating actions being taken to cross check against the declarations made.

The Committee agreed to close down the actions for this job planning round and noted that a report would be considered by the Committee next year on the additional progress achieved. The Committee also agreed to keep the issue of declarations for private practice on the internal audit recommendations tracker.

	Internal audit progress report and recommendations' tracker Committee members discussed the progress report and the recommendations tracker. They noted the work in progress on reports for the Committee covering assurance mapping, the Healthcare Financial Management Association checklist mandated by NHS England (this replaced reviews on financial planning and key financial controls) and data quality. In reply to Committee members' concerns raised regarding slippage in the internal audit plan and whether this might impact on the ability to produce a robust Head of Internal Audit Opinion at year end, assurance was provided by RSM that the timeline and plan was achievable and that any delays would be escalated to the Chief Finance Officer. It was agreed that internal audit review reports would be circulated to Committee members as they were completed and that an update on progress with the internal audit plan would be provided to the Committee Chair on 31 October. Committee members highlighted the overdue actions in relation to medicines management and noted that updates had been received since Committee papers were issued. They also received assurance that delays with implementing these internal audit recommendations would be drawn to the attention of the Trust's Management Group. **Trust Risk Register** The Associate Director of Quality apologised to the Committee for the circulation of a report outlining the June position and agreed to circulate the latest version of the trust risk register following the meeting. The verbal update delivered at the meeting confirmed that a review of all risk register entries was underway and included a tightening of all risk descriptors and ensuring a consistent approach to the scoring of individual risk entries, in line with NHS guidance. Committee members also received assurance that the Trust's Management Group reviewed the risk register quarterly in line with the risk management strategy, and more frequently at the moment, as entries were being reviewed and updated.
3.	**Other reports** Committee members also discussed these reports: • Tender waiver and breaches – it noted the reduction in tender waivers for quarter one compared with the preceding period and received assurance on the work taking place to enforce waiver rules more robustly, including the option of making it a disciplinary offence. • Losses and special payments – the recommendation to write off two salary overpayment cases was endorsed. The Committee also agreed to a recommendation write off aged overseas patient debts and received assurance that these debts had been fully provided for with the net effect that the expenditure write off was zero. The Committee agreed that further details be provided to the Trust Management Group and to this forum's next meeting on the number of patients involved, the rate of recovery and benchmarking and learning from other North Central London providers. Furthermore, the Committee also agreed that overseas patient debts be included in the 2023/24 internal audit plan.

	• Debtors – Committee members were updated on the recovery of NHS and non-NHS debts, with the Royal Free Group and the London Borough of Hackney highlighted • 2022/23 external audit plan – the Committee noted a verbal update on the work taking place and that the plan would be reviewed at its next meeting in December. • The Committee's forward work plan was noted.
4.	**20 September 2022 meeting attendance:** **Present:** Rob Vincent, Non-Executive Director (Committee Chair) Amanda Gibbon, Non-Executive Director Glenys Thornton, Non-Executive Director **In attendance:** Vivien Bucke, Business Support Manager Helen Brown, Chief Executive Kevin Curnow, Chief Finance Officer Clare Dollery, Medical Director John Elbake, Senior Manager, RSM Jonathan Gardner, Director of Strategy and Corporate Affairs Gillian Lewis, Associate Director of Quality Martin Linton Assistant Director of Financial Services Sola Makinde, Associ ate Medical Director, Workforce Clive Makombera, Partner, RSM Phil Montgomery, Procurement Business Partner Dale-Charlotte Moore, Interim Chief Operating Officer James Shortall, Local Counter Fraud Specialist, BDO Swarnjit Singh, Trust Secretary Craig Waterman, KPMG LLP Sarah Wilding, Chief Nurse and Director of Allied Health Professionals **Apologies:** Jerry Francine, Operational Director of Finance Fleur Nieboer, Director, KPMG LLP

Meeting title	**Trust Board – public meeting**	**Date: 30 September 2022**
Report title	**Integrated performance report**	**Agenda Item: 8**
Executive director lead	Jonathan Gardner, Director of Strategy and Corporate Affairs	
Report Owner	Paul Attwal, Head of Performance, Chloe Hubbard, Performance Manager	
Executive summary	The performance report attached is in process of development towards a more analytical approach using Statistical Process Control (SPC) charts. This month we have begun with the Emergency Department metrics with the view to converting the format for all measures over the next few months. Board Members should note that all ED metrics are shown in summary, but only certain measures have been highlighted for further analysis and explanation based on their trajectory, importance and assurance. **With regard to performance, areas to draw to Board members' attention are:** **Emergency Department (ED) four hours' wait** During August 2022, performance against the 4-hour access standard was 73.1%, higher than the NCL average of 71.06%, the London average of 71.64% and the national average of 71.44%. However, the trend continues to be slowly worsening. There were 34 12-hour trolley breaches in August. The breaches were due to challenges in allocation of beds due to capacity, and high number of medically optimised patients in the trust. **Cancer** Compliance against the national cancer standards has not been achieved since April 2020. 28 Day Faster Diagnosis was at 61.4% against a standard of 73% in July 2022. 62-day performance was at 28.6% for July 2022 versus a target of 85%. All of these metrics are showing a decline over the last 6 months. **Referral to Treatment: 52 + week waits** At the end of August 2022 there were 479 patients waiting more than 52 weeks for treatment. This number been gradually growing since March. Additional insourcing from 18-week Support for surgery has restarted in September to help reduce the overall backlog. The contract is in place until the end of the financial year. **Elective Recovery** August activity levels are at 98% of 2019/20 levels. This is expected to improve through September. The Trust is expected to achieve 0 patients	

	waiting more than 78 weeks by the end of October 2022 and is currently on target to achieve this. **Workforce** There has been an improvement in the number of days to hire reducing from 100 in July to 84.1 in August against the target of 63 days. The compliance against Mandatory Training was 84.3% in August 2022, a drop of 2.7% compared to the previous month, against a target of >90%.
Purpose:	Review and assurance of Trust performance compliance
Recommendation (s)	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan
Risk Register or Board Assurance Framework	The following BAF entries are linked: Quality 1; Quality 2; Quality 3; People 1; and, People 2.
Report history	Trust Management Group
Appendices	Appendix 1: Community Performance Dashboard Appendix 2: Community Waiting Times Dashboard Appendix 3: Cancer Performance – 62D and 2WW by Tumour Group Appendix 4: Trust Level Activity

Whittington Health
NHS Trust

Performance Report
September 2022

Month 05 (2022 – 2023)

Date & time of production: 12/09/2022 09:05

Scorecard

Deliver outstanding safe, compassionate care

Indicator	Target	Reporting Mth	Step Change	Control Limit	Prev. Month	Reporting Mth	2022-2023
Emergency Department waits (4 hrs wait)	>95%	Aug			69.0%	73.1%	73.5%
Cancer - 14 days to first seen	>93%	Jul			43.1%	54.3%	50.5%
Cancer - 62 days from referral to treatment	>85%	Jul			31.6%	28.6%	40.2%
DM01 - Diagnostic Waits (<6 weeks)	>99%	Aug			87.79%		87.80%
RTT - Incomplete % Waiting <18 weeks	>92%	Aug			68.3%		70.3%
Referral to Treatment 18 weeks - 52 Week Waits	0	Aug			452	0	1642
Community - FFT % Positive	>90%	Aug			95.0%	96.6%	97.0%
% seen <=2 hours of Referral to District Nursing Night Service	>80%	Aug					
% seen <=48 hours of Referral to District Nursing Service	>95%	Aug			100.0%	96.4%	96.1%

Transform and deliver innovative, financially sustainable services

Indicator	21_22 Target	Reporting Month	Step Change	Control Limit	Prev. Month	Reporting Month	2022-2023
Theatre Utilisation	>85%	Aug			69.94%	74.06%	72.90%
Acute DNA % Rate	<10%	Aug			11.2%	11.8%	11.0%
Community DNA % Rate	<10%	Aug			8.3%	8.7%	7.9%
Outpatients New:FUp Ratio	2.3	Aug			1.70	1.72	1.74
Elective and Daycase		Aug			2169	1999	10074
Outpatient Attendances		Aug			24938	25092	128005
Community Face to Face Contacts		Aug			40451	34084	199539

Integrate care with partners and promote health and wellbeing

Indicator	21_22 Target	Reporting Mth	Step Change	Control Limit	Prev. Month	Reporting Mth	2022-2023
Breastfeeding Initiated	>90%	Aug			92.6%	91.3%	92.5%
% e-Referral Service (e-RS) Slot Issues	<4%	Aug			30.1%	31.5%	32.0%
% of MSK pts with Improvement in function (PSFS)	>75%	Aug			88.6%	87.7%	82.7%
Rapid Response - % of referrals with an improvement in care		Aug			0.0%	0.0%	0.0%

Empower, support and develop engaged staff

Indicator	21_22 Target	Reporting Month	Step Change	Control Limit	Prev. Month	Reporting Month	2022-2023
Appraisals % Rate	>90%	Aug			74.1%	71.5%	70.8%
Mandatory Training % Rate	>90%	Aug			87.0%	84.3%	85.1%
Permanent Staffing WTEs Utilised	>90%	Aug			86.7%	86.9%	87.0%
Staff FFT % recommended work	>50%	Aug			50.9%		51.1%
Staff FFT response rate	>20%	Aug					
Staff sickness absence %	<3.5%	Jul			4.07%	4.72%	4.36%
Staff turnover %	<13%	Aug			13.9%	13.7%	13.9%
Vacancy Rate against Establishment	<10%	Aug			13.3%	13.1%	13.0%

Step Change	Where a new step change has been triggered by five consecutive points above or below the mean (average).
Control Limit	The Control Limit is where the latest reported month is above the upper confidence limit or below the lower confidence limit.

If the step change or control limit icon is green, this suggests performance in changing in a positive	If the Step change or Control Limit icon is red, this suggests performance is changing a negative

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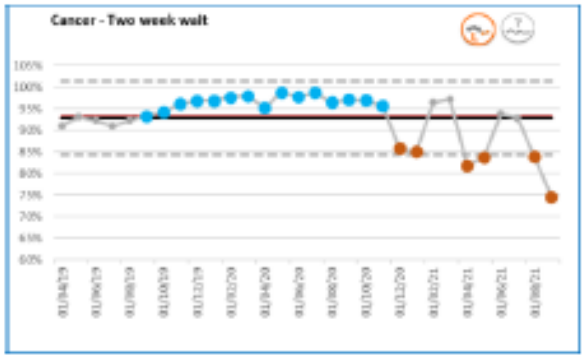
A note on SPC charts

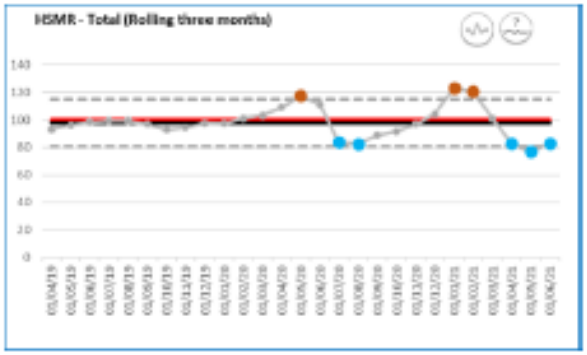
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

SPC rules – Special Cause Variation

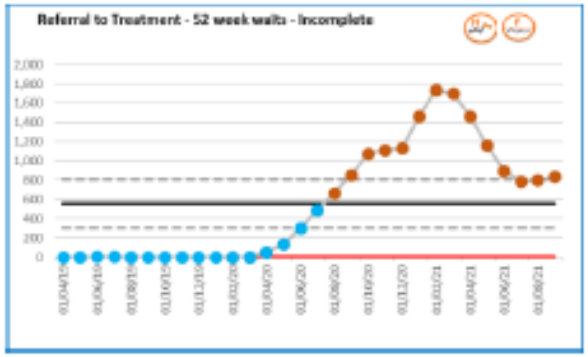
A breach of the upper/lower control limit



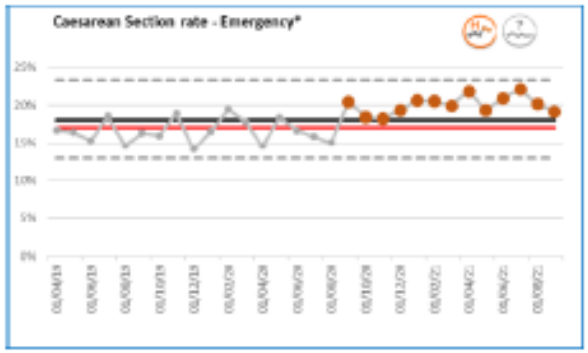
2 out of 3 points close to the control limit



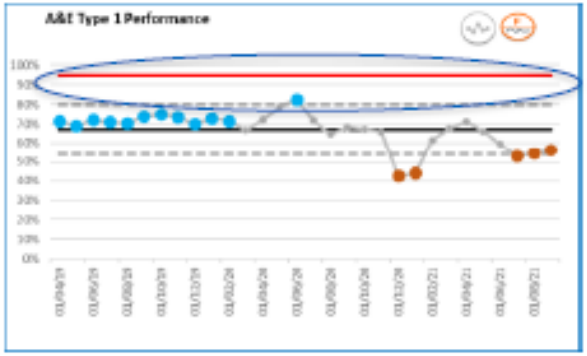
A run of ascending/descending data points



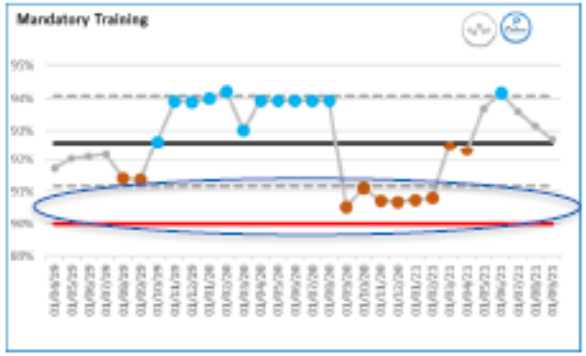
A run of points all one side of the mean



Variation indicating consistently failing the target – target line above upper control limit

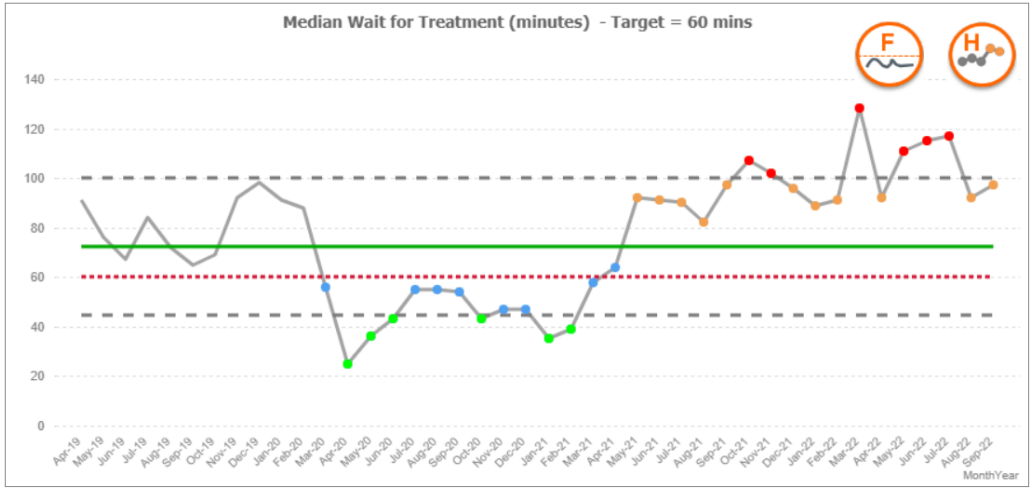


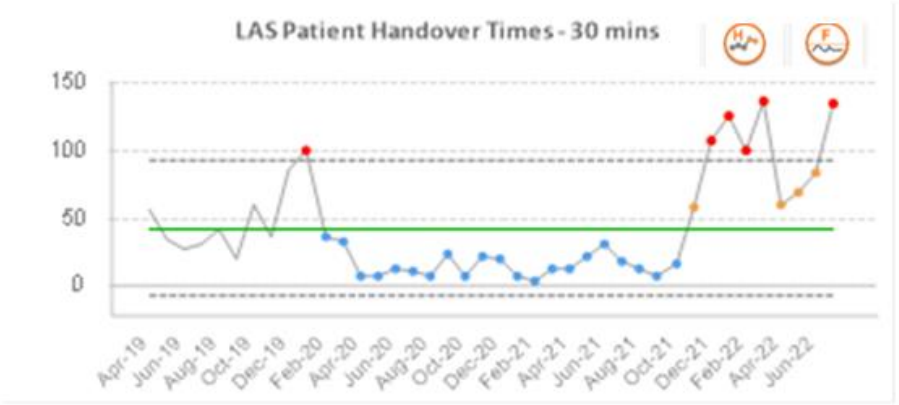
Variation indicating consistently passing the target – target line below lower control limit



