NHS
Whittington Health
NHS Trust

Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board held in public on **Wednesday, 24 May 2023** from **9.30am to 11.00am** held at rooms A1 and A2 Whittington Education Centre Highgate Hill London N19 5NF

Item	Time	Title	Presenter	Action
		Standing agenda items		
1.	*0930*	Patient experience story	Chief Nurse	Discuss
2.	*0945*	Welcome, apologies, declarations of interest	Trust Chair	Note
3.	*0946*	30 March 2023 public Board meeting minutes, action log, matters arising	Trust Chair	Approve
4.	*0950*	Chair's report	Trust Chair	Note
5.	*0955*	Chief Executive's report	Chief Executive	Note
		Quality and safety		
6.	*1010*	Quality Assurance Committee report	Committee Chair	Note
		Performance		
7.	*1020*	Integrated performance report	Director of Strategy and Corporate Affairs	Discuss
8.	*1025*	Finance, capital expenditure and cost improvement report	Chief Finance Officer	Discuss
		Governance		
9.	*1035*	Workforce Assurance Committee Chair's report	Committee Chair	Note
10.	*1040*	Innovation and Digital Assurance Committee Chair's report	Committee Chair	Note
11.	*1050*	Questions to the Board from the public agenda items	Committee Chair	Note
12.	*1055*	Any other urgent business	Trust Chair	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 30 March 2023

Present:	
Baroness Julia Neuberger	Non-Executive Director and Trust Chair
Dr Junaid Bajwa	Non-Executive Director
Helen Brown	Chief Executive
Kevin Curnow	Deputy Chief Executive and Chief Finance Officer
Dr Clare Dollery	Medical Director
Amanda Gibbon	Non-Executive Director
Chinyama Okunuga	Chief Operating Officer
Baroness Glenys Thornton	Non-Executive Director
Rob Vincent CBE	Non-Executive Director
Naomi Fulop	Non-Executive Director
In attendance:	
Deborah Clatworthy	Deputy Chief Nurse
Swarnjit Singh	Joint Director of Inclusion & Trust Secretary
Norma French	Director of Workforce
Jonathan Gardner	Director of Strategy & Corporate Affairs
Tina Jegede MBE	Joint Director of Inclusion & Nurse Lead, Islington Care Homes
Marcia Marrast-Lewis	Assistant Trust Secretary
Juliette Marshall	Director of Communication and Engagement
Vanessa Cooke	Director of Operations, Children & Young People's Services Integrated Clinical Service Unit

No.	**Item**
1.	**Welcome, apologies and declarations of interest**
1.1	The Chair extended a warm welcome to everyone. Apologies for absence were received from Sarah Wilding, Chief Nurse and Director of Allied Health Professionals.
1.2	No new declarations of interest were noted.
2.	**Minutes of the meeting held on 23 January 2023**
2.1	The minutes of the previous meeting were approved as a correct record and the updated action log was noted. There were no matters arising.
3.	**Patient experience story**
3.1	Deborah Clatworthy introduced Mrs X who talked about the experience of her late husband when he attended the emergency department in July 2022. Mrs X explained that her husband was aged 73 with a history of dementia and Parkinson's disease, the latter of which he had suffered for 20 years. He was