Indicator	Target	Latest Month Reported	Performance			Variation	Assurance
			Latest Month	Previous Month	2022-2023		
LAS Patient Handover Times - 30 mins	0	Jul	135	84	442	H	F
LAS Patient Handover Times - 60 mins	0	Jul	48	18	107		F
% streamed to an onsite service	>7.5%	Aug	2.5%	1.7%	1.7%	H	F
Median Wait for Treatment (minutes)	< 60 min	Aug	92	117	117	H	F
% of ED attendance seen by clinician within 60 mins of arrival		Aug	39.0%	34.4%	34.4%	L	
Median time from Arrival to Decision to Admit		Aug	04:12	04:50	04:50	H	
12 Hour Trolley Waits in ED	0	Aug	34	95	95	H	F
Total ED Attendances in dept for more than 12 hours (arrival to dept)		Aug	490	509	509	H	
% of ED Attendances over 12 hours from Arrival to Departure	<2%	Aug	6.1%	7.3%	7.3%	H	F
Emergency Department waits (4 hrs wait)	>95%	Aug	73.1%	69.0%	69.0%	L	F
% left ED before being seen		Aug	10.3%	12.6%	12.6%	H	
% ED re-attendance within 7 days		Aug	10.0%	9.8%	9.8%		

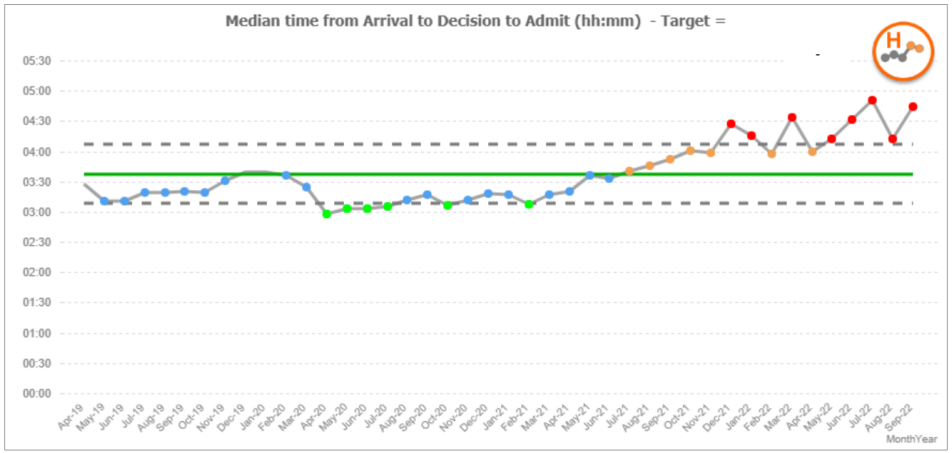
Special Cause Variation – Performance/Assurance – Median Wait for Treatment (minutes) and LAS handover 30mins





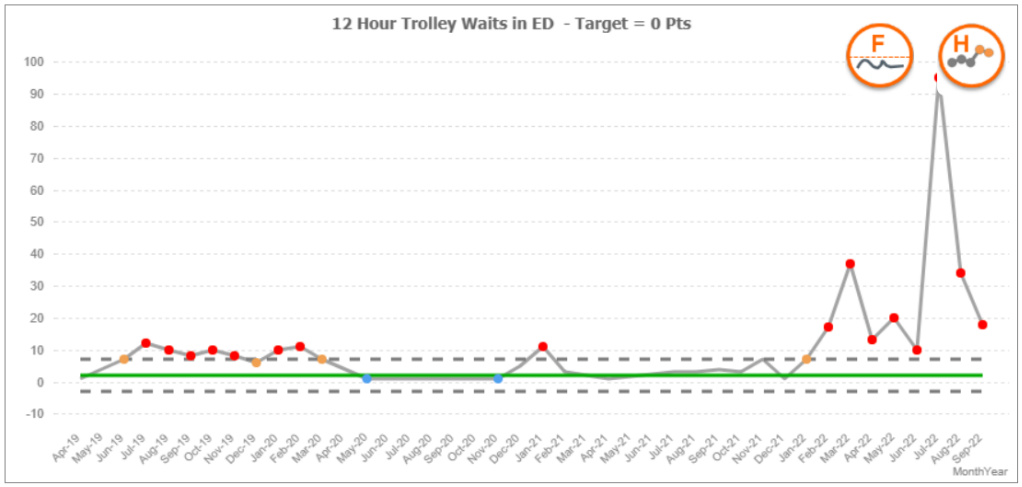
Background	What the Data tells us	Issues	Actions	Mitigations
Median time to treatment is the median time from arrival in ED to the time when a patient is seen by a decision-making clinician to diagnose the problem and arrange or start treatment as necessary. The target is 60mins. LAS Patient Handover time should be less than 30 mins.	During the first wave of the pandemic the performance improved considerably for both measures, since May 21 (and Dec 21 for LAS) these have deteriorated and are getting worse and remain 'out of control'. The median time to treatment for August was 92 minutes compared to 117 minutes the previous month.	• Higher number of lower acuity patients attending than available capacity (Staffing and cubicle space). • Long waits for admission due to in-patient bed availability have a known effect on wait times and the ability to accept ambulance handover according to standards	• Optimise streaming and triage pathways • The Trust has ring fenced ambulatory care space to manage patients without the need for admission. • Review IPC pathways with covid protocol to maximise flexible use of space across the acute floor • Enact Fit to Sit where needed, escalate bed requirements early, board on wards when required	• Ensuring patients are on the right streaming pathway to minimise waits • Allocation of senior decision maker to RAT • Safety checks of long waiting patients • Clinical review of patients waiting on ambulance • Regular departmental huddles to ensure staffing distribution to meet the demands of the department.

Special Cause Variation – Performance – Median Time from Arrival to Decision to Admit



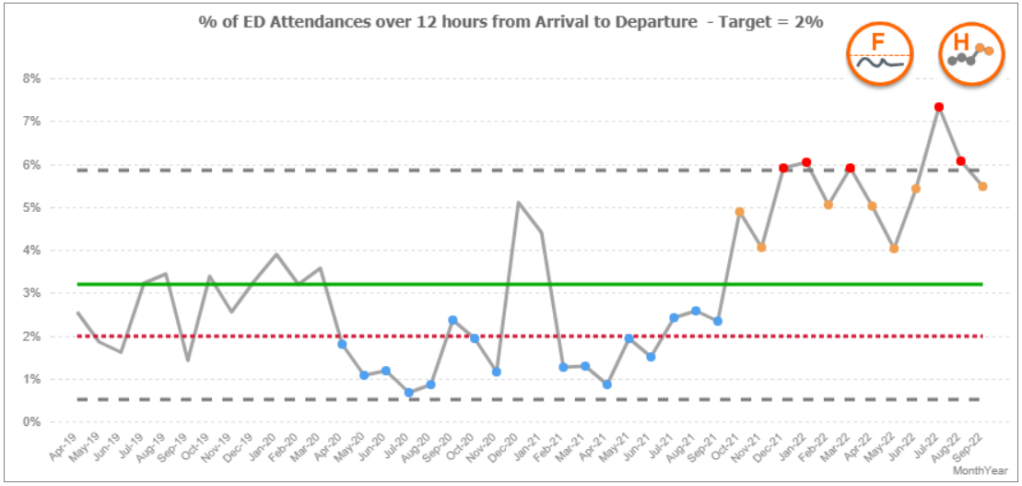
Background	What the Data tells us	Issues	Actions	Mitigations
This metric measures the median time from arrival to the time a decision is made by a senior decision maker to admit the patient.	There has been an upward trend in time waiting since June last year. The data shows that the median time from arrival to DTA in August was 04:12 hh:mm compared to 04:50 hh:mm the previous month.	• Longer waits to be seen mean that decisions are being made later in the patient journey • Inconsistent understanding of new Emergency Care Data Set standards and admission process	• Clinical lead to review professional standards • Review protocol for pathway management against 4hr standard • Regular huddles and escalations to monitor quality and performance against targets	• The department is working closely with the site team and in-patient teams to ensure early allocation of beds • Internal Professional Standards refresh as preparedness for Winter Plan • Refresh flow programme to include management of 4hr standard and escalations to create capacity and flow

Special Cause Variation – Performance/Assurance – 12 Hour Trolley Waits in ED



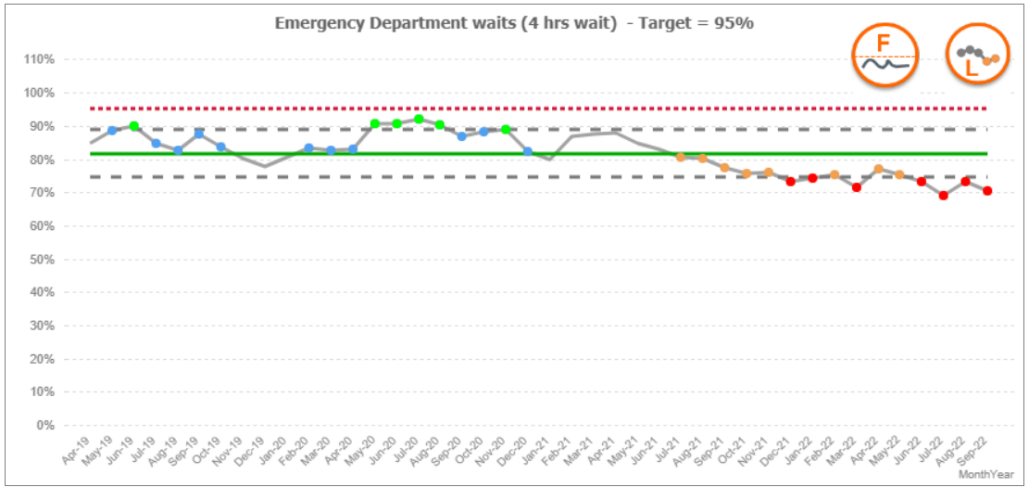
Background	What the Data tells us	Issues	Actions	Mitigations
12-hour trolley waits is the numbers of patients who waited longer than 12 hours to be admitted to the ward following a decision to admit (DTA)	There has been an upward trend of 12-hour breaches from February and this has seen a major spike in breach numbers in July. There is a direct correlation to bed availability and flow issues within the hospital. There were 34 trolley breaches in August compared to 95 trolley breaches in July.	• High number of medically optimised patients in the Trust • Larger proportion of discharges occurring during later part of the day. • Lack of Mental Health beds available in the system	• Long length of stay reviews on the wards • System meetings to de-escalate trust Medically Optimised (MO) position • Zero tolerance approach to 12-hour breaches re-invigorated • All breached patients are reviewed for potential harm	• Safety check for all patients awaiting beds • Escalation at huddle and access meetings • Review escalation triggers and actions to prevent long waits in ED including boarding decisions

Special Cause Variation – Performance/Assurance – % of ED Attendances over 12 hours from Arrival to Departure



Background	What the Data tells us	Issues	Actions	Mitigations
This metric measures the percentage of patients who spent longer than 12 hours from arrival to discharge. The target is 2%	There has been an increase in this metric since October 2021, this has remained high and peaked in July. Like many of these metrics SPC would suggest that the current process is unable to deliver the target (hence the F). In August 6.1% of the patients spent longer than 12 hours in the department compared to 7.3% the previous month.	• Long waits for admission due to in-patient bed availability have a known effect on wait times and the ability to accept ambulance handover in a timely fashion. • Non admitted patients waiting in the department longer than required for discharge or treatment plan	• Audit non-admitted patients waiting over 12 hrs • Zero tolerance policy to boarding in SDEC • Refreshed flow programme to consider non-admitted pathway management including review of internal professional standards • Early review of patients in ED who can be supported at home rather than being admitted.	• Safety check for all patients awaiting beds • Audit and QI work required to manage non-admitted performance • Flow Programme for 2022-2023 to refresh priorities for non-admitted pathway

Special Cause Variation – Performance/Assurance – Emergency Department waits (4 hrs wait)



Further analytical work of all the flow metrics suggest that the process for medically fit patients is 'not in control' [note this is a statistical statement not a management statement] and that neither is the length of stay for those over 21 days, these two factors are likely to be made worse by the pre 5pm discharge process that is deteriorating, and are probably driving Acute Assessment Unit (AAU) length of stay (LOS) and ED arrival to departure time. However, with reduced ED attendances and improved UCC rates, one would expect to see a better improvement in median time to treatment so effort is being put in there also.

Background	What the Data tells us	Issues	Actions	Mitigations
This metric looks at percentage of patients discharged from ED within 4 hours from arrival. Target is 95%	There has been a decline throughout the pandemic, with the lowest on record in July. Again the system is out of control and unable to deliver the target. Overall performance for August against the 4-hour target was 73.1%. This performance was against an attendance of 8,010 patients. This was an improvement from 69.01% recorded the previous month. Albeit this was against a lower overall attendance.	• 4-hour performance is not improving despite improving site position and increased workforce coverage. • Opel 4 afforded some intelligent conveyancing but no redirects due to wider system pressures • Emergency Department footprint challenging to meet demands of UTC attendances due to configuration and IPC standards	• Optimise streaming and triage pathways. • Early escalation to LAS of Opel status • Zero tolerance policy to boarding in SDEC • Review of IPC pathways across Emergency and Acute Medicine	• Ensuring patients are on the right streaming pathway to minimise waits • Review Acute Front Door programme priorities and actions to ensure improvement trajectory for ED performance • Allocation of senior decision maker to RAT

Indicator	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022-2023	Performance
Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI C Difficile	<16	0	0	0	1	2	1	2	2		1			3	
Actual Falls	400	27	23	21	33	40	23	31	25	28	30	39	40	162	
Category 3 or 4 Pressure Ulcers	0	20	3	4	10	4	8	9	17	9	10	10	12	58	!
Medication Errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
MRSA Bacteraemia Incidences	0	0	0	0	0	0	0	0	0		0			0	
Never Events	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
Serious Incidents	N/A	3	1	1	3	2	1	5	3	2	2	1	0	8	
VTE Risk Assessment %	>95%	77.0%	77.8%	80.7%	84.1%	93.1%	92.0%	91.2%	95.2%	95.2%	94.9%	94.9%	94.9%	95.0%	
Mixed Sex Accomodation Breaches	0	0	2	14	7	2	4	5	4	5	14	7	16	46	!
Summary Hospital Level Mortality Indicator (SHMI)	1.14	0.88			0.89			0.91							

! **Target has not been achieved for the past three months

Date & time of production: 12/09/2022 09:05

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Category 3 or 4 Pressure Ulcers, Deep Tissue Injury and Device Related Pressure Ulcers reported in 2022/2023 **Pan Trust Standard (to be confirmed)** Zero category 3 & 4 pressure ulcers. 10% reduction in the total number of attributable PUs during 2022/23 compared to 2021/22 including a breakdown of Pressure Ulcers by category	**Variance against Plan:** **Total Trust numbers of reported Pressure Ulcers:** July 2022: 63 (+ 15 deep tissue injuries). A total number of 55 patients were reported as affected. August 2022**:** 54 (+ 24 deep tissue injuries). A total number of 42 patients were reported as affected. July 2022 (hospital/community) / August 2022 (hospital/community) Category 2: 42 (13/29) / 24 (13/11) Category 3: 8 (1/7) / 12 (4/8) Category 4: 2 (0/2) / 0 Mucosal: 1 (1/0) / 3 (2/1) Unstageable: 10 (2/8) / 15 (6/9) Deep Tissue Injury: 15 (2/13) / 24 (19/5) Medical device related: 5 / 9 In July 2 category 4 pressure ulcers developed in the community setting. In August there were no category 4 pressure ulcers. Work continues to achieve the 10% overall pressure ulcer reduction. **Action to Recover:** • Weekly pressure ulcer incident review meetings in Adult Community services with an ICSU action to undertake deep dives into category 4 pressure ulcer incidents • Recommencement of OSCE based practical training in Adult Community Services • Provision of full day face to face pressure ulcer training in October & December • Documentation Group to be set up by Deputy Chief Nurse to look at nursing documentation/care plans	**Named Person:** Lead Specialist Nurse – Tissue Viability **Time Scale to Recover Performance:** 6 months

	• Planned review of Trust based pressure ulcer education platforms to address training space deficits and capacity challenges • Active recruitment into Tissue viability Team vacancies to optimise support for clinical areas • ICSU led review of pressure ulcer incidents in Quality & Risk meetings	
Mixed Sex Accommodation Breaches	**Variance against Plan:** All the mixed gender breaches occurred in CCU (Critical Care Unit). This was due to the unavailability of beds on wards, and in particular, single rooms needed for infection control reasons. **Action to Recover:** The lack of availability of beds to transfer patients out of CCU was exacerbated by the number of Covid 19 positive patients occupying beds which restricted availability. It is expected that this will improve with the decline in the number of in patients with Covid 19.	**Named Person:** Deputy Chief Nurse **Time Scale to Recover Performance:** Ongoing review

Indicator	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022-2023	Performance
ED - FFT % Positive	>90%	77.7%	78.0%	74.7%	77.1%	82.2%	79.2%	72.4%	79.1%	75.3%	74.6%	72.5%	79.8%	76.2%	
ED - FFT Response Rate	>15%	10.6%	10.6%	10.5%	11.3%	11.5%	10.8%	10.0%	10.6%	11.3%	12.4%	11.1%	12.0%	11.5%	
Inpatients - FFT % Positive	>90%	94.1%	94.7%	95.9%	96.5%	96.3%	96.4%	96.8%	94.2%	93.2%	93.3%	93.9%	96.7%	94.3%	
Inpatients - FFT Response Rate	>25%	18.8%	18.1%	23.9%	16.0%	18.7%	17.2%	14.9%	16.5%	19.1%	29.1%	17.9%	20.8%	20.0%	
Maternity - FFT % Positive	>90%		99.0%	94.9%	97.8%	96.5%	100.0%	77.8%	80.0%	100.0%	100.0%	49.6%		51.1%	
Maternity - FFT Response Rate	>15%	0.0%	16.1%	20.1%	8.4%	9.6%	1.6%	0.9%	1.0%	0.4%	0.2%	39.6%		10.5%	
Outpatients - FFT % Positive	>90%	96.3%	75.0%	88.9%	90.0%	98.1%	93.3%	89.5%	75.0%	87.9%	90.0%	89.2%	87.0%	88.5%	
Outpatients - FFT Responses	400	27	20	54	60	54	60	76	4	33	100	93	92	322	
Community - FFT % Positive	>90%	95.1%	96.5%	98.0%	98.2%	99.2%	99.4%	99.1%	97.2%	99.2%	97.3%	95.0%	96.6%	97.0%	
Community - FFT Responses	1500	509	567	611	547	486	462	572	470	627	672	643	783	3195	
National Quarterly Pulse Survey (NQPS)	800	686				314			327			759		1086	
NQPS Staff % recommended work	>50%	57.3%				48.4%			51.7%			50.9%		51.1%	
Complaints responded to within 25 or 40 working days	>80%	45.7%	63.0%	78.3%	13.3%	40.0%	40.7%	44.4%	61.1%	77.8%	52.2%	57.1%	34.8%	57.1%	
Complaints (including complaints against Corporate division)	N/A	35	27	23	15	20	27	18	18	27	23	21	23	112	

**Target has not been achieved for the past three months

Date & time of production: 12/09/2022 09:05

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
FFT Positive Responses and Response Rate:	**Variance against Plan:** ED response rates and positivity rates have remained relatively stable for over 12 months, but with a small increase in both in August. However, both scores are below the target, as improvement work is taking longer than expected to show results. Outpatient responses are still below target, but are stable at c.100 per month, which has tripled since May and well above the average this year. Community responses have continued to improve from a previous low in April and have seen a 21% increase from July. However, this is still below the target. **Action to Recover:** The Patient Experience team continue to work with service leads to support with expected improvements over the coming months. This includes communication campaigns and QR codes available to all patients and staff. Engagement with the new Wood Green CDC will hopefully see a further increase in September for outpatient responses. QR codes will be making surveys available in 9 foreign languages, and QR codes will be available to all patients and staff. Community paediatrics have created a dedicated Patient Experience Group, attended by Patient Experience Team, to increase engagement. In addition, training sessions have been arranged with key staff to understand the system better in community.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** December 2022
Complaints responded to within 25 or 40 days	**Variance against Plan:** There were 23 complaints received where a response was required in August 2022. The Trust performance for August 2022 was 35% which is worse than previous months. **Action to Recover:** There is a backlog of complaints due which is being managed and being brought down quickly, once this is dealt with the in-month performance should improve. The board should note, all urgent issues have been actioned.	**Named Person:** PALS & Complaints Manager **Time Scale to Recover Performance:** Ongoing

Indicator	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022-2023	Performance
Hospital Cancelled Operations	0	16	14	5	0	8	6	2	13	6	8	13		40	
Cancelled ops not rebooked < 28 days	0	0	2	0	0	0	0	0	1	0	5	2		8	
Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0		0	
Theatre Utilisation	>85%	67.86%	69.25%	70.62%	69.54%	65.67%	71.34%	68.65%	73.02%	74.67%	73.21%	69.94%	74.06%	72.90%	
Breastfeeding Initiated	>90%	91.5%	92.0%	93.4%	92.1%	92.0%	89.7%	92.0%	90.3%	93.6%	94.6%	92.6%	91.3%	92.5%	
Mortality rate per 1000 admissions in-months	14.4	7.2	8.0	7.7	7.9	10.3	6.2	9.0	8.7	5.1	8.7	9.3	7.6	7.9	
Community DNA % Rate	<10%	7.7%	7.1%	7.4%	7.6%	6.8%	7.6%	7.5%	7.6%	7.4%	7.6%	8.3%	8.3%	7.8%	
Community Services - Provider Cancellations	<8%	7.3%	7.8%	7.8%	11.1%	11.0%	8.2%	8.6%	7.3%	7.4%	8.2%	9.0%	8.4%	8.1%	
Acute DNA % Rate	<10%	11.1%	10.4%	10.1%	10.9%	11.0%	10.6%	11.1%	11.2%	10.3%	10.4%	11.2%	11.8%	11.0%	
% e-Referral Service (e-RS) Slot Issues	<4%	35.7%	28.8%	31.2%	35.2%	29.4%	31.8%	31.6%	32.9%	33.0%	32.6%	30.1%	31.5%	32.0%	
Outpatients New:FUp Ratio	2.3	1.71	1.66	1.79	1.85	1.78	1.71	1.68	1.81	1.75	1.71	1.70	1.72	1.74	
Delayed Transfers Of Care % of Occupied Bed Days	<2.4%														
Non Elective Re-admissions within 30 days	<5.5%	4.36%	4.14%	3.86%	5.35%	4.05%	4.30%	4.36%	4.43%	5.17%	4.23%	4.52%	4.40%	4.56%	
Rapid Response - % of referrals with an improvement in care		55.2%	52.9%	55.5%	53.6%	59.6%	30.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	

**Target has not been achieved for the past three months

Date & time of production: 12/09/2022 09:05

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Theatre Cancellations on The Day:	**Variance against Plan:** 13 cancellations of which the majority are due to Covid. 11 of these were rebooked within 28 days, the two breaches were because the earliest consultant availability was outside of the 28-days. **Action to Recover:** A cancellation on the day group has been established to trouble shoot cases with the potential to cancel and from a governance perspective demonstrate all preventative actions and escalation was appropriately managed. It is also to support learning from cancellations and a review will be undertaken at the theatre scheduling meeting.	**Named Person:** Theatres General Manager **Time Scale to Recover Performance:** October 2022
Theatre Utilisation % Rates:	**Variance against Plan:** 74.06% against a target of 85%. Performance has remained static in recent months. **Action to Recover:** 1] A new virtual pre-operative assessment template has increased the pool of cases ready for TCI (to come in) by 80% so availability of cases to book has been resolved. There were 168 and 180 patients completing POA in first 2 weeks compared to average of 106 patients previously. 2] There is a new escalation process for any requests to adjust the list once booked and will now need to be authorised by the service manager/ General Manager once signed off by surgeon.	**Named Person:** Theatres General Manager **Time Scale to Recover Performance:** October 2022
Appointment Slot Issues (ASIs)	**Variance against Plan: 31.5% against a target of <4%.** Performance in August 2022 continues to remain behind the 4% target, and this is consistent with the last 12 months and a known trend. There are a number of specialties experiencing higher than planned ASI issues, these sit within Surgery and Cancer ICSU. **Action to Recover:** ENT is carrying out super-weeks of activity to reduce overall backlog and increase capacity in September 2022. Dermatology continues to have increased referrals. Regular ASI review meetings with the surgery ICSU to address their backlogs are beginning on 27th September.	**Named Person:** Head of Performance **Time Scale to Recover Performance:** To be agreed in ASI review meeting.

Indicator	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022-2023	Performance
Cancer - 14 days to first seen	>93%	79.1%	79.3%	69.5%	77.6%	62.0%	55.1%	60.9%	50.8%	54.9%	43.1%	54.3%		50.5%	
Cancer - 14 days to first seen - breast symptomatic	>93%	90.9%	93.5%	92.5%	87.5%	9.1%	11.8%	20.8%	0.0%	5.0%	18.6%	3.7%		8.4%	
Cancer - 62 days from referral to treatment	>85%	64.1%	58.0%	43.9%	59.5%	41.5%	50.0%	54.7%	45.2%	54.2%	31.6%	28.6%		40.2%	
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%	63.2%	56.9%	43.1%	58.1%	39.4%	52.4%	51.6%	40.0%	54.2%	28.3%	26.7%		37.7%	
Cancer ITT - % of Pathways sent before 38 Days	>85%	37.5%	33.3%	20.0%	20.0%	18.2%	33.3%	16.7%	20.0%	42.9%	11.1%	0.0%		18.8%	
Cancer - % Pathways received a Diagnosis within 28 Days of Referral		72.4%	71.7%	71.9%	70.5%	74.2%	81.4%	81.8%	63.9%	64.8%	63.9%	61.4%		63.5%	
Cancer - 31 days to first treatment	>96%	95.7%	96.7%	100.0%	87.2%	80.5%	94.6%	97.4%	83.3%	97.1%	90.5%	80.0%		88.7%	
Cancer - 31 days to subsequent treatment - surgery	>94%														
Cancer - 62 Day Screening	>90%	60.0%	100.0%	66.7%	100.0%	25.0%	50.0%	66.7%		50.0%	100.0%	0.0%		57.1%	
DM01 - Diagnostic Waits (<6 weeks)	>99%	96.97%	98.96%	96.46%	93.10%	92.34%	94.71%	92.22%	87.55%	88.30%	87.54%	87.79%	83.47%	87.03%	
RTT - Incomplete % Waiting <18 weeks	>92%	76.0%	76.7%	76.7%	74.2%	74.4%	73.4%	73.8%	71.0%	72.1%	69.8%	68.3%	69.8%	70.2%	
Referral to Treatment 18 weeks - 52 Week Waits	0	569	558	514	547	486	457	384	373	375	442	452	479	2121	
% seen <=2 hours of Referral to District Nursing Night Service	>80%														
% seen <=48 hours of Referral to District Nursing Service	>95%	94.3%	96.7%	97.1%	93.3%	93.3%	94.7%	96.8%	95.0%	94.1%	96.7%	100.0%	95.9%	96.0%	
Haringey New Birth Visits - % seen within 2 weeks	>95%	91.5%	93.6%	92.6%	87.7%	91.1%	91.7%	87.3%	93.7%	95.9%	93.5%	93.2%		94.1%	
Islington New Birth Visits - % seen within 2 weeks	>95%	94.3%	94.0%	95.0%	93.7%	93.6%	93.7%	94.9%	97.0%	95.3%	95.5%	95.4%		95.8%	
% of Rapid Response Urgent referrals seen within 2 Hours of R...		94.2%	84.1%	88.7%	79.8%	75.2%	74.1%	71.8%	76.3%	81.8%	81.3%	69.1%	76.8%	76.6%	

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
28 days Faster Diagnosis Standard (FDS) Performance July 2022	**Going forward 28-day FDS will be the primary cancer performance measure.** **28 days FDS Performance:** 61.4% against the standard of 73% for July 2022 • Colorectal & Urology are both performing below 50% of the FDS standard. Poor performance in Colorectal is a direct impact of high referrals and established capacity is not sufficient to meet demand. Urology poor performance is due to workforce issues, with 2 of 4 substantive consultants in post and 4 of 6 registrars. • Dermatology – With high levels of referrals performed at 82.9% and are the strongest performing tumour group for June • Breast performance has improved by 10.3% from May to June **2WW Performance:** 54.3% against the standard of 83% for July 2022. • Breast – 2WW referrals numbers are now stable and referral numbers are meeting capacity. Performance is expected to improve over the next few months • Colorectal – Have seen a spike in referrals which has resulted in capacity challenges • Gynaecology – Remains in a similar position with a number of known issues relating to demand, workforce, backlog numbers. The service is continuing to book at 28 days. • Dermatology – 2WW referrals have continued to increase, with the service receiving 316 referrals for the month of June, with core capacity of 44 2WW slots per week. • All other tumour groups have managed capacity despite increased 2WW referral numbers. **62-day Performance:** 28.6% against the standard of 85% for July 2022 • 24 treatments • 18 breaches **Action to Recover:** • Colorectal – The service has implemented a review process for all patients following their first appointment to ensure diagnosis is given within the 28-day standard. 2WW Straight to test (STT) pathway planning is now in place with go a live date expected for October 2022.	**Named Person:** Service Manager Cancer, Breast & Plastics **Time Scale to Recover Performance:** Weekly reviews in place

	This is expected to improve the 2WW pathway in this specialty. A STT nurse has been recruited and has been in post from July who will support the triage of 2WW referrals. • Dermatology – 2WW service is booking at 28 days and this has impacted performance. Capacity challenges are continuing to be discussed and monitored within NCL ICS as Royal Free Hospital and University College London Hospital are also in a similar position. There are also capacity challenges for minor operations which impacts 62-day performance. There is twice weekly deep dive or Skin PTL for best management of minor operations appointments. • Urology – Additional results clinics have been opened to support 28 FDS standard. There are staffing challenges within the surgical team. Urology is working with UCLH to move to a 5 Day emergency model. This will enable the service to focus existing medical establishment on provision of core services. • Gynaecology – The service is continuing to work with NCL ICS (North Central London ICS) reviewing pathways. We are looking to get mutual aid from other trusts to help with colposcopy waiting times. • The breast service is in the process of clearing the backlog from the increased referrals/activity from the past few months with (non-symptomatic) performance now beginning to improve. • There is continued review of the cancer PTL, with twice weekly senior management review of over 62 & 104-day long waiters chaired by the Director of Operations • There is continued escalation to Directors of Operations with any concerns	
DM01 Diagnostics	Update: 83.47% against a target of >99%. There has been a steady downward trajectory in the delivery of DM01. This has been as a result of capacity constraints due to the Covid pandemic. Community audiology continues to have a large backlog following the merger of Barnet and Enfield services. The community audiology recovery plan is in place. The trust is looking to see a reduction in the backlog over the coming months with the aim to be compliant by the end of the financial year. The Trust is expecting improvements in compliance in endoscopy and imaging through September, which will be reported in October, and are currently in line with recovery plans as agreed by NCL ICS.	**Named Person:** Head of Performance **Time Scale to Recover Performance:** Ongoing
Referral to Treatment: Incomplete % waiting < 18 weeks **52 + week waits**	**Update:** The Trust is seeing a downward trajectory against this standard and it is not being achieved. Performance was at 69.8% for August 2022.	**Named Person:** Head of Performance

	There were 479 52-week waiters in August 2022, and this is gradually growing. There is one 104-week breach. This patient was a mutual aid patient that was transferred from the Royal Free and the patient was treated in August. **Action to Recover:** Additional capacity to support the general surgery waiting list has re-started in September 2022. There is continued monitoring of the elective recovery programme. High Volume Low Complexity work is being increased. Weekly review of the surgery specific patient tracking list is carried out to support delivery of compliance.	**Time Scale to Recover Performance:** Ongoing

Indicator	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022-2023	Performance
Appraisals % Rate	>90%	65.3%	66.8%	65.5%	66.0%	64.9%	65.6%	65.6%	66.9%	70.4%	71.5%	74.1%	73.6%	71.3%	
Mandatory Training % Rate	>90%	77.3%	78.8%	81.2%	82.2%	82.2%	82.5%	83.1%	84.1%	85.1%	85.1%	87.0%	84.3%	85.1%	
Permanent Staffing WTEs Utilised	>90%	88.1%	88.6%	88.0%	88.1%	87.9%	87.6%	87.6%	87.2%	87.3%	86.9%	86.7%	86.9%	87.0%	
National Quarterly Pulse Survey (NQPS)	800	686				314			327			759		1086	
NQPS Staff % recommended work	>50%	57.3%				48.4%			51.7%			50.9%		51.1%	
Staff sickness absence %	<3.5%	4.34%	4.32%	5.50%	5.30%	4.72%	4.86%	4.88%	4.79%	3.85%	4.07%	4.72%		4.36%	
Staff turnover %	<13%	14.3%	11.9%	12.4%	12.4%	12.5%	12.8%	13.6%	13.8%	14.0%	14.2%	13.9%	13.7%	13.9%	
Vacancy % Rate against Establishment	<10%	11.9%	11.4%	12.0%	11.9%	12.1%	12.4%	12.4%	12.8%	12.7%	13.1%	13.3%	13.1%	13.0%	
Average Time to Hire (Days)	<63 Days	63	59	66	59	70	61	61	64	71	92	100	84	82	
Nursing Staff Average % Day Fill Rate - Nurses		83.8%	74.9%	85.9%	79.2%	89.2%	83.5%	87.9%	91.5%	98.4%	87.7%	92.4%	96.0%	93.3%	
Nursing Staff Average % Night Fill Rate - Nurses		91.3%	81.8%	93.1%	88.2%	100.3%	93.2%	92.9%	98.8%	100.3%	89.7%	93.7%	101.4%	96.9%	
Safe Staffing Alerts - Number of Red Shifts		33	36	34	36	30	20	31	9	5	9	30	14	67	
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		11.7	9.1	9.1	9.6	9.4	11.6	9.3	12.8	11.6	10.8	9.1	9.7	10.7	

**Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Mandatory Training % Rate: 84.3% Target >90%	**Variance against Plan: -5.7%** **Action to Recover:** It is disappointing that this is slowly dropping by approximately 0.5-1% per month. It is possible that this previous slow rise was challenged by staff shortages and the additional pressure on resources from staff holidays during the summer. Recent covid infection rates resulted in additional caution for close face-to-face sessions, reducing class numbers or postponing sessions. This is borne out with results in Moving and Handling L2 at 76%. Online learning continues to be available for as many subjects as possible. The WEC has now opened to enable those without computers to undertake online learning and plans are being drafted to reopen the computer suite in the Jenner basement.	**Named Person:** Assistant Director, Learning & Organisational Development **Time Scale to Recover Performance:** six months depending on the continued challenges of staff shortages
Permanent Staffing WTEs Utilised: 86.9% Target > 90%	**Variance against Plan: -3.1%** **Action to Recover:** Permanent staff utilisation has increased by 0.2% from last month. Issues have been identified in relation to the Recruitment Shared Service and internal support is being provided in order to expedite recruitment matters.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** Ongoing
Staff Sickness Absence %: 4.72% Target < 3.5%	**Variance against Plan: -1.22%** **Action to Recover:** The Trust has seen an increase in sickness absence between June 2022 and July 2022. However, the daily figures are showing a marked reduction and stabilisation to 4% through August and September. Monthly sickness surgeries and training for managers has been carried out during August and September and a targeted approach for those that are off long term to support them back to work is being taken.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** Ongoing
Staff Turnover Rates: 13.7% Target < 13%	**Variance against Plan: -0.7%** **Action to Recover:** The Trust is beginning to see a reduction in turnover rates over the last four months. HR Business Partners continue to offer support to ICSU's and areas to address issues and establish any patterns to be addressed to reduce turnover rates further.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** Ongoing