	also non-verbal and had silent aspiration. In 2013, the family had to decide on a do not resuscitate order after Mr X suffered a cardiac arrest and a stroke. The stroke had left him severely disabled, but he was awarded NHS continuing care cover in 2015.
3.2	In mid-July 2022, Mr X was unwell with viral diarrhoea and was visited several times by a caring and dedicated community matron who carried out blood tests, which found that Mr X had kidney failure. He was brought into hospital on 22 July 2022 and admitted to the emergency department. Mrs X and both her sons had been granted a lasting power of attorney for Mr X; however, this had no impact as the family were told that none of them could stay with him in the emergency department, despite his inability to speak and the lasting power of attorney being in place. Mrs X found the situation extremely stressful and it triggered a bout of post-traumatic stress disorder which had originally been caused by a previous situation, when she had to make resuscitation decisions for her husband remotely, without any medical support.
3.3	On this occasion, Mr X's diagnosis included sepsis, pneumonia and kidney failure, but his family were still not allowed on the ward to be with him. Mr X's care plan had also been disregarded, which meant that antibiotics were administered to treat the sepsis, despite the care plan stating that this should not be the case. Mrs X found the situation overwhelming and felt that she had to leave the hospital, hoping that she would be called, should his condition change. Mrs X suffered even more stress when she learned that her husband's carer was allowed to visit her husband, without any challenge from the staff in the emergency department.
3.4	Mrs X explained that Mr X had not been admitted to the Mary Seacole Ward until the end of the week, so that consultants had to review his medical history, without the input of community services' colleagues. Mrs X felt that this was not in the best interest of her husband, as his care plan was disregarded. While a promised conversation with the emergency department consultant who had treated Mr X did not in fact take place, staff on the Mary Seacole ward were accommodating, helpful and extremely supportive of the family's personal wishes. Apart from a phone call from a senior registrar, there were no other calls from consultants over the weekend and the family was kept up to date by email from their community matron who was off duty at the time. By Sunday of that week, the on-call consultant rewrote Mr X's care plan, taking into consideration the family's outlook. He removed the antibiotics and held a positive meeting with Mrs X and her sons. The remainder of Mr X's hospital stay was more positive, with good support from the medical and nursing teams. Mr X was discharged with 24-hour care and robust support from their community matron and received palliative care for the final 36 hours of his life, supported by the community matron. Mr X died on 21 July 2022.
3.5	Mrs X highlighted the excellent care received from the rapid response, virtual ward and multi-agency teams and felt their invaluable contribution should be recognised. As her legacy to her husband, Mrs X suggested that a hospital passport system should be implemented at the Trust. She explained that this scheme had been introduced successfully at the Royal Free Hospital and Barts

	Hospital in London and many other trusts nationally and was endorsed by the Royal College of Nurses. The Care Quality Commission also recommended the use of Hospital Passports, advising that providers needed to ensure that appropriate and reasonable adjustments were made to meet individual needs, in line with statutory obligations. Mrs X recommended that the Board adopted the scheme, as it would greatly support patients with disabilities when they were admitted to the emergency department and would mitigate stress and anxiety for patients and their families. It would also comply with equality legislation which allowed for patients with disabilities to be accompanied by a family member or carer into hospital.
3.6	Mrs X recommended that robust training to increase knowledge on adhering to disability equality legislation and lasting power of attorney, specifically at the point of entry, should be mandatory for all staff. She recounted her experience of indirect discrimination when she attended the emergency department for an injury where she was met by her son, also an employee at the Trust, who was not allowed to wait with his mother. Mrs X stated that she was happy to meet with any member of the Board to discuss the issues raised by her presentation.
3.7	The Chair thanked Mrs X for her open and honest account of her experience at the hospital and gave an undertaking that the hospital passport scheme would be considered for implementation.
3.8	Amanda Gibbon acknowledged the difficult nature of her patient experience and thanked Mrs X for her feedback. as it was important that the issues raised were brought to the attention of member of the Board. She also noted that the same considerations given to patients and families at the beginning of life should be applied to those at the end of life, particularly on admission to the hospital.
3.9	Clare Dollery reported that hospital passports were in use in some areas of the hospital but not across the entire organisation, and this would be reviewed to understand why the scheme had not been adopted universally. She empathised with Mrs X as she had experienced a similar situation at a different NHS trust. **The Trust Board thanked Mrs X for her patient story and gave its assurance that members of the Board would meet with her separately to resolve the issues raised.**
4.	**Chair's report**
4.1	The Chair presented her report. On behalf of the Board, she thanked all staff who continued to work ceaselessly to minimise the impact of industrial action taken by junior doctors, particularly the consultant body who covered shifts to ensure continuity of care for patients.
4.2	The Chair highlighted her visit with Rob Vincent to the Lordship Lane Health Centre to meet two service teams - a proactive multidisciplinary team and a district nursing team. The visit also provided an opportunity to say thankyou and bid farewell to Varda Lassman, Associate Director of Nursing, who was