	The London average for turnover is 18% with NCL sitting at 17%.	
Vacancy Rates: 13.1% Target < 10%	**Variance against Plan: -3.1%** **Action to Recover:** The vacancy rate has begun to stabilise over the last three months but remains over the Trust target. Current focus to improve this rate is on converting bank and agency workers to permanent staff, reviewing skills mix within departments, assessing and developing non-qualified roles and international recruitment.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** Ongoing
Recruitment: 84.1 days **Target: 63 days**	**Variance against Plan: Time to hire has reduced over the summer and sits at 84.1 days against the target of 63 days (a variance of 21.2 days)** **Action to Recover:** North London Partners Shared Services (NLPSS) have committed to a 12-week recovery action plan that was signed off at the end of July 2022. The Trust has put in place a temporary retained team for general high priority recruitment and meet with the NLPSS on a daily basis. The HR Director (HRD) has regular contact with the senior recruitment team to prioritise work and meets every week with the shared service at HRD level. The key bottleneck is the pre-employment check phase which has a target of 20 days and is currently at 40 days. Overall, the Trust backlog has reduced significantly over recent weeks.	**Named Person:** Associate Director of Workforce **Time Scale to Recover Performance:** Review by WAC (Workforce Assurance Committee)

Appendix 1. Community Performance Dashboard

Indicator	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022-2023	Performance
IAPT Moving to Recovery	>50%	53.4%	53.9%	51.4%	49.5%	57.2%	47.6%	47.5%	48.5%	52.1%	50.2%	48.7%		50.0%	
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	94.6%	90.9%	90.0%	93.4%	88.5%	89.6%	91.9%	91.9%	92.6%	95.2%	93.3%		93.2%	
Haringey - 8wk Review % carried out before child aged 8 weeks	N/A	62.6%	67.8%	71.4%	67.8%	62.9%	62.3%	63.7%	60.3%	70.9%	60.2%	63.2%		63.6%	
Haringey - HR1 % carried out before child aged 15 months	N/A	70.9%	73.8%	69.1%	61.4%	56.5%	53.1%	73.1%	75.9%	68.0%	76.2%	75.5%		74.0%	
Haringey - HR2 % carried out before child aged 30 months	N/A	75.7%	74.2%	65.5%	65.9%	67.6%	61.8%	64.5%	53.5%	53.9%	67.5%	73.4%		62.0%	
Islington - 8wk Review % carried out before child aged 8 weeks	N/A	79.9%	76.7%	76.6%	78.2%	55.9%	69.2%	68.3%	68.0%	70.5%	77.2%	74.2%		72.6%	
Islington - HR1 % carried out before child aged 15 mths	N/A	86.1%	80.9%	86.3%	77.4%	78.4%	66.5%	81.0%	81.0%	80.4%	80.8%	85.4%		82.0%	
Islington - HR2 % carried out before child aged 30 mths	N/A	74.9%	84.3%	82.9%	81.6%	72.5%	73.5%	78.5%	79.3%	73.7%	77.5%	77.0%		77.0%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	90.6%	93.8%	78.4%	81.0%	88.9%	94.8%	91.5%	83.6%	73.5%	83.3%	88.6%	87.7%	82.7%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%			100.0%	60.0%	78.9%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	80.6%	77.0%	77.9%	70.0%	71.7%	74.7%	72.2%	70.7%	74.4%	73.5%	70.8%	72.7%	72.5%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	96.3%	93.0%	96.3%	94.9%	96.3%	93.2%	88.6%	92.9%	90.6%	93.4%	95.2%	96.4%	93.4%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	88.9%	50.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 we...	>45%	58.6%			57.0%			61.5%			52.0%			52.0%	
Islington Self-Management - Average Increase in PAM Score	>=9														
Haringey Self-Management - Average Increase in PAM Score	>=9														

Date & time of production: 12/09/2022 09:05

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Children Community Waiting Times	**Community paediatrics** In Haringey and Islington, the service is recruiting to posts (permanent and temporary), and this will support a reduction in waiting times. **SLT** Short term funding continues to help to reduce waits for initial appointments and therapy intervention. Islington LA have given additional funding to meet the outstanding requirements on EHCPs until end March. We will continue to work with partners in each borough in response to recommendations from the NCL community services review and in the longer term this work will reduce waiting times. **OT** The OT service in Islington & Haringey continues to experience longer waiting times due staffing gaps and challenges. **Looked after children** In Islington the service is still struggling to manage the increase in Unaccompanied Asylum Seeking Children (UASC). A business case has been submitted to the ICB (Integrated Care Board) for a leaving care nurse, outcome expected in the next month. **Social communication** In Haringey and Islington, the service is working with the ICB and other local providers to agree where additional recurrent funding will be invested to support reduction of waiting times. The Trust is leading work to provide additional autism assessments across NCL over the next 18 months to help reduce waiting times. **Islington CAMHS** We have seen an improvement in waiting times from 18.1 Weeks to 11.6 weeks, bringing the service closer to the target of 8 weeks. Referral rates reduced during August as expected and in accordance with annual variation. Continued high level of referrals requiring complex CBT interventions received. Some clinicians will be trained in evidence-based treatment for Tics and Tourette's by Great Ormond Street Hospital in September 2022 and will be able to offer group-based interventions.	**Named person:** Director of Operations, Children and Young People's Services

<table>
<tr><td></td><td>Autism/ADHD: Additional clinicians across different CAMHS teams will be ADOS trained through NCL training in the autumn to increase less complex assessment capacity. Work led by Whittington to provide additional assessments across NCL will begin in the autumn of 2022 and will help to reduce waiting times.</td><td></td></tr>
<tr><td>Adult Community Waiting Times</td><td>Overall summary:

All services are running with their Business-as-usual models now and most services are progressing positively with their backlogs.

There remains a focus of 3 key areas for recovery:
MSK, Podiatry, Pulmonary Rehabilitation (PR).

<u>MSK</u>: The number of patients waiting for an MSK appointment is now 9512, however the waits for appointments are beginning to fall. There have been nine Super Saturdays in the last 3 months which has helped the reduction. The impact would have been greater however the service is seeing much more complexity than pre-pandemic and the referral rate is now increasing.
Average waiting time: CATS – 10.1 weeks in August down from 12.9 in July
: Routine – 13.1 weeks in August up from 14.2 in July

<u>Podiatry</u>: Workforce issues continue to be the main issue with this service. Wait times continue to increase. There is a comprehensive action plan in place to mitigate the risk of the waits growing further which is being monitored very closely
Average waiting time: 16.2 in August up from 15.5 weeks in July. Below are the waiting times over the last 6 months.
<table>
<tr><td>Aug</td><td>July</td><td>June</td><td>May</td><td>April</td><td>March</td></tr>
<tr><td>16.2</td><td>15.5</td><td>16.3</td><td>14.1</td><td>12.3</td><td>11.2</td></tr>
</table>

<u>Pulmonary Rehabilitation</u> Pulmonary Rehabilitation is now fully functional. Although the average waiting time shows an increase in waiting time from 44 weeks up from 38.3 weeks. This is an administrative issue. Despite all patients being contacted and wanting to remain on the waiting list, patients then DNA, but insist on staying on the waiting list till the next available option. These patients will now be discharged from the waiting list instead of adding them back on. They will be discharged with an opt in letter which will clear the wait list and also address the ongoing issue with the pre-pandemic issue of QOF. The figures should be significantly change by end of October 2022.</td><td>Named person: Director of Operations, Adult Community Services</td></tr>
</table>

Appendix 2. Community Waiting Times Dashboard

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Jun-22	Jul-22	Aug-22	Avg Wait (Aug)	No. of Pts Seen	% Threshold	Target Weeks	Jun-22	Jul-22	Aug-22	Avg Wait (Aug)	No. of Pts Seen
CAMHS	>95%	8	62.1%	58.2%	68.5%	11.6	73	>95%	2	50.0%	66.7%	100.0%	0.7	5
Child Development Services	>95%	12	75.0%	94.1%	80.0%	6.5	5	>95%	2				-	0
IANDS	>95%	18	77.7%	80.9%	79.8%	14.0	114	>95%	2				-	0
Community Children's Nursing	>95%	2	69.6%	74.6%	63.1%	2.0	65	>95%	1	100.0%	100.0%	100.0%	0.1	10
Community Paediatrics Services	>95%	18	67.0%	50.0%	47.8%	17.2	46	>95%	1				17.2	0
Family Nurse Partnership	>95%	12				-	0	>95%	-				-	0
Haematology Service	>95%	12				-	0	>95%	-				-	0
Looked After Children	>95%	4	58.8%	59.1%	45.5%	4.8	11	>95%	-				-	0
Occupational Therapy	>95%	18	26.7%	31.6%	28.6%	26.9	14	>95%	-				-	0
Physiotherapy	>95%	18	98.6%	94.8%	100.0%	7.2	52	>95%	2				-	0
PIPS	>95%	12	100.0%	72.2%	93.8%	3.4	16	>95%	-				-	0
School Nursing	>95%	12	88.6%	95.9%	98.7%	1.6	75	>95%	-				-	0
Speech and Language Therapy	>95%	8	56.7%	46.5%	48.5%	15.7	97	>95%	2	0.0%	25.0%	0.0%	8.9	3
Bladder and Bowel - Children	>95%	12				-	0	>95%	-				-	0
Community Matron	>95%	6	96.0%	100.0%	97.1%	1.1	35	>95%	2				-	0
Adult Wheelchair Service	>95%	8	100.0%	92.1%	97.7%	4.3	44	>95%	2	100.0%	100.0%		-	0
Community Rehabilitation (CRT)	>95%	12	78.1%	82.2%	84.2%	8.1	101	>95%	2	81.1%	54.5%	56.4%	7.0	39
ICTT - Other	>95%	12	87.2%	76.7%	86.4%	5.2	103	>95%	2	0.0%	14.3%	0.0%	4.3	21
ICTT - Stroke and Neuro	>95%	12	66.7%	77.8%	82.4%	8.9	17	>95%	2	0.0%	50.0%	33.3%	2.6	6
Home-based Intermediate Care Se...	>95%	6	61.8%	40.6%	51.8%	7.7	56	>95%	2				-	0
Community Bed-based Intermediat...	>95%	6	100.0%	100.0%	100.0%	0.1	8	>95%	2				-	0
Paediatric Wheelchair Service	>95%	8	100.0%	85.7%	85.7%	4.8	7	>95%	2	0.0%			-	0
Bladder and Bowel - Adult	>95%	12	34.5%	54.2%	42.9%	14.3	184	>95%	2				-	0
Musculoskeletal Service - CATS	>95%	6	20.9%	31.0%	29.3%	10.2	458	>95%	2	0.0%	9.1%	50.0%	3.8	6
Musculoskeletal Service - Routine	>95%	6	31.0%	32.0%	35.6%	14.4	1194	>95%	2	32.3%	57.9%	62.4%	2.1	133
Nutrition and Dietetics	>95%	6	93.3%	97.5%	97.2%	2.7	216	>95%	2		100.0%	100.0%	0.0	3
Podiatry (Foot Health)	>95%	6	26.6%	32.8%	33.6%	16.4	336	>95%	2	0.0%	0.0%	0.0%	6.6	4
Lymphodema Care	>95%	6	100.0%	100.0%	53.8%	4.6	13	>95%	-				-	0
Tissue Viability	>95%	6	100.0%	93.2%	100.0%	1.4	33	>95%	2				-	0
Cardiology Service	>95%	6	81.5%	87.8%	78.1%	4.1	32	>95%	2	0.0%		100.0%	0.0	1
Diabetes Service	>95%	6	87.7%	96.2%	95.3%	3.6	86	>95%	2				-	0
Respiratory Service	>95%	6	63.5%	83.3%	85.7%	5.1	14	>95%	2	100.0%		100.0%	0.3	1
Spirometry Service	>95%	6	40.6%	82.5%	88.9%	4.5	72	>95%	2				-	0

Children's Community Waits Performance

SERVICE	ROUTINE REFERRALS							URGENT REFERRALS						
	% Threshold	Target Weeks	Jun-22	Jul-22	Aug-22	Avg Wait (Aug)	No. of Pts Seen	% Threshold	Target Weeks	Jun-22	Jul-22	Aug-22	Avg Wait (Aug)	No. of Pts Seen
CAMHS	>95%	8	62.1%	58.2%	68.5%	11.6	73	>95%	2	50.0%	66.7%	100.0%	0.7	5
Community Children's Nursing	>95%	2	69.6%	74.6%	63.1%	2.0	65	>95%	1	100.0%	100.0%	100.0%	0.1	10
Community Paediatrics - Haringey	>95%	18	62.1%	42.6%	32.4%	21.8	34	>95%	1				-	0
Community Paediatrics - Islington	>95%	18	94.1%	73.3%	100.0%	1.8	10	>95%	1				-	0
Family Nurse Partnership - Islington	>95%	12				-	0	>95%	-				-	0
Haematology Service - Islington	>95%	12				-	0	>95%	-				-	0
Haringey - SCT	>95%	20	0.0%	0.0%	0.0%	43.3	23	>95%	2				-	0
IANDS - SCT	>95%	20	9.1%	0.0%	10.5%	41.8	19	>95%	2				-	0
IANDS	>95%	18	100.0%	100.0%	100.0%	1.4	6	>95%	2		0.0%		-	0
Looked After Children - Haringey	>95%	4	0.0%	66.7%		-	0	>95%	-				-	0
Looked After Children - Islington	>95%	4	64.3%	53.3%	45.5%	4.8	11	>95%	-				-	0
Occupational Therapy - Barnet	>95%	18	73.3%	90.6%	74.1%	15.7	27	>95%	-				-	0
Occupational Therapy - Haringey	>95%	18	26.7%	31.6%	28.6%	26.9	14	>95%	-				-	0
Occupational Therapy - Islington	>95%	18	20.0%	22.2%	0.0%	34.5	5	>95%	-				-	0
Paediatrics Nutrition and Dietetics - Haringey	>95%	12	80.0%	100.0%	100.0%	0.4	1	>95%	2				-	0
Paediatrics Nutrition and Dietetics - Islington	>95%	12	96.3%	100.0%	94.4%	5.7	18	>95%	2				-	0
Physiotherapy - Barnet	>95%	18	41.5%	54.5%	63.2%	20.5	57	>95%	6	0.0%	0.0%		-	0
Physiotherapy - Haringey	>95%	18	98.6%	94.8%	100.0%	7.2	52	>95%	2				-	0
Physiotherapy - Islington	>95%	18	100.0%	98.0%	100.0%	8.0	58	>95%	2				-	0
PIPS	>95%	12	100.0%	100.0%	100.0%	2.3	10	>95%	-				-	0
SALT - Barnet	>95%	18	11.8%	29.7%	35.9%	37.1	39	>95%	6		0.0%		-	0
SALT - Haringey	>95%	13	46.9%	37.9%	44.7%	15.5	38	>95%	2	0.0%	33.3%	0.0%	8.9	3
SALT - Islington	>95%	13	66.7%	47.9%	50.0%	16.8	36	>95%	2				-	0
SALT - MPC	>95%	18	79.3%	68.4%	57.1%	13.3	21	>95%	-				-	0
School Nursing - Haringey	>95%	12	72.5%	86.8%	80.0%	11.2	5	>95%	-				-	0
School Nursing - Islington	>95%	12	98.1%	100.0%	100.0%	0.6	65	>95%	-				-	0

Appendix 3. Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

Indicator	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022-2023	Performance
Breast	>85%	25.0%	60.0%	0.0%	58.3%	66.7%	40.0%	20.0%	0.0%	25.0%	12.5%	0.0%		10.0%	
Gynaecological	>85%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%		33.3%		0.0%			20.0%	
Haematological (Excluding Acute Leukaemia)	>85%	100.0%		100.0%	50.0%	28.6%	100.0%	100.0%		100.0%	100.0%	33.3%		60.0%	
Lower Gastrointestinal	>85%	100.0%	0.0%	50.0%	0.0%	45.5%	60.0%	85.7%	25.0%	16.7%	0.0%	66.7%		26.7%	
Lung	>85%	50.0%		100.0%	0.0%	0.0%	0.0%	50.0%	100.0%		75.0%	50.0%		75.0%	
Other	>85%		100.0%					100.0%							
Skin	>85%	95.2%	88.2%	66.7%	83.3%	60.0%	100.0%	100.0%		100.0%	72.7%	0.0%		83.9%	
Testicular	>85%				100.0%							100.0%		100.0%	
Upper Gastrointestinal	>85%	66.7%			50.0%	0.0%	0.0%	0.0%		100.0%	100.0%			100.0%	
Urological (Excluding Testicular)	>85%	54.2%	35.3%	33.3%	65.0%	33.3%	33.3%	27.3%	72.7%	30.4%	10.5%	12.5%		27.5%	