	leaving the Trust to join Homerton Hospital NHS Trust.
4.3	The Chair reported that she and Glenys Thornton had undertaken a thorough review of their parliamentary memberships and amended their declarations of interests accordingly.
4.4	The Chair advised that preparations for the 11-14 April junior doctors' industrial action were in progress at the Trust and across the North Central London system. Significant operational pressures were expected as the strike would coincide with the end of the Easter holidays, Ramadan and the end of Passover. The support provided by staff during this difficult time was welcomed. **The Trust Board noted the Chair's report.**
5.	**Chief Executive's report**
5.1	Helen Brown summarised her report and added her thanks to all staff who supported the hospital during the first junior doctors' strike. She noted, in particular, the hard work undertaken by Clare Dollery, Norma French and Dale-Charlotte Moore, who worked tirelessly to prepare for the impact of industrial action.
5.2	Helen Brown reported on the Care Quality Commission's (CQC) unannounced inspection of Simmons House, which was primarily focussed on safeguarding matters. The initial feedback was broadly positive with some immediate actions being taken in areas highlighted.
5.3	Helen Brown highlighted the unannounced CQC inspection of maternity and neonatal services in January. The Trust had received the draft report which was being reviewed for factual accuracy. A final report would be published shortly after the Easter period.
5.4	Helen Brown also confirmed that the results of NHS staff survey had been released. The Trust was on the average quartile, as a whole. An action plan was being developed to respond to the key findings and to also focus on staff experience and wellbeing. Progress would be reported through the Workforce Assurance Committee.
5.5	Helen Brown thanked Kevin Curnow and the finance team for the hard work undertaken to prepare the 2023/24 annual plan submission. She also drew attention to the good engagement work across the Trust to develop its green sustainability plan.
5.6	Amanda Gibbon acknowledged the positive impact that virtual wards had on patient flow, but she also noted that virtual wards were still reliant on physical staff who were required to visit patients in their homes. She queried whether more could be done to support staff with parking issues across local boroughs. Helen Brown explained that the issue of parking for community staff had been raised with local authority colleagues and was particularly relevant with the advent of low traffic zones. She confirmed that discussions would be taken

	forward with local authority counterparts. In addition, work would be undertaken on travel and transport, as part of the Trust's green sustainability plan, to explore ways in which community staff could manage their visits in the best way possible. The Chair queried whether there was more that could be done with the help of the North Central London Integrated Care Board (ICB). Helen Brown confirmed that travel and transport would be taken forward at ICB level and was being led by Central London Community Healthcare NHS Trust, which had carried out similar significant work in the North West London sector.
5.7	Naomi Fulop highlighted specific issues with remote home monitoring technology, which was widely used in the virtual ward model, but was only appropriate for some patients and not a substitute for face-to-face care. Helen Brown concurred, as remote home monitoring was a complementary facet of the virtual ward model and targeted towards specific groups of patients. **The Trust Board noted the Chief Executive's report and recorded that discussions would take place with the leaders of Haringey and Islington local authorities regarding car parking arrangements for community services' staff.**
6.	**Quality Assurance Committee Chair's report**
6.1	Naomi Fulop presented the report and highlighted items where moderate assurance was taken: • The pressure ulcer improvement program update found that the number of category 3 and 4 pressure ulcers had reduced. There had been an overall increase in the incidence of pressure ulcers during quarter 3. • Performance in meeting national response times for complaints was still below target. • The standard for administering pain relief in the sickle cell service had not yet been met.
6.2	The Committee had welcomed a presentation on the Bliss Baby Charter which outlined the findings of the self-assessment of the quality of family-centred care against seven core principles. The Trust had received a bronze and silver accreditation and plans were in place to achieve a gold accreditation.
6.3	Naomi Fulop highlighted the three key risks for the attention of the Trust Board: • The review and updating of out-of-date policies which was picked up by the CQC during the inspection of maternity services. • The continued high demand for services remained a challenge, particularly in the emergency department. • The impact of industrial action by junior doctors.
6.4	The Chair noted that pressure ulcers continued to be a challenge at the Trust and sought assurance on the action taken to address these ongoing issues. Deborah Clatworthy acknowledged that progress was slow, and although the number of pressure ulcers remained high, the severity of pressure ulcers cases had improved. She outlined measures being taken to address the issues.

	These included the Pressure Ulcer Working Group, which would continue to monitor and report on the progress achieved, a refresh of the "back to the floor" model and a review of equipment, closing the gaps in knowledge and mandatory training compliance for healthcare support workers and improved quality of documentation.
6.5	Clare Dollery informed the Board that the audits of the sickle cell service and fracture neck of femur related to the speed of analgesic administration within the emergency department. She provided assurance that the fracture neck of femur service was broadly compliant with audit findings, particularly around time to operation and overall outcomes.
6.6	Rob Vincent stated that his visit to the Lordship Lane Health Centre underlined the assertion that the identification of pressure ulcers was as much the responsibility of community care staff as well as acute services' staff. **The Trust Board noted the Chair's assurance report for the meeting held on 8 March 2023 and agreed the following actions:** • **an update be provided on sickle cell disease at the May 2023 Quality Assurance Committee meeting** • **a report on pressure ulcers be reported to the July 2023 Quality Assurance Committee meeting** • **an update on progress with implementing actions from the end-of-life care audit be presented at the May 2023 Quality Assurance Committee meeting**
7.	**Integrated Performance Report**
7.1	Jonathan Gardner presented the report. He highlighted the following areas: • There had been an upward trend in mixed sex breaches for the year. • There were marginal improvements made on complaints response times. • 14-day performance on cancer was at 43% a decline from 44% in December 2022. • A reduction in the 28-day faster cancer diagnosis from 69% in December 2022 to 61% in January 2023. A significant number of patients had breached the target in the gynaecology and urology services. • Overall, performance against the 62-day cancer target had dropped back to 39% in January. However, the 62-day backlog remained ahead of trajectory. • The Trust recorded one incident of clostridium difficile in February. • There was a general decline on the referral to treatment position. The number of patients who had waited longer than 52 weeks saw a small increase of 28 patients. The 78-week position had reduced to 18 patients and the target was to reduce this to zero by the end of April. • Diagnostic standards stood at 88%, an increase of 4% since January. • The emergency department continued to face significant pressure in February. • Elective recovery activity during February was at 105% of 2019/20 performance.