Cancer - 2WW Performance by Tumour Group

Indicator	20_21 Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022-2023	Performance
Breast	>93%	96.0%	98.2%	91.5%	94.4%	10.1%	18.1%	19.2%	9.4%	6.9%	25.2%	13.6%		14.0%	
Childrens	>93%				0.0%										
Gynaecological	>93%	91.3%	93.1%	68.7%	44.8%	44.4%	35.6%	40.3%	37.0%	47.7%	43.2%	43.9%		43.3%	
Haematological	>93%	95.7%	95.0%	75.0%	100.0%	100.0%	95.5%	93.8%	95.7%	100.0%	96.2%	96.0%		96.8%	
Lower Gastrointestinal	>93%	21.8%	3.0%	5.8%	52.3%	91.7%	68.5%	51.5%	70.8%	41.0%	30.6%	83.6%		61.0%	
Lung	>93%	66.7%	81.8%	91.3%	88.0%	85.7%	71.4%	80.0%	94.4%	93.8%	96.2%	87.5%		93.4%	
Skin	>93%	92.9%	96.7%	87.7%	93.0%	88.7%	85.0%	94.1%	65.2%	72.8%	38.1%	35.9%		52.1%	
Upper Gastrointestinal	>93%	96.6%	96.2%	100.0%	100.0%	98.1%	98.2%	96.7%	100.0%	100.0%	94.1%	100.0%		98.9%	
Urological	>93%	52.4%	53.6%	65.9%	55.4%	43.8%	48.6%	49.4%	54.6%	74.6%	69.4%	82.1%		68.5%	

Appendix 4. Trust Level Activity

Category	Indicator	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Activity
ED	ED Attendances	8285	9273	9432	9089	8179	8285	7990	9763	8787	9742	9387	9117	8081	
ED	ED Admission Rate %		12.6%	12.5%	12.1%	12.8%	12.6%	12.1%	11.5%	11.0%	9.8%	9.5%	10.2%	10.6%	
Community	Community Face to Face Contacts		38860	41270	44445	35390	37968	37974	45398	37739	45056	42184	40478	36728	
Admissions	Elective and Daycase		2036	1915	2004	1630	1668	1787	2007	1739	2090	2077	2169	1999	
Admissions	Emergency Inpatients		1940	1973	1934	1779	1725	1583	1910	1700	1707	1713	1670	1676	
Referrals	GP Referrals to an Acute Service		12667	14759	15001	12348	14228	14345	16097	12679	15081	13742	13737	13991	
Referrals	% of GP Referrals that were completed via ERS		83.9%	86.2%	85.2%	82.8%	83.5%	83.5%	84.9%	84.0%	84.1%	85.8%	87.4%	87.2%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	35.7%	28.8%	31.2%	35.2%	29.4%	31.8%	31.6%	32.9%	33.0%	32.6%	30.1%	31.5%	
Maternity	Maternity Births	320	288	319	324	279	249	237	271	265	244	262	264	271	
Maternity	Maternity Bookings	377	327	319	326	339	320	250	343	323	388	284	327	277	
Outpatients	Outpatient DNA Rate % - New	<10%	11.6%	10.6%	10.3%	11.3%	11.6%	10.7%	11.2%	11.7%	10.6%	10.5%	11.5%	12.8%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	10.7%	10.2%	10.0%	10.7%	10.5%	10.4%	11.0%	10.8%	10.0%	10.4%	10.9%	10.9%	
Outpatients	Outpatient New Attendances		10392	10291	9953	8394	8707	8723	10205	8497	10045	9884	9236	9231	
Outpatients	Outpatient FUp Attendances		17747	17117	17777	15513	15486	14921	17136	15399	17546	16869	15720	15913	
Outpatients	Outpatient Procedures		5778	5737	5762	5244	5250	5467	6245	5251	6338	5893	5988	6166	

Meeting title	**Trust Board – public meeting**	**Date: 30/09/2022**
Report title	Finance Report August (Month 05) 2022/23	**Agenda item: 9**
Executive director lead	Kevin Curnow, Chief Finance Officer	
Report author	Finance Team	
Executive summary	The Trust is reporting a deficit of £5.13m at the end of August which is £1.95m worse than plan. The planned deficit for August was £3.18m. The year-to-date adverse financial performance to plan is mainly driven by • Non-delivery of savings on Cost Improvement Programmes (CIP) • Unfunded escalation beds • Non-pay overspends within theatres and estates • Elective recovery fund (ERF) underperformance Cash position at the end of August was £74.6m Trust has spent £4.31m on its Capital projects as of the 31st of August 2022. The Trust is currently forecasting to deliver its planned deficit of £112k for 2022-23.	
Purpose:	To discuss August performance.	
Recommendation(s)	To note August financial performance, recognising the need for improve savings delivery.	
Risk Register or Board Assurance Framework	BAF risks S1 and S2	
Report history	Trust Management Group	
Appendices		

CFO Message

Finance Report M05

Trust reporting £5.13m deficit at the end of August – £1.95m worse than plan

The Trust is reporting a deficit of £5.13m at the end of August which is £1.95m worse than plan. The planned deficit to end of August was £3.18m.

The year-to-date adverse financial performance is mainly driven by.

- Underperformance of £1.69m against year-to-date Cost Improvement Programmes (CIP) target; The Trust delivered £2.39m savings year to date against a target of £4.08m.
- Enhanced pay rates and temporary staff premiums.
- Use of temporary staffing for covid related reasons mainly to cover red and green areas within the Accident and Emergency (A&E) and sickness and agency premium within theatres.
- Unfunded escalation medical beds and pay overspends within ITU.
- Non-pay overspends within theatres and reactive maintenance costs within Estates
- Elective/Day case performance continues to be below plan. Elective recovery fund (ERF) underperformed in month by £0.27m.

Some of the adverse variances above were partly offset non-recurrently by slippage in planned investments.

Cash of £74.60m at end of August

As at the end of August, the Trust's cash balance stands at £74.6m – a decrease of £6.8m from 31 March 2022. The Trust's reported deficit is the principal driver for the decrease.

Year to date capital spend of £4.31m

The Trust's capital plan for 2022-23 is £30.4m. This includes self-funded schemes of £25.4m and £5m relating to elective recovery (Targeted Investment Fund yet to be approved). The Trust's internal capital plan of £25.4m is funded through depreciation (£11.4m) and cash reserves (£13.9m).

Capital expenditure as of the 31st of August 2022 totals £4.31m, which is £2.40m below plan. This is the continued reflection that the Trust's principal capital projects are yet to get fully underway for this fiscal year.

Better Payment Practice Performance – 90.2% for non-NHS by value

The Trust is signed up to the NHS commitment to improve its Better Payment Practice Code (BPPC) whereby the target is to pay 95% of all invoices within the standard credit terms. Overall, the Trust's BPPC is 93.8% by volume and 88.0% by value. The BPPC for non-NHS invoices is 90.2% by value and 94.6% by volume.

2022-23 Forecast Outturn

The Trust is currently forecasting to deliver its planned deficit of £112k. In the coming weeks, the Trust will be working on developing a more detailed initial forecast position including recovery actions required.

1. Summary of Income & Expenditure Position – Month 05

	In Month			Year to Date			
	Plan	Actual	Variance	Plan	Actual	Variance	Annual Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income							
NHS Clinical Income	27,888	28,004	115	138,036	138,260	225	333,407
High Cost Drugs - Income	909	888	(21)	4,490	4,665	175	10,713
Non-NHS Clinical Income	1,147	1,072	(75)	5,735	5,738	3	13,772
Other Non-Patient Income	2,125	2,393	269	10,584	11,641	1,056	25,072
Elective Recovery Fund	656	382	(274)	3,297	3,023	(274)	7,891
	32,726	**32,739**	**13**	**162,141**	**163,327**	**1,185**	**390,855**
Pay							
Agency	(13)	(1,431)	(1,418)	(64)	(7,521)	(7,458)	(77)
Bank	(422)	(2,976)	(2,554)	(1,959)	(13,586)	(11,627)	(4,216)
Substantive	(22,512)	(19,371)	3,141	(114,392)	(99,450)	14,942	(271,441)
	(22,947)	**(23,778)**	**(831)**	**(116,414)**	**(120,557)**	**(4,143)**	**(275,734)**
Non Pay							
Non-Pay	(7,095)	(6,455)	640	(35,325)	(34,547)	778	(82,933)
High Cost Drugs - Exp	(711)	(749)	(38)	(3,803)	(3,784)	19	(8,779)
	(7,805)	**(7,204)**	**602**	**(39,128)**	**(38,331)**	**797**	**(91,713)**
EBITDA	**1,974**	**1,758**	**(216)**	**6,599**	**4,440**	**(2,160)**	**23,408**
Post EBITDA							
Depreciation	(1,437)	(1,440)	(4)	(7,183)	(7,173)	10	(17,244)
Interest Payable	(92)	(82)	10	(460)	(409)	51	(1,288)
Interest Receivable	51	82	31	155	308	153	512
Dividends Payable	(458)	(458)	(0)	(2,290)	(2,292)	(2)	(5,500)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(1,936)	**(1,898)**	**38**	**(9,778)**	**(9,566)**	**212**	**(23,520)**
Reported Surplus/(Deficit)	**38**	**(140)**	**(178)**	**(3,179)**	**(5,127)**	**(1,948)**	**(112)**

- The Trust is reporting a deficit of £5.13m (excluding donated asset depreciation and impairments) at the end of August which is £1.95m worse than plan.
- The planned deficit to the end of August was £3.18m excluding donated asset depreciation.
- Adverse variance on CIP delivery and other expenditure overspends are currently being offset by slippage on planned investments.
- The reported position includes non-recurrent benefits of £4.38m. This is £2m higher than the level of non-recurrent support assumed in the plan.
- The normalised position excluding non-recurrent benefits is £9.51m deficit which is £6.33m worse than the plan.

2. 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	1,663	1,455	(208)	8,207	8,071	(137)
Elective	2,031	1,493	(538)	10,897	8,634	(2,263)
Non-Elective	5,110	4,390	(721)	25,225	22,222	(3,002)
Critical care	598	1,216	618	2,952	2,744	(208)
Outpatients	3,984	3,684	(300)	21,373	19,539	(1,834)
Ambulatory	534	539	5	2,637	2,728	91
Direct Access	910	1,159	249	4,883	5,515	632
Community	6,337	6,337	0	31,684	31,684	0
Other Clinical income NHS	7,631	8,621	990	34,667	41,788	7,121
NHS Clinical Income	**28,798**	**28,892**	**94**	**142,525**	**142,925**	**400**
Non NHS Clinical Income	1,147	1,072	(75)	5,735	5,738	3
Elective recovery fund (ERF)	656	382	(274)	3,297	3,023	(274)
Income From Patient Care Activities	**30,601**	**30,346**	**(255)**	**151,557**	**151,686**	**129**
Other Operating Income	**2,125**	**2,393**	**268**	**10,584**	**11,641**	**1,056**
Total	32,726	32,739	13	162,141	163,327	1,185

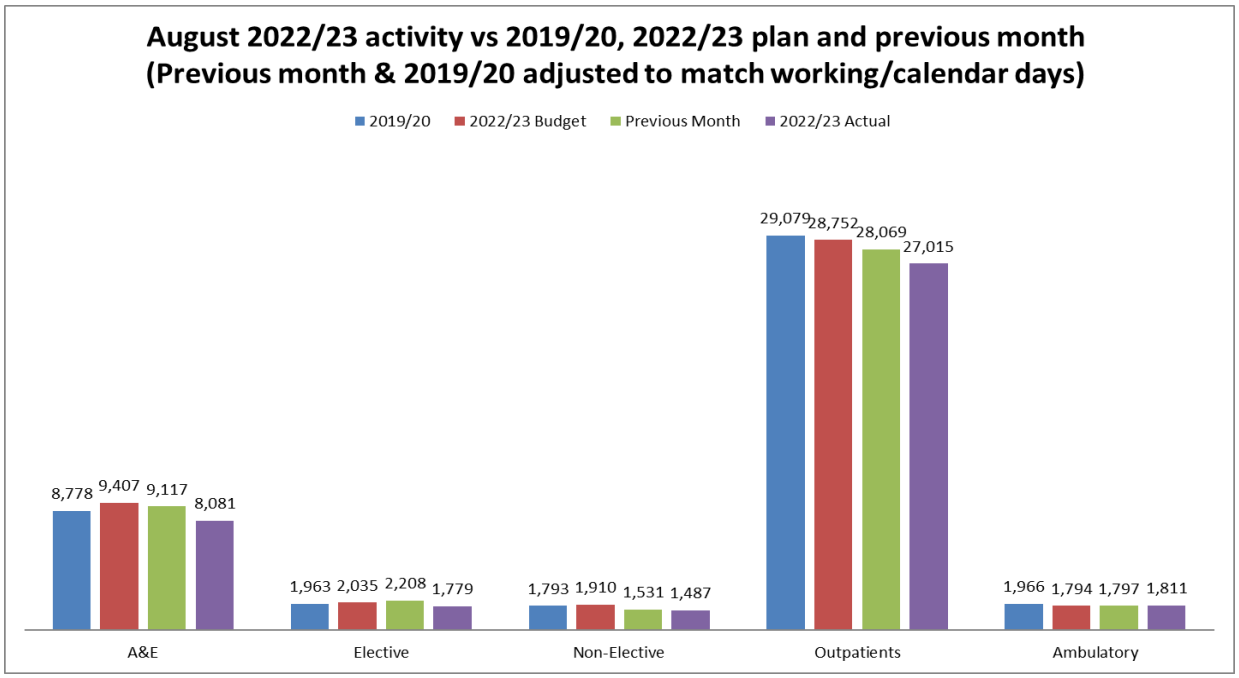
- Income was on plan in month and £1.2m ahead of plan YTD.
- In month performance is driven by £0.3m other operating income and £0.3m elective recovery fund (ERF) underperformance.
- NHS clinical income is mainly CCG and NHSE block contract income, with small variable element for provider-to-provider income. The income shown against the points of delivery, e.g. A&E are notional activity-based values, with the balancing amount to block values shown against other clinical income NHS.
- ERF is assumed at 100% for April to July. This may be revised in future months after confirmation from NHSE/I on no reduction for Q1 and ongoing calculation/treatment. The £0.3m underperformance is the estimate for August.
- Other operating income overperformance of £0.3m is driven by several small variances, the largest being £0.1m R&D income in other revenue offset by expenditure.
- Significant underperformance in A&E, elective, non-elective, and outpatients, with overperformance in Critical care, Ambulatory, and direct access.

2.2 Activity Performance – August

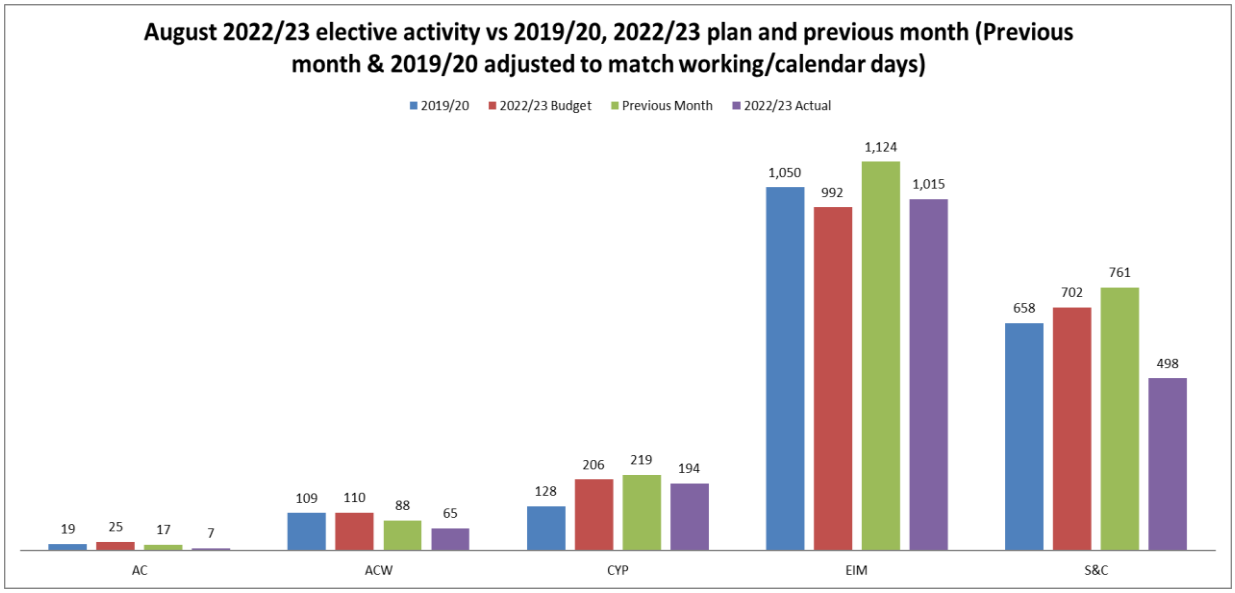
Activity	In Month Activity Plan	In Month Activity Actual	In Month Variance	In month Activity Diff%	YTD Activity Plan	YTD Activity Actual	Activity Diff	YTD Activity Diff%
A&E	9,407	8,081	(1,326)	(14%)	46,426	45,114	(1,312)	(3%)
Elective	2,035	1,779	(256)	(13%)	10,924	9,633	(1,291)	(12%)
Non-Elective	1,910	1,488	(422)	(22%)	9,425	7,584	(1,841)	(20%)
Critical care	450	697	247	55%	2,223	1,754	(469)	(21%)
Outpatients	28,752	27,017	(1,735)	(6%)	154,240	136,546	(17,694)	(11%)
Ambulatory	1,794	1,811	17	1%	8,856	9,166	310	4%
Direct Access	76,954	97,403	20,449	27%	413,119	474,423	61,304	15%

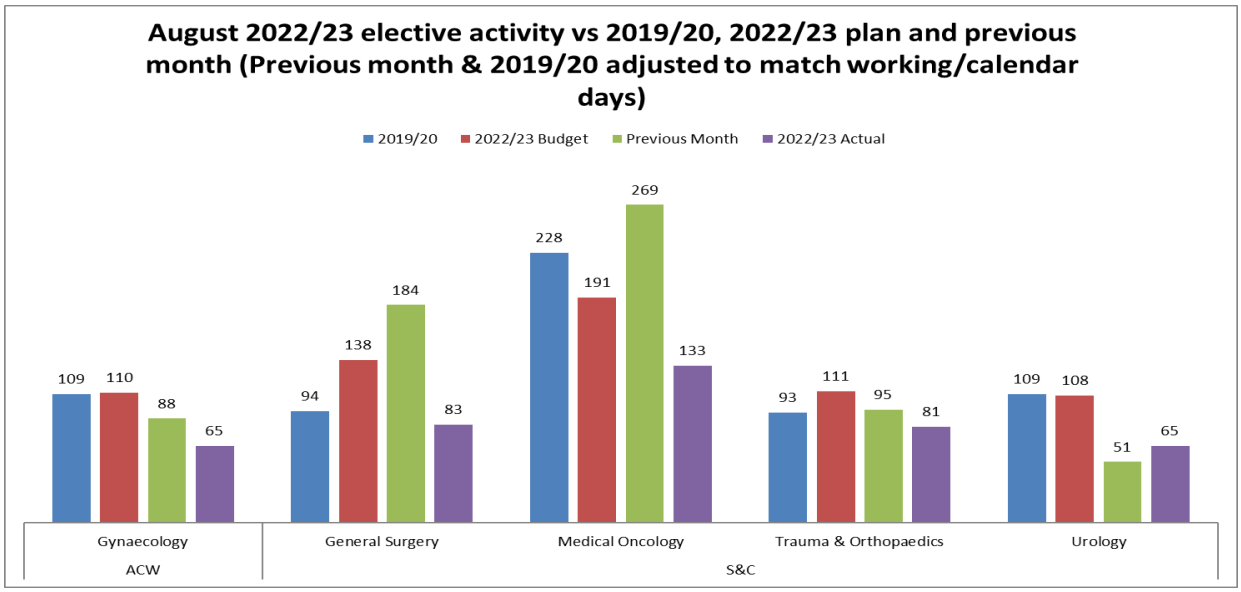
- Except for Critical care, ambulatory and direct access, activity continues to be under plan. Based on this initial early data it strongly suggests that the Trust is at risk of not achieving the 109% activity target needed to achieve 100% of the £8m planned ERF.