7.2	Vanessa Cooke delivered a presentation on waiting times in Children's and Young People's Community Services. She explained that the challenges faced in the service were similar to those being experienced across the health service - an increase in demand and workforce challenges - coupled with variation in commissioned services. Vanessa Cooke reported that waiting times across the service had not changed dramatically over the year. She confirmed that several initiatives had been implemented to address long waiting times and had successfully reduced waiting lists in the audiology service in Barnet and Enfield. The lessons learnt from this approach in Barnet and Enfield would be taken forward and included in action plans for Haringey, Islington and Camden. Vanessa Cooke also reported that the Barnet Therapy Service had been transferred to the Whittington Hospital. This action had reduced the overall numbers waiting for first appointments and had increased staffing stability across the service.
7.3	Vanessa Cooke outlined specific problems in areas which were less successful in dealing with current challenges. She reported that the health visiting service had been adversely impacted by the shortage of health visitors, long waits remained in place for autism and attention deficit hyperactivity disorder (ADHD) assessments and that therapy services across the North Central London sector, particularly for speech and language therapy, continued to have long waiting times for assessment and intervention. In reply to a question from Amanda Gibbon, she confirmed that a number of interventions were in place and improvements were expected by April 2023.
7.4	**The Board noted the integrated performance report and the presentation on waiting times in the Children & Young People Services. The Trust Board agreed the following actions:** • **an update be provided to the September Quality Assurance Committee and Board meetings on progress in reducing wating times for autism and ADHD assessments.** • **a timetable for integrated clinical support units to report on performance against trajectories for backlogs be provided to the May Board meeting.**
8.	**Finance, capital expenditure and cost improvement report**
8.1	Kevin Curnow reported that, at the end of February, the Trust had a deficit of £2.1m, which was below plan. He confirmed that there was a good degree of assurance that the forecast breakeven position would be achieved by the end of the financial year, through technical adjustments and non-recurrent payments. Kevin Curnow confirmed that £17.56m of the capital programme had been spent and that some schemes had been brought forward to utilise some of the allocated funding in the current financial year. The Trust also maintained a strong cash position of £77m.
8.2	Kevin Curnow advised that financial planning for 2023/24 had not yet concluded and the Trust's submission to the North Central London system was under review. He reported that the Trust was expected to deliver a breakeven

	position for 2023/24 which would be difficult to achieve, particularly given inflationary and other pressures.
8.3	Naomi Fulop sought clarification on the NHS pay deal and its potential implications for Trust finances. Kevin Curnow explained that guidance had been received and, although a final agreement between the Department of Health and Social Care and trade unions was yet to be confirmed, the Trust would plan to accrue for the settlement that had been publicised and included a non-consolidated pay award for staff for 2022/23, estimated at £8.5m for the Trust. He also clarified that funding for the 2023/24 element of the proposed pay deal was yet to be confirmed. **The Trust noted the finance and capital expenditure report.**
9.	**Audit and Risk Committee Chair's assurance report**
9.1	Rob Vincent summarised the report, which detailed key points from the meeting held on 23 March 2023. He explained that the Committee considered internal audit reports which had provided significant assurance on risk management and the board assurance framework and staff health wellbeing & engagement, the latter report had been remitted to the Workforce Assurance Committee.
9.2	The Committee considered the timetable for the end of year accounts with external auditors and noted the work taking place to agree the draft accounts before the Committee's 20 June meeting,
9.3	Rob Vincent drew attention to the Committee's terms of reference, which had been reviewed in line with good governance practice and the quarter four Board Assurance Framework. **The Trust Board noted the Audit and Risk Committee Chair's assurance report for the meeting held on 23 March 2023 and approved the updated terms of reference.**
10.	**Charitable Funds Committee Chair's Assurance report**
10.1	Amanda Gibbon presented the report of the Committee's 21 February meeting. She thanked Sam Lister for his work on refining and improving the process for the Charity. She highlighted the annual impact report in the appendix, which outlined work undertaken by the Charity for the year.
10.2	Amanda Gibbon reported that the Committee had agreed to hold a Board seminar or separate meeting to raise awareness of the relationship between the Charity and its corporate trustees. **The Trust Board noted the Charitable Funds Committee Chair's report and agreed that the responsibilities of corporate trustees for the Charity be considered at the Board meeting in May.**
11.	**Workforce Assurance Committee Chair's Assurance report**
11.1	Rob Vincent highlighted discussions from the Committee meeting on 25

	January 2023. He drew attention to preparations to minimise the impact of industrial action, good outcomes from the healthcare support workers' recruitment event held in mid-December 2022, and the focus on health inequalities in the 2023/24 planning guidance. Rob Vincent also reported on the welcome testimonials from the first cohort of staff on the grades 2-7 career development programme.
11.2	In response to a question on the final number of staff vaccinations, Norma French highlighted the figures included within the Chief Executive's report – 40.9% of staff received the influenza vaccine and 41.1% had the Covid-19 vaccine. She recognised that staff vaccination levels were lower than the previous year and provided assurance that preparations for the 2023/24 staff vaccination campaign had begun. **The Trust Board noted the report.**
12.	**Questions from the public**
12.1	The Chair confirmed that questions had been received from a member of the public relating to items on the agenda. One of the questions asked whether staff sickness data included sickness related to the menopause. A written response had been sent which explained that the Trust had run Menopause Cafes for staff in the past and was working to resurrect these going forward, alongside a policy aligned to guidance issued by NHS Employers.
14.	**Any other business**
14.1	There were no other business items reported.

Trust Board, 30 March 2023 public Board action log

Agenda item	Action	Lead(s)	Progress
Patient story	Hold a face-to-face meeting with the patient's family to provide an update on the implementation of the hospital passport initiative at Whittington Health	Sarah Wilding	A meeting date has been set with the family
Chief Executive's report	Liaise with the leaders of Haringey and Islington local authorities regarding parking for staff during industrial action	Helen Brown	Discussions have begun with both Islington and Haringey
Quality Assurance Committee (QAC) Chair's report	Provide an update on pressure ulcers to the July QAC meeting	Sarah Wilding	In hand for the July Committee meeting
	Provide an update on sickle cell disease to the May QAC meeting	Clare Dollery and Chinyama Okunuga	Completed
	Provide an update on progress with implementing actions from the end-of-life care audit to the May QAC meeting	Clare Dollery and Sarah Wilding	Completed
Integrated performance report	Provide an update to the QAC meeting and Trust Board in September regarding progress in reducing waiting times for autism and ADHD assessments	Vanessa Cooke and Chinyama Okunuga	In hand for September 2023 meetings
	Provide the 2023/24 timetable for ICSUs to report on performance and trajectories for waiting times' backlogs to the next Board meeting	Chinyama Okunuga	Completed – see addendum to these minutes
Charitable Funds Committee Chair's report	Hold a discussion at the May Board seminar on the relationship with corporate trustees	Jonathan Gardner	Completed – separate trustees' meeting taking place on 24 May

Action log addendum

2023/24 Integrated Clinical Service Units' Board schedule

Month	Service	Integrated Clinical Service Unit
June 2023	***Cancer***	Surgery & Cancer
	Breast	
	Upper Gastrointestinal	
July	***Cancer***	
	Gynaecology	
September	***Emergency Department***	Emergency & Integrated Medicine
	4 hr standard	
	12 hour waits	
	Ambulance handover delays	
October	***RTT***	Surgery & Cancer
	Long waits	Acute Patient Access, Clinical Support Services and Women's Health
	Appointment slot issues	Emergency & Integrated Medicine
	Outpatients	
November	***DMO1***	Acute Patient Access, Clinical Support Services and Women's Health
	MRI	
	CT Scans	
December	***DMO1***	Children and Young People
	Audiology	
January 2024	***Community waits***	Adult Community Services
February	***Emergency Department***	Emergency & Integrated Medicine
	4 hr standard	
	12 hour waits	
	Ambulance handover delays	
March	***Referral to treatment***	Surgery & Cancer
	Long waits	Acute Patient Access, Clinical Support Services and Women's Health
	Appointment slot issues	Emergency & Integrated Medicine
	Outpatients	

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2023**
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 in March.	
Purpose	Noting	
Recommendation	Board members are asked to note the report.	
Board Assurance Framework	All entries	
Report history	Report to each Board meeting held in public	
Appendices	None	

Chair's report

This report updates Board members on activities since the last Board meeting held in public.