- Activity decreased compared to previous month adjusted for calendar/working days, except for non-elective activity.

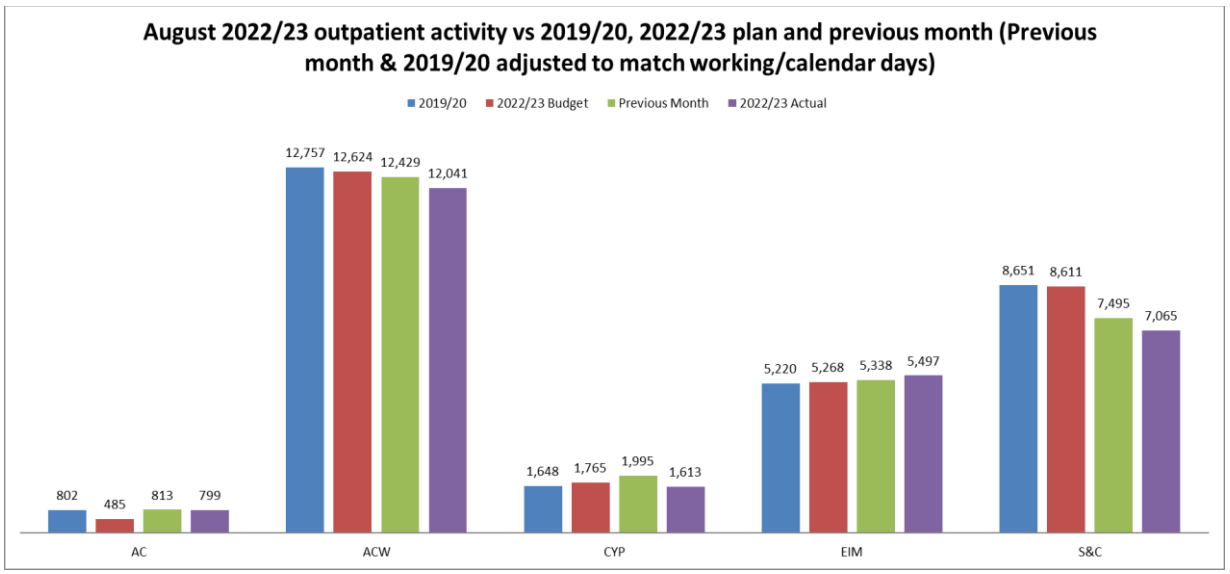


- 13% underperformance in total elective activity driven mainly by urology (40% under plan), gynaecology (41%) medical oncology (30%), General Surgery (40%) and trauma & orthopaedics (27%).





- 6% underperformance in outpatient activity driven mainly by urology (38% under plan), paediatrics (14%), ophthalmology (22%), preassessment (57%), gynaecology (9%), respiratory (25%), rheumatology (33%) and tele dermatology (48%). Offset by overperformance in physio (104% over plan due to change in coding), gastroenterology (74%), cardiology (56%) and clinical haematology (55%).



3. Expenditure – Pay & Non-pay

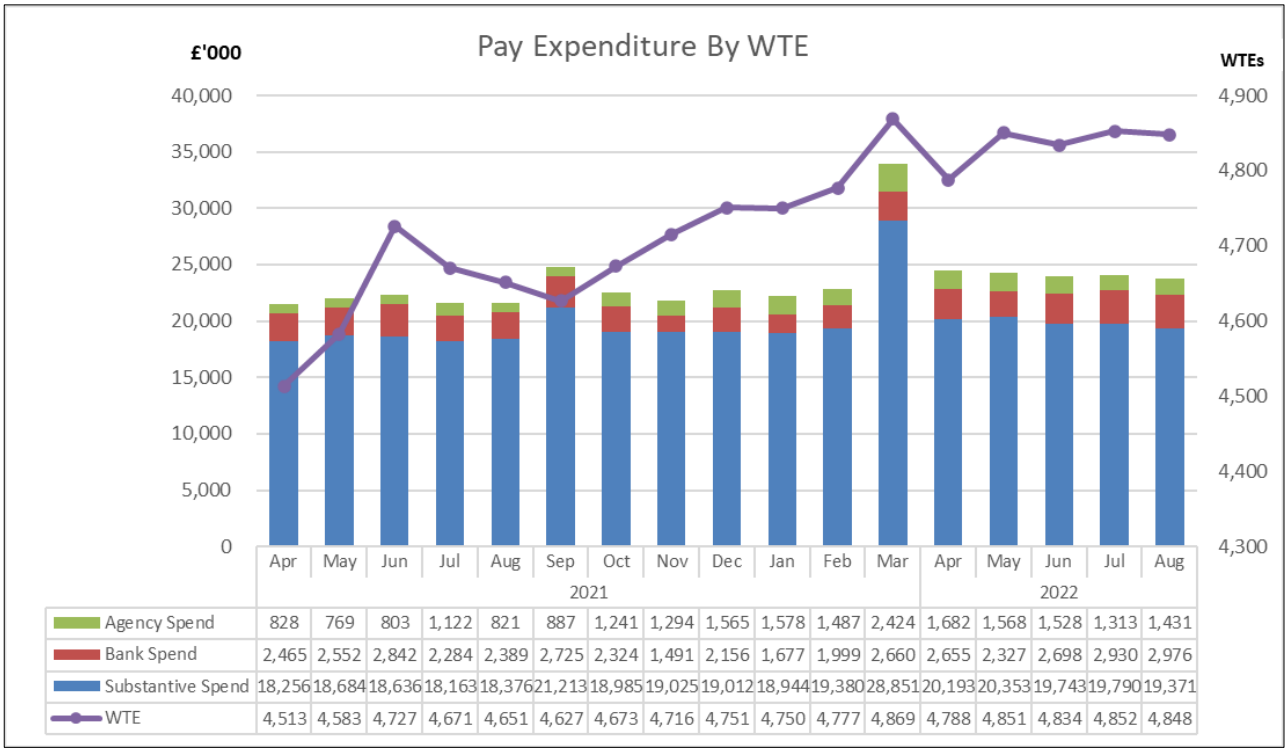
3.1 Pay Expenditure

Overall pay is overspent by £4,143k year to date compared to plan. The overspend is mainly driven by unachieved CIPs of £1,499k across all ICSUs, covid requests to cover red/green areas (£1,412k ED and £173k in Theatres), unfunded escalation beds open (£1,457k in Wards and £385k Enhanced Care) and £857k in ITU which is related to increased acuity on the wards, and agency staff required to cover staff on limited duties. Part of the unachieved CIPs is currently being offset by vacancies and slippages in some of the planned investments.

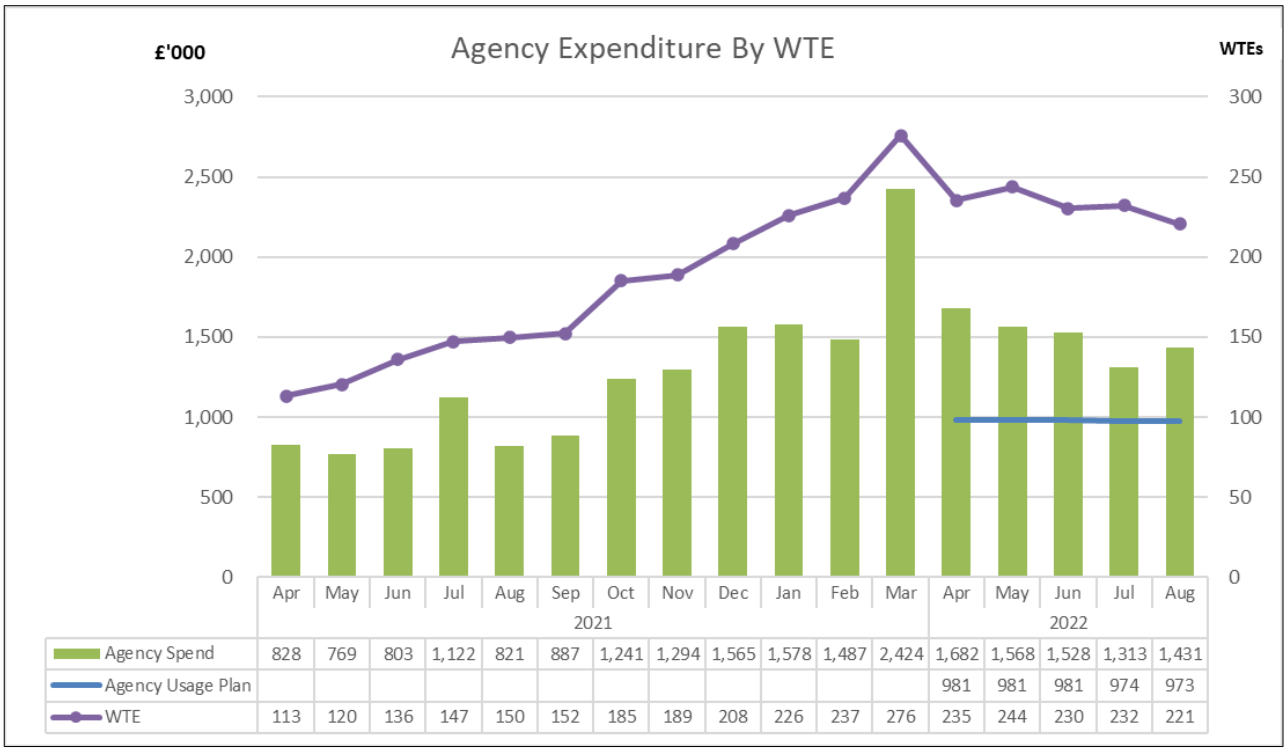
Pay expenditure for August was £23,778k which was £255k lower compared to previous month. The decrease in pay costs compared to previous month is mainly due to recoding of non-operational pay costs (£200k) to non-pay. Non-operational costs include an estimate for pay uplift (2%) for 2022-23 and annual leave costs for bank staff.

Pay spend within ICSUs and corporate divisions for August was £23.5m and was similar to the spend in July.

	2021-22			2022-23					
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Mov^t
Agency	1,170	1,145	1,568	1,678	1,615	1,528	1,313	1,431	118
Bank	2,045	2,310	2,644	2,551	2,424	2,586	2,836	2,900	64
Substantive	18,880	19,178	20,037	19,170	19,366	19,283	19,355	19,179	(175)
Total Operational Pay	**22,095**	**22,632**	**24,249**	**23,399**	**23,405**	**23,397**	**23,504**	**23,511**	**6**
Non Operational Pay Costs	103	234	9,686	1,131	843	572	528	267	(261)
Total Pay Costs	**22,198**	**22,866**	**33,934**	**24,530**	**24,248**	**23,969**	**24,033**	**23,778**	**(255)**



** (Excludes Chair & Non-Exec Directors)*



**2022-23 agency cap figures will be issued by NHSI in Q2.*

Review actions on pay expenditure include

- Review use of additional staffing for Covid
- Review additional staffing related to IPC guidance
- Review vacancies to help with non-recurrent CIP delivery

3.2 Non-pay Expenditure

Overall, non-pay is £797K underspent year to date compared to plan. Overspends relating to unachieved CIPs (£179k), clinical supplies (£614k), general supplies (£332k), use of independent sector (£143k) and PFI costs (£552k) which are related to legal and consultancy fees along with increased staffing for fire safety are being offset by slippages in planned investments and non-recurrent benefits released.

In month non-pay expenditure remained in line with prior month with both months lower than previous months due to non-recurrent benefits which were released in July and August.

	2022-22			2022-23					
Non-Pay Costs	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Mov^t**
Supplies & Servs - Clin	3,624	2,633	3,103	2,616	2,884	2,537	2,721	2,776	55
Supplies & Servs - Gen	447	488	316	24	262	512	337	351	14
Establishment	260	305	210	287	214	207	237	240	3
Healthcare From Non Nhs	210	282	293	87	226	71	276	376	100
Premises & Fixed Plant	2,193	2,977	6,010	2,203	1,482	2,701	1,900	1,647	(253)
Ext Cont Staffing & Cons	175	(2)	85	142	147	120	175	192	17
Miscellaneous	2,225	2,374	8,377	1,653	1,651	1,517	774	848	74
Chairman & Non-Executives	12	12	12	11	11	11	9	12	2
Non-Pay Reserve				(8)	66	14	14	14	
Total Non-Pay Costs	**9,146**	**9,068**	**18,404**	**7,016**	**6,943**	**7,690**	**6,444**	**6,455**	**11**

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

Miscellaneous Expenditure Breakdown

	2022-22			2022-23					
Miscellaneous Breakdown	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Mov^t**
Ambulance Contract	157	152	144	168	176	208	190	172	(18)
Other Expenditure	58	323	4,993	52	51	14	(276)	(981)	(705)
Audit Fees	9	9	107	8	8	8	8	9	1
Provision For Bad Debts	612	364	(266)	100	161	35	(505)	66	570
Cnst Premium	837	837	735	827	827	827	827	827	0
Fire Security Equip & Maint	0	15	3	5	11	12	4	6	2
Interpretation/Translation	24	19	1	21	16	9	10	11	1
Membership Subscriptions	196	126	113	128	134	135	139	140	1
Professional Services	244	422	1,535	298	188	171	277	371	95
Research & Development Exp		11	296	1	(1)	(2)	(1)	134	135
Security Internal Recharge	20	10	10	10	10	10	10	10	(0)
Teaching/Training Expenditure	65	85	698	34	65	86	87	79	(8)
Travel & Subs-Patients	1	1	8	1	4	4	3	3	1
Total Non-Pay Costs	**2,225**	**2,374**	**8,377**	**1,653**	**1,651**	**1,517**	**774**	**848**	**74**

3.3 Cost Improvement Programmes (CIP)

The CIP target for 2022-23 is £13.83m. The targets have been allocated to ICSU and corporate divisions as part of 2022-23 budgets.

ICSU	22/23 CIP Target Allocated £'000
ADULT COMMUNITY	1,192
CHILDREN & YOUNG PEOPLE	1,839
EMERGENCY & INTEGRATED MEDICINE	1,653
SURGERY & CANCER	1,569
ACW	1,728
ICSU TOTAL	**7,980**
CORPORATE SERVICES TOTAL	2,020
CENTRAL	3,829
CIP GRAND TOTAL	**13,829**

CORPORATE DIRECTORATES	22/23 CIP Target Allocated £'000
CHIEF OPERATION OFFICER	75
ESTASTES & FACILITIES	1,006
FINANCE	186
ICT	252
MEDICAL DIRECTOR	67
NURSING & PATIENT EXPERIENCE	183
TRUST SECRETARIAT	74
WORKFORCE	177
CORPORATE TOTAL	**2,020**

Year to Actuals

At the end of August, the Trust is reporting actual delivery of £2.39m year to date of CIP against a target of £4.08m.