March and April private Board meetings and April Board seminar
The Board of Whittington Health held private meetings on 30 March and 28 April. Agenda items discussed at the March meeting included an update on fire remediation work and the private finance initiative building, a draft 2023/24 operational plan submission, draft 2023/24 corporate objectives and a Chair's assurance report for the Finance and Business Development Committee meeting held on 21 March. The April meeting covered a further update on fire remediation, a finance report for the position as of 31 March and the integrated performance report. It also approved the 2023/24 corporate objectives and noted annual declarations in respect of safeguarding for adults and children and for mixed gender accommodation.

The April Board seminar discussed a draft self-assessment analysis against the key lines of enquiry in the well-led framework and a draft 2023/24 board assurance framework.

Wingman memorial
On 19 April, I joined staff for a memorial to Debbie Saunders, a member of the Project Wingman team, who ran the Wingman lounge during the pandemic. The Wingman Lounge was an invaluable support for tired hospital staff during the pandemic, with 93% of hospital staff praising Project Wingman's services during the first wave of COVID-19. In May 2022, the incredible Wingman team were recognised for their extraordinary generosity and efforts at the Staff Awards, receiving the Chair's Award.

Corporate induction and Medical Committee
On 17 April, I took part in corporate induction training to welcome new starters and, on 26 April, I attended the Medical Committee's meeting.

Consultant recruitment panels
Since the March Board meeting, I am grateful to Amanda Gibbon, Vice-Chair, for participating in the following recruitment and selection panels for a consultant posts:

Post title	Non-Executive Director	Selection panel date
Consultant Breast Radiologist	Amanda Gibbon	4 April 2023
Consultant Paediatrician (Diabetes)	Amanda Gibbon	2 May 2023
Consultant Radiologist (Cross Section & MSK-CDC)	Amanda Gibbon	9 May 2023

North Central London Integrated Care Board
On 15 May, I attended the meeting of the Integrated Care Board for the North Central London.

Partnership Development Committee
On 16 May, I chaired the first meeting of the Partnership Development Committee-in-Common between University College London Hospitals NHS Foundation Trust and Whittington Health.

Industrial action
I was involved in meetings with Whittington Health and North Central London system colleagues to be updated on preparations for industrial action.

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2023**
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 national and local developments since the last meeting held in public in March 2023. Board members are also presented with an updated 2023/24 Board Assurance Framework and the annual provider licence self-certifications.	
Purpose	Noting	
Recommendation	Board members are invited to note the report and the 2023/24 Board Assurance Framework and to review and approve the provider licence self-certifications for 2022/23	
Board Assurance Framework	All Board Assurance Framework entries	
Report history	Report to each Board meeting held in public	
Appendices	1: 2023/24 Board Assurance Framework 2: 2022/23 Provider licence self-certifications	

Chief Executive's report

Industrial action

The Trust and North Central London system partners were involved in preparations for the industrial action by the Royal College of Nurses (30 April to 1 May) and by junior doctors (11-14 April). In general, services managed to mitigate the impact well and good partnership working continued with staff side representatives. In addition, staff managed the impact of industrial action taken by teachers on 27 April and 2 May well within individual team rosters. I am grateful for the hard work and dedication shown by so many staff, including in the executive team, to ensure that disruption as a result of the industrial action was kept to a minimum at Whittington Health. Ballots for further action are planned by the Royal College of Nursing and the British Medical Association and the Trust is taking forward plans to prepare for further disruption to services caused by more strikes.

NHS pay offer

Following national negotiations between the Government and NHS trades unions, the pay award for all staff on the Agenda for Change pay and conditions of service (the vast majority of substantive staff with the exception of doctors and dentists who are on a different pay scale) will have their new rates of pay and arrears paid in the pay run on 27 June 2023. Colleagues on agenda for change will receive a further uplift in their consolidated pay as well as a one-off non-consolidated 'NHS backlog bonus' which recognises the sustained pressure facing the NHS following the pandemic and the extraordinary effort staff have been making to hit backlog recovery targets. Staff in receipt of universal credit payments will be given the option of having the lump sum payment for 2022/23 paid in monthly instalments over a six-month period to minimise any immediate impact on their universal credit payments which are assessed from month to month.

NHS London Regional Director

I would like to congratulate Caroline Clarke, Chief Executive of the Royal Free London Foundation Trust, on her appointment as the new NHS London regional director. I would also like to congratulate Pete Landstrom who is now the Royal Free London's acting Group Chief Executive.

Care Quality Commission

On 28 April, the Care Quality Commission (CQC) published its report of the inspection of maternity services on 23-24 January. The report includes both positive findings and areas for improvement. The CQC rated our maternity service as 'good' for Well-Led, as 'requires improvement' for Safety and as 'requires improvement' overall. Our overall hospital site and trust ratings remain as 'Good'. While there is much to be proud of in the inspection report, the Trust has asked the CQC for a review of the overall rating for the service by the CQC. This is because the January 2023 inspection assessed the maternity service on only two of the CQC's domains and the Trust believes that the 'Good' ratings from the 2016 inspection for the other three domains (effective, caring and responsive) should be taken into account in the overall rating of the service.

NHS 2023/24 priorities and planning guidance submission
The North Central London Integrated Care System has held star chamber challenge sessions on individual organisation's proposed financial, activity and workforce planning submissions for 2023/24. Whittington Health reviewed and updated its final submission on 4 May which had a surplus of £2m.

2023/24 Board Assurance Framework
The Board Assurance Framework contains the principal risks to the delivery of Whittington Health's strategic objectives. April's Board seminar reviewed the risk descriptors for entries on the Board Assurance Framework, reflecting updates to the Trust's strategic objectives. After further comments and feedback, the revised document is shown at appendix 1 for approval.

NHS Provider Licence
The Trust Board is required by NHS England complete a self-certification of its governance. The Board is asked to certify that the Trust complies with Condition G6 (3) and Condition FT4 (8) as set out below:

Directions from the Secretary of State requires NHS England to ensure that NHS Trusts comply with the Conditions G 6 (3) and Condition FT4 (8) as it deems appropriate. NHS Trusts are also required to confirm that they have complied with governance requirements.

The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and are required to self-certify under these conditions (which are set out in the NHS provider licence). The licence includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution.

The Board is asked to certify compliance with the following conditions which are required by NHS England under the NHS Provider Licence, Health and Social Care Act 2012 and NHS Constitution with regard to:

- Licence Condition G6 (3) - the provider has taken all precautions necessary to comply with Condition G6 (3) of the licence, NHS Acts and NHS Constitution.
- Licence Condition FT4 (8) – the provider has complied with required governance

Following review by the executive team, the Trust intends to make a positive confirmation on these licence conditions and Board members' approval is sought for these declarations for 2022/23 before they are included on our external webpages.

International Day of the Midwife and International Nurses' Day
On 5 May, Whittington Health marked the International Day of the Midwife by celebrating the profession and recognising the valuable contribution our maternity service's team's work makes to maternal and new-born health. On 12 May, the Trust held an event which included a Nursing and Midwifery awards ceremony and special guest speakers including Chris Caldwell, Chief Nurse, North Central London

Integrated Care Board, and Huda Mohamed, our female genital mutilation specialist midwife who shared their nursing journeys.

Bright Start Islington

Bright Start Islington, a collaboration between The London Borough of Islington, Whittington Health, University College London Hospitals NHS Foundation Trust and voluntary sector partners launched their 2023-28 strategy for maternity and early years[1]. The strategy was developed in partnership with maternity, early childhood services and parents and carers, and identifies their priorities and pledges over the next five years, which include increasing accessibility, reach and inclusion and developing their workforce - all which support their mission to improve outcomes for families, and help ensure all children in Islington to have the best start in life.

[1] Bright Start Strategy 2023 28 | Islington