ICSU	22/23 CIP Target Allocated £'000	YTD Plan £'000	YTD Actuals £'000	YTD Variance £'000	YTD Actuals vs YTD Plan %
ADULT COMMUNITY	1,192	349	271	(78)	77.7%
CHILDREN & YOUNG PEOPLE	1,839	540	387	(153)	71.6%
EMERGENCY & INTEGRATED MEDICINE	1,653	485	24	(461)	4.9%
SURGERY & CANCER	1,569	460	78	(382)	17.1%
ACW	1,728	505	240	(265)	47.5%
ICSU TOTAL	**7,981**	**2,339**	**1,000**	**(1,339)**	**42.8%**
CORPORATE SERVICES	1,014	299	145	(154)	48.5%
ESTASTES & FACILITIES	1,006	294	95	(199)	32.2%
PROCUREMENT	-	-	-	-	0.0%
CENTRAL	3,829	1,149	1,149	(0)	100.0%
CIP GRAND TOTAL	**13,829**	**4,081**	**2,389**	**(1,692)**	**58.5%**

4.0 Statement of Financial Position (SoFP)

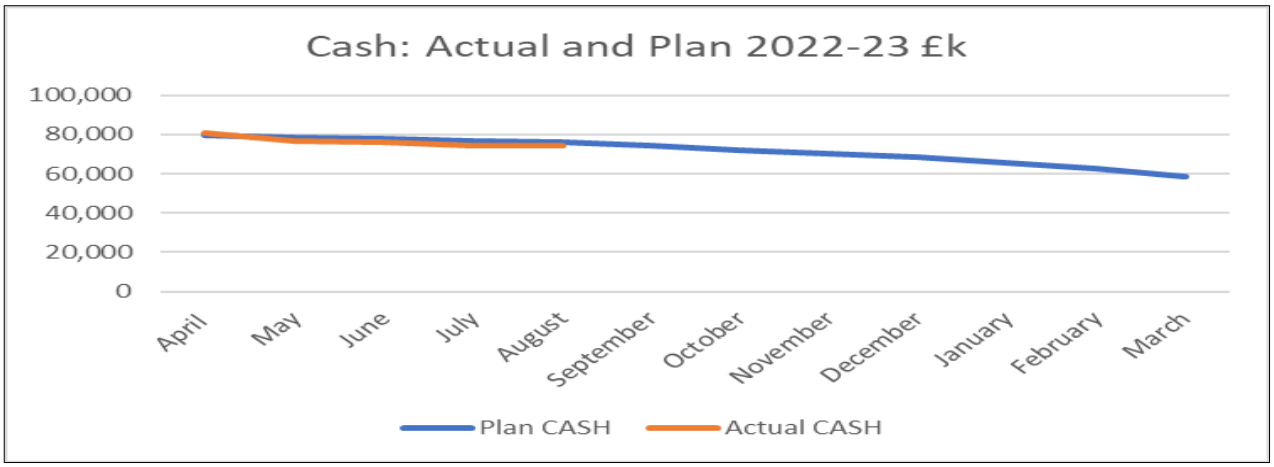
The net balance on the Statement of Final Position as of 31st August 2022 is £228.6m, £5.2m down from March 2022, as shown in the table below.

Statement of Financial Position as at 31st August 2022	2021/22 M12 Balance	2022/23 M03 Balance	2022/23 M04 Balance	2022/23 M05 Balance	Movement in Month	MOVEMENT IN YR
	£000	£000	£000	£000	£000	(£000)
NON-CURRENT ASSETS:						
Property, Plant And Equipment	225,710	223,171	222,327	221,547	(780)	(4,163)
Intangible Assets	9,711	9,076	8,860	8,589	(271)	(1,123)
Right of Use Assets	0	41,361	41,862	41,479	(383)	41,479
Assets Under Construction	20,484	22,650	23,695	24,795	1,100	4,311
Trade & Other Rec -Non-Current	415	487	500	529	29	114
TOTAL NON-CURRENT ASSETS	**256,321**	**296,745**	**297,244**	**296,939**	**(305)**	**40,618**
CURRENT ASSETS:						
Inventories	788	807	867	908	41	120
Trade And Other Receivables	12,742	17,027	16,780	15,982	(798)	3,240
Cash And Cash Equivalents	81,416	76,300	74,601	74,643	42	(6,774)
TOTAL CURRENT ASSETS	**94,946**	**94,134**	**92,248**	**91,533**	**(715)**	**(3,413)**
CURRENT LIABILITIES						
Trade And Other Payables	(66,576)	(69,528)	(64,439)	(65,990)	(1,550)	587
Borrowings: Finance Leases	(79)	(132)	(47)	(220)	(173)	(141)
Borrowings: Right of Use Assets	0		(2,096)	(2,078)	18	(2,078)
Borrowings: Dh Revenue and Capital Loan - Current	(118)	(131)	(136)	(140)	(4)	(22)
Provisions for Liabilities and Charges	(704)	(674)	(1,007)	(573)	435	132
Other Liabilities	(1,859)	(2,392)	(5,333)	(3,791)	1,542	(1,932)
TOTAL CURRENT LIABILITIES	**(69,337)**	**(72,857)**	**(73,059)**	**(72,792)**	**268**	**(3,455)**
NET CURRENT ASSETS / (LIABILITIES)	**25,609**	**21,277**	**19,189**	**18,742**	**(447)**	**(6,867)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**281,930**	**318,022**	**316,433**	**315,680**	**(753)**	**33,751**
NON-CURRENT LIABILITIES						
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,740)	(1,740)	(1,740)	(1,740)	0	0
Borrowings: Finance Leases	(4,754)	(45,937)	(4,448)	(4,190)	258	564
Borrowings: Right of Use Assets	0		(39,829)	(39,480)	348	(39,480)
Provisions for Liabilities & Charges	(41,622)	(41,622)	(41,622)	(41,622)	0	0
TOTAL NON-CURRENT LIABILITIES	**(48,116)**	**(89,300)**	**(87,639)**	**(87,033)**	**606**	**(38,917)**
TOTAL ASSETS EMPLOYED	**233,813**	**228,722**	**228,794**	**228,647**	**(147)**	**(5,166)**
FINANCED BY TAXPAYERS EQUITY						
Public Dividend Capital	113,854	113,854	113,854	113,854	0	0
Retained Earnings	21,147	16,056	16,128	15,980	(148)	(5,166)
Revaluation Reserve	98,813	98,813	98,813	98,813	0	0
TOTAL TAXPAYERS EQUITY	**233,813**	**228,722**	**228,794**	**228,647**	**(148)**	**(5,166)**

IFRS16 is the new accounting standard implemented across the NHS on 1st April 2022, which requires the Trust to recognise an increased range of its leases as finance leases. This reclassification required the assets, and a corresponding finance lease creditor, to be added to the SoFP. These balances are now shown separately in the summary above, under Right of Use Assets and Borrowings: Right of Use Assets, respectively.

4.1 Cash & Cash Equivalents

As at the end of August, the Trust's cash balance stands at £74.6m – a decrease of £6.8m from 31 March 2022, unchanged from July's figure and £1.3m below Plan. The balance has reduced since 31st March as the Trust reports a year-to-date deficit of £5.2m. The Trust's ongoing cash requirements have not changed materially in terms of staff pay and capital expenditure, and the Trust continues to strive to pay suppliers early in the current economic climate.



Statement of cash flows for the 5 months ended 31st August 2022	
	(£000)
Cash flows from operating activities	
Operating surplus/(deficit)	(2,774)
Non-cash income and expense:	
Depreciation and amortisation	7,199
(Increase) in trade and other receivables	(3,354)
(Increase) in inventories	(120)
(Decrease) in trade and other payables	(3,499)
Increase in other liabilities	1,932
Increase in provisions	(132)
Net cash generated from / (used in) operations	**(747)**
Cash flows from investing activities	
Interest received	308
Purchase of intangible assets	(119)
Purchase of property, plant and equipment	(3,092)
Net cash generated from/(used in) investing activities	**(2,903)**
Cash flows from financing activities	
Capital element of finance lease rental payments	(423)
Interest paid	(23)
Interest element of finance lease	(386)
PDC dividend (paid)	(2,292)
Net cash generated from/ (used in) financing activities	**(3,124)**
(Decrease) in cash and cash equivalents	**(6,774)**
Cash and cash equivalents at start of period	**81,416**
Cash and cash equivalents at end of period	**74,643**

The recent increases in interest rates have resulted in a total of £308k interest being reported for the first four months of the year. This is £153k more than Plan. The Trust continues to monitor the available interest rates and the monthly sum of interest received.

5.0 Capital Expenditure

Capital expenditure as of the 31st of August 2022 totals £4,311k, which is £2,396k below plan, a reflection that the Trust's principal capital projects for this financial year are yet to get fully underway. The in-month total is £1,099k.

The Trust's capital plan for 2022-23 is £30.4m. This includes self-funded schemes of £25.4m and £5m relating to elective recovery (Targeted Investment Fund yet to be approved).

Meeting title	**Trust Board – public meeting**	**Date:30 September 2022**
Report title	**Cost of living and supporting staff financial wellbeing**	**Agenda item: 10**
Executive director leads	Norma French Director of Workforce	
Report authors	Norma French	
Executive summary	The Trust recognises that the need to support the wellbeing of staff has never been stronger. With rising energy prices and the cost of living generally any member of staff could suffer financial difficulties, even high earners. This report seeks to outline the ways in which the Trust can accelerate and make financial support readily accessible. Additionally, the work led by the Strategy Directorate in conjunction with local authorities and as an anchor institution will be key to reducing the impact of cost-of-living crisis on our staff, patient population and local communities. The Trust has implemented a three-strand approach: 1. Provide a fair and liveable wage 2. Support in-work progression to help people increase their earning potential 3. Support financial wellbeing. This report sets out Whittington Health staff profiles and expands the above three strands in turn highlighting progress and areas for further discussion.	
Purpose	Discussion and noting	
Recommendations	Trust Board is asked to note the contents of this paper and progress to date and debate other areas that the Trust may wish to consider in the future.	
BAF	Quality strategic objective entries	
Appendices	1: Supporting staff financial wellbeing	

Cost of Living and Supporting Staff Financial Wellbeing

1.0 Background and Context

The need to support staff financial wellbeing has never been stronger with rising energy prices and other costs affecting our colleagues. Any member of staff could have difficulties with their financial wellbeing, including high earners, and the Trust has a shared responsibility between employer and employee. This paper outlines ways in which we can accelerate and make financial support readily accessible. It is recognised that the cost-of-living crisis impacts our patient population and local communities and although this paper focuses on Trust staff, the work being led by our Strategy Directorate in conjunction with local authorities and as an anchor institution is key.

Our colleagues' health and wellbeing are of the utmost importance to Whittington Health (aligned with our strategic objective of empowering, supporting and developing engaged staff), and in turn it underpins high quality and safe patient care. The Trust wants to help stretch employees' earnings by providing staff benefits and explore which benefits suit the needs of the workforce. Benefits should be available to all and offered flexibly so that individuals can select those that best suit their circumstances. Support mechanisms should be put in place should employees fall into financial difficulties.

The cost-of-living crisis refers to the fall in 'real' disposable incomes (that is, adjusted for inflation and after taxes and benefits) that the UK has experienced since late 2021. It is being caused predominantly by high inflation outstripping wage and benefit increases and has been further exacerbated by recent tax increases and rising utility, food and fuel costs. Work can, and should, be a reliable route out of poverty. But with one in eight UK workers living in poverty, and the cost of living rising, many staff are likely to be struggling to cope.

The Chartered Institute of Personnel and Development (CIPD) is asking all employers to consider and implement a three-strand financial wellbeing policy that minimises in-work poverty:

1. Provide a fair and liveable wage
2. Support in-work progression to help people increase their earning potential;
3. Support financial wellbeing.

The remainder of this paper sets out Whittington Health staff profiles and takes the above three strands in turn highlighting progress and areas for further discussion.

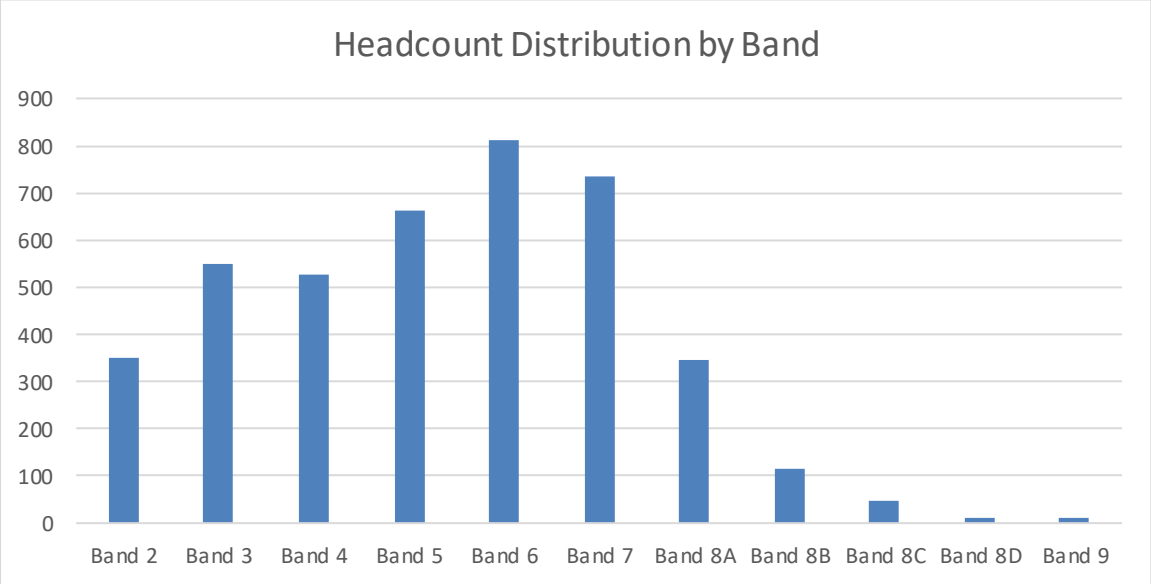
2.0 Whittington Health Staff Profile

NHS terms and conditions are set by two pay review bodies: Agenda for Change (AfC) and Medical and Dental (M&D), in addition there is the Very Senior Managers (VSM) framework. Lower earning staff tend to be in the lower AfC bands.

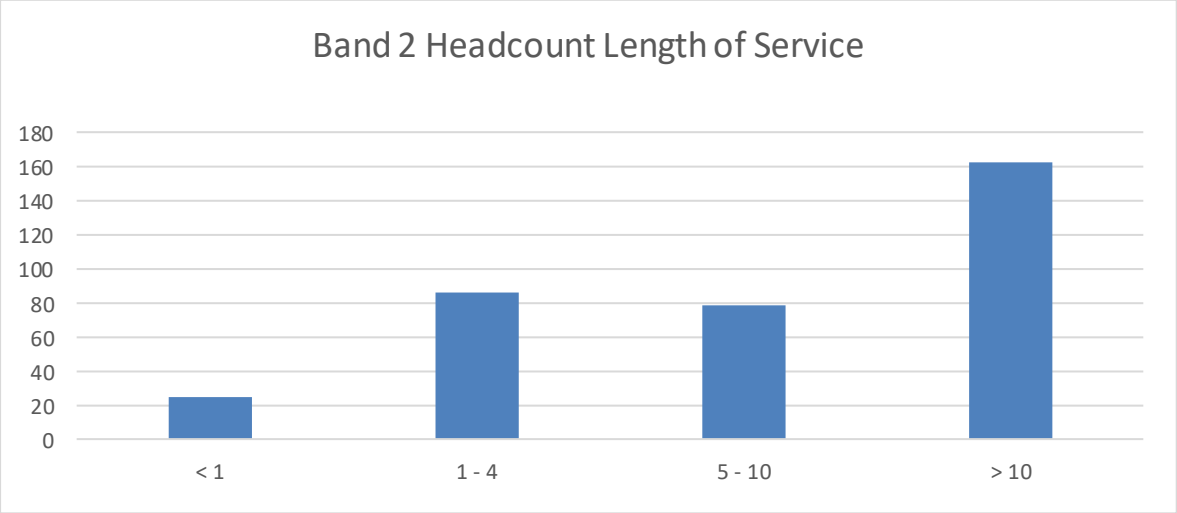
The graphs below give detail on band distribution of AfC bands and length of service of AfC Band 2. Graph 1 shows that we have over 300 staff employed at Band 2, with

over 500 at AfC Band 3. Graph 2 shows that the majority of band 2 staff (162 of 351) have been employed at AfC Band 2 for over 10 years.

Graph 1



Graph 2



The majority of roles held by staff employed in AfC Band 2 are in the Facilities Directorate (portering and domestic staff), there are also healthcare assistant and clerical assistant/receptionist roles across the Trust within this group.

The UK government has announced that NHS staff in England will get a pay increase of at least £1,400 for 2022/2023. The new pay ranges of Agenda for Change (AfC) Bands 2 and 3 are set out in the tables below.

2022/23 Pay Range (inclusive of inner HCAS)		
AfC Band 2	£25,158 (£12.87 ph)	£26,206 (£13.40ph)
AfC Band 3	£26,618 (£13.61 ph)	£28,065 (£14.35 ph)
2022/23 Pay Range (inclusive of outer HCAS)		
AfC Band 2	£24,378 (£12.47ph)	£25,426 (£13 ph)
AfC Band 3	£25,838 (£13.21ph)	£27,285 (£13.95)

8.4% of Trust staff are employed at the lowest AfC Band 2 pay band and a further 13.2% at AfC Band 3.

3.0 **CIPD Framework Comparison**

As mentioned above the CIPD have developed a Framework against which employers should consider their financial wellbeing offering to staff. The Framework and best practice can be found in Appendix 1. The following sections summarise the Trust's current position, recent changes and asks what more could be considered.

3.1 **Provide a Fair and Liveable Wage**

The Trust is an accredited London Living Wage (LLW) employer with the LLW currently £11.05 ph. In-work poverty is likely to have a greater impact on staff in the cohort of staff in our lower AfC bands and should be the focus of Trust efforts to support.

NHS pay and terms and conditions are subject to national negotiation, and there are legal aspects such as HMRC rules which the Trust must work within. There are steps that the Trust has taken to demonstrate our commitment to provide a fair and livable wage. This includes:

- Through our internal communications channels and access to the human resources function the Trust is open about how pay is set, increment points and how people can secure a pay rise through progression – there is a Pay Progression Policy which is available to all staff.
- All job vacancies are advertised internally and externally through NHS Jobs and include details of salary and banding.
- The Trust is a London Living Wage employer and continually reviews this and hours of work contractually agreed are guaranteed.
- All staff, regardless of professional background or seniority are able to register and take on additional shifts through Bank Partners;
- Details of the Trust Gender Pay Gap are shared on an annual basis and publicly available;

There will always be a need to employ staff in the roles that the lower bands cover. Consideration could be given to targeting groups of people who could afford to fulfil them, for example, school-leavers still living at home, provided they are supported by clear progression maps for their next roles, discussed below. Without these the school-leavers could potentially be stuck in poverty in the parental home and unable to leave. This is an ideal place to offer a range of apprenticeships depending on the desired next steps of each individual, as most apprenticeships require the student to be in an appropriate role that relates to the study. There will also need to be a well-developed

induction and training programme for new starters in these roles as turnover will be high.

It is important that managers are more familiar with modern apprenticeships, and this can be achieved through general briefing at the Managers' Forum, localised support and advice, and the potential for extending current queries and advice into 'career clinics'. There is some evidence that this is a successful approach from (a) pre-pandemic nursing career sessions, and (b) those who were not successful on getting on to the AfC Band 2-7 programme were offered personal development plans to progress their careers.

3.2 Support In Work Progression to Help People Increase Their Earning Potential.

Exploration through a 'deep-dive' into the Trust's Workforce Race Equality Standards (WRES) results highlighted a need for internal progression for black, Asian and ethnic minority staff. For someone living in poverty, a route to progress out of a low-paying job can be a light at the end of the tunnel. Whether it's developing skills, providing clear pathways free of barriers or challenging perceptions, people professionals play a vital role in helping staff progress in the workplace.

There are several ways that the Trust strives to provide a culture of learning through access to opportunities supported by our Learning and Organisational Development Team; corporate nursing and AHP development, and medical education teams. Targeted programmes have been developed recently, for example:

- Bands 2–7 Development Programme for Staff from a black, Asian or minority ethnic background.
- The Adult Community ICSU have created a Black, Asian and minority ethnic development programme.
- Flexible working (when people work) and hybrid working (how and where people work) are supported across all staff groups where practical – however these decisions are locally made and agreed with line managers and there is currently no central record of work patterns that can help the Trust analyse uptake.
- There is a Manager's Forum in place to develop our line managers so that they are equipped to support their teams to progress.
- Apprenticeships for HCA staff at low bands (AfC Band 2-3) to get into nursing have become established in recent years. This focuses on developing colleagues into qualified AfC band 5 roles

The Trust will explore the potential to develop clear progression maps for staff at lower bands to understand what direction and how to progress to higher bands, together with appraisal conversations that refer to career development (as they do now) and the choice of pathways (which is yet to be developed).

3.3 Support Financial Wellbeing

By offering employee benefits that help incomes go further, sign-posting relevant financial advice and guidance, and creating a safe place to talk about money worries, employers can make a big difference to people's lives.

A review of internal and external benefits currently available has been undertaken and the range of support currently available identified. Much of this is already available via our intranet in different parts of the search function. This offer has been consolidated into a one stop shop for staff that is available with a new Financial Wellbeing Hub, launched in August.

The Hub is structured to provide signposting for:

- **Making my money go further** – benefits and discounts
- **Managing my finances** –financial advice
- **Finance help** – urgent help through difficult times

All staff are signposted to free, confidential and independent money and debt advice and these are communicated fully through broadcast communications, CEO briefings and the intranet. The information and offers available to staff are broad and range from salary sacrifice schemes: bike scheme, car lease scheme, season ticket scheme (with plans to extend to electronics and potentially white goods); to links with local Food Banks; and discounts with local restaurants and gyms.

The Trust has recently agreed to improve the terms and conditions of the national mileage allowance, effective from 1st April 2022 until 31st December 2022 when it will be reviewed. We have increased the mileage rates for work journeys to 61p per mile, from 56p. Additionally, we have increased the mileage cap from 3,500 to 10,000 miles annually.

We are reviewing subscribing to the Wagestream App (which is a financial advice and draw down salary facility). Other Trusts have created Hardship Funds that staff can access. The Trust is also reviewing its retail and restaurant offerings and in doing so will be cognisant of ensuring affordable and healthy meals for staff through the working week.

4.0 Recommendations

Whilst there is a range of support available currently, it is important that the Trust continually engages with staff to ensure it knows what they would find helpful to shape future developments and initiatives.

It is recommended that the newly created Cost of Living Group (which comprises members from human resources, communications, occupational health and wellbeing, EDI and organisational development) continues as a working group over the coming months. Through this Group, which is chaired by the Associate Director of Workforce, continual staff engagement events will be established, Trust offerings can be reviewed and enhanced based on feedback and need. There may be the opportunity develop targeted support to some staff groups – for example exploring in work apprenticeships for lower banded posts.

To support some of the suggested next steps in the report, it is recommended that the Trust should:

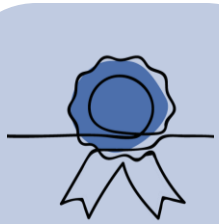
- Attract specific groups of candidates to the lower banded roles and support their development to higher bands;

- Create an efficient induction and training programme for new starters in lower bands;
- Develop clear progression paths for staff at lower bands;
- Ensure appraisals cover not only career aspirations, but also include choice of pathways;
- Consider creating career clinics;
- focus on increasing range of apprenticeships we offer and maximising the apprentice levy. In doing so will provide further briefing and training to managers on apprenticeships.
- Run listening events in departments that employ large cohorts of AfC bands 2 and 3 (e.g. estates and facilities) to ensure we are continually asking the question about what would make a difference to them and action where practicable;
- Consider expanding existing benefits, for example salary sacrifice schemes, to support purchases staff may need to make.

The Trust will continue to engage in conversations with providers across the ICS and nationally on sharing best practice and implement locally where possible

Trust Board is asked to note the content of this paper and progress to date and debate other areas that the Trust may wish to consider in the future.

Provide a fair and livable wage



We must accept that NHS pay and terms and conditions are subject to national negotiation, and there are legal aspects such as HMRC rules which we have no influence on. There are however still steps that can be taken by an employer to demonstrate the commitment to provide a fair and livable wage.

01

Be open about how pay is set, increment points and how people can secure a pay rise through progression

02

Create transparency by advertising all job vacancies with salary/band ranges – for all role types and for every advertising medium

03

Pay a wage that enables people to meet the true cost of living and, wherever possible, provide security of hours if workers need it

04

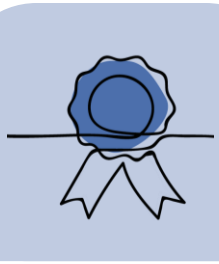
Remove any barriers preventing people from working the hours necessary to meet their financial needs

05

Ensure that pay outcomes and processes are fair – by checking the reasons for gender, ethnicity or disability pay gaps

People Promise

Support in-work progression to help people increase their earning potential



For someone living in poverty, a route to progress out of a low-paying job can be a light at the end of the tunnel. Whether it's developing skills, providing clear pathways free of barriers or challenging perceptions, people professionals play a vital role in helping staff progress in the workplace.

01

Promote a culture of lifelong learning and show people of all ages and stages of their careers a clear path to progression if they want it

02

Invest in targeted training and development to help people fulfil their potential, regardless of age, disability, or other factors

03

Promote an inclusive flexible working culture that ensures those who work flexibly are not overlooked for development opportunities

04

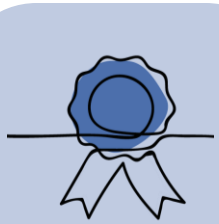
Put in place a clear structure to ensure everyone in our organisation knows what they need to do if they want to take on higher-paid roles

05

Develop our line managers, so that they are equipped to support their teams to progress

People Promise

Support financial wellbeing



By offering employee benefits that help incomes go further, sign-posting relevant financial advice and guidance, and creating a safe place to talk about money worries, employers can make a big difference to people's lives.

01

Signpost our workforce to free, confidential and independent money and debt advice

02

Review our benefits package to ensure that it is current, effective and accessible for all

03

Make sure we fully communicate the benefits that we currently offer and how to make the most of them

04

Use behavioural insights to positively influence behaviours using key employee segments, such as age, life stage or career stage

05

Normalise conversations about money worries at work; showing concern and empathy can help to break down any stigma

People Promise

Meeting title	**Trust Board – public meeting**	**Date: 30 September 2022**
Report title	**Charitable Funds Committee Chair's Assurance report**	**Agenda item: 11**
Non-Executive Director	Tony Rice, Committee Chair	
Executive director leads	Kevin Curnow, Chief Finance Officer	
Report author	Swarnjit Singh, Joint Director of Inclusion and Trust Secretary	
Executive summary	In line with governance arrangements, this Committee Chair's report reports on areas of assurance on the items considered at the 18 July 2022 Charitable Funds Committee meeting which included: • Charity report • Month 3 Finance report. • Investment in the Charity • Branding and fundraising readiness review • Applications for funding There were no items covered at these meetings for which where the Committee is reporting limited assurance to the Trust Board.	
Purpose:	Noting	
Recommendation(s)	Board members are invited to note the Chair's assurance report for the Charitable Funds Committee meeting held on 19 May 2022 and the applications for funding agreed.	
Report history	Public Board meetings following each committee meeting	
Appendices	None	

Committee Chair's Assurance report:	Charitable Funds Committee
Date of meeting	19 May 2022

Summary of assurance:

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

Charity report
Committee members noted the report for the period, 13 May to 6 July 2022. In particular, they welcomed a major gift donation for the Michael Palin Centre which could be worth more than £1m over a five-year period. The Committee also noted and welcomed the receipt of a £20k gift for respiratory services, the rollout of the new charitable funds structure and process, and the recruitment of a fundraising manager. In addition, the Committee was apprised on the work taking place in fundraising projects for the birth centre, the maternal health centre and the neonatal intensive care unit.

Month 3 Finance report
The Committee reviewed a report for quarter one covering an overview of charitable funds and a breakdown of fund balances. Income for the quarter was £70k, with expenditure totalling £86k. Donations and grants contributed 86% of total income during the quarter.

The Committee noted that the investment portfolio continued to be affected by global events and a quarter one outturn was awaited from Investec. The total fund balance as at 30 June was £2.3m.

Investment in the Charity – branding collateral and fundraising
Committee members reviewed a paper which set out three priority areas for investment – charity brand completion and rollout, strategic support to achieve and to accelerate growth and a donor acquisition project.

They concurred with the proposal to use the development grant from NHS Charities Together to compete the rebranding work and to also complete a readiness review. Committee members supported proposals to achieve sustainable growth and to deliver a successful capital campaign utilising the maternity and neonatal capital project as a catalyst for conversations with donors.

2. **Applications for Funding**
The Committee reviewed and approved all of the bids received. They were:

- Classical music programme - £14, 750
- Innowalks for children with cerebral palsy - £3,000
- Sing for your lungs - £5,520
- Headsets for the new education centre - £21,000
- Extension of the psychological support programme - £65,000

3.	**Attendance:** Tony Rice, Non-Executive Director (Committee Chair) Julia Neuberger, Trust Chair Amanda Gibbon, Non-Executive Director Kevin Curnow, Chief Finance Officer Jonathan Gardner, Director of Strategy & Corporate Affairs **In attendance** Vivien Bucke, Business Support Manager Clare Dollery, Medical Director Martin Linton, Assistant Director Financial Services Sam Lister, Head of Charity Alex Ogilvie, Deputy Head of Financial Services Swarnjit Singh, Joint Director of Equality Diversity & Inclusion and Trust Secretary **Apologies for Absence** Allison Balsamo, Trusts & Foundations and Charity Projects Manager Helen Brown, Chief Executive Marcia Marrast, Assistant Trust Secretary

Meeting title	**Trust Board – public meeting**	**Date: 30 September 2022**
Report title	**Update on the Strategic Projects**	**Agenda item: 12**
Executive director lead	Jonathan Gardner, Director of Strategy and Corporate Affairs	
Report author	Jonathan Gardner	
Executive summary	This paper contains the following updates: • Maternity and Neonatal Phase 1 progress • Maternity and Neonatal Phase 2 business case progress • Wood Green Community Hub • Wood Green Diagnostic Centre • Electronic Patient Record • the NCL Elective Hub Proposals	
Purpose:	This paper is to provide the Board with an update on progress.	
Recommendation(s)	The Board is asked to note the update on progress and on-going actions.	
Risk Register or Board Assurance Framework	Risk Register: Maternity and Neonatal facilities, and Power Infrastructure	
Report history	Transformation Programme Board	
Appendices	None	

Phase 1 – Maternity and Neonatal Building Project

Background
The phase 1 project was approved at £13.4m in November 2021.

Update
Since then, despite COVID, we have managed to procure New Engineering Contract (NEC)project managers and a Principal Supply Chain Partner (PSCP) as part of the Procure 22 framework. A steering group has been created and meets monthly with Northmores as the NEC programme managers and Arup as the maternity (and power) project managers. Grahams are the PSCP.

Due to slow procurement processes, cost increases and crucial design changes, we have not been able to bottom out the final scope of phase 1 until recently. This along with delays to the planning permission has led to challenges in getting the PSCP to start work and delays to the expected starting of building.

Planning permission is expected in October and we are now in a position where Grahams have begun a sprint (4 weeks left) of work to come up with a guaranteed maximum price for phase 1 with the intention of starting building work hopefully before the end of the financial year.

Phase 2 – Maternity and Neonatal Building Project Business Case

Background
Phase 2 business case as agreed earlier in the year will now include all the phases up to the expansion (2-4). Because this is over £15m it will need to go through formal NHS England approval processes.

Update
1:200 designs for the whole project will be completed shortly. The whole team have completed the "better business case" training run nationally, so that we can ensure that the Outline Business Case (OBC) is compliant with national guidelines. The aim is to get the business case approved by Finance and Business Development Committee (F&BD) in October followed by Board in November. We will then need to source a loan and agree the allocation of capital via the Integrated Care Board, and finally get NHSE and Department of Health approval.

Wood Green Community Hub

Background
This is the project to bring together GPs, council, mental health and community services into the Wood Green Shopping City a few doors down from the Community Diagnostic Centre.

Update
We have finished negotiation with the landlords and have an agreed demise and cost. The business case is due to be completed in October. Currently further work is required to get it as close to cost neutral as possible. Also a large amount of work is underway to redesign processes and systems with the council and other colleagues so we can be truly transformative in our way of working and design. .

Wood Green Community Diagnostic Centre

Background
This is a nationally funded initiative the Whittington is hosting on behalf of NCL to increase capacity of diagnostics in the community.

Update
Wood Green Community Diagnostic Centre opened on time and on budget on the 24th August. We are now live with ophthalmology, ultrasound, x-ray and phlebotomy tests. Phase 2 which creates space for an MRI and CT in the basement has now been approved nationally and building is underway with the view to opening in Autumn 2023. The formal opening ceremony is scheduled for the 11th October. Mike Richards, national head of diagnostics will be attending, and Amanda Pritchard and Tim Ferris and the Secretary of State have been invited.

Electronic Patient Record Procurement

Background
Our electronic patient record contract comes up for renewal in 2.5years. The innovation and digital committee oversees this work and F&BD are kept in the loop for the financial implications.

Update
We have procured Deloitte to update our Strategic Outline Case and to write a compliant Outline Business Case. This will be the process by which we decide whether we extend System C (our current supplier) or go with an extension of the instance of EPIC at UCLH. We expect this business case to be ready in December.

North Central London Elective Hubs

Background
Whittington have been working with North Central London commissioners and providers for some time on what is the best way to make the most of our staff and theatre resource to reduce the elective surgical backlog and treat cancer patients more quickly

Update
Providers across the sector continue to collaborate and share activity through mutual aid, whereby one trust uses their capacity to help reduce the waiting list at another trust. Whittington have been doing this for our neighbouring trusts particularly in endoscopy, general surgery and urology. Our strength is day cases and so the focus has been in that area. Building on the success of the orthopaedic work in particular the ICB and provider collaborative is exploring options to create higher volume centres for key specialities to maximise productivity and address long waits for care.

Start well review
The start well review into maternity and children's services continues with strong engagement from Whittington Health. The case for change has been approved and the next step is engagement around potential solutions to issues and clinical models. 2 stake holder workshops have taken place and more are planned.

Borough partnership work
No particular update this month.

Provider Partnerships
No particular update this month

Community Review

The providers are working together in workstreams to implement various recommendations. We are proud to be leading on the Children's community workstream, and the adult virtual ward workstream. Whittington have received additional funding for Haringey community to support services in meeting some of the gaps in the Adult Core Offer. This recurrent investment will be to bolster Specialist Tissue Viability and wound management thus preventing patients being hospitalised with sepsis from wounds.

WH is leading work to support reductions in waiting times for CYP therapy services and autism assessments across NCL with funding in 2022/23. Future investment in NCL CYP services will be confirmed by the end of this year, once engagement work about gaps and priorities for recurrent funding has been completed. Current recommendations include the expansion of hospital at home across NCL, strengthening services for looked after children and addressing gaps in therapy service provision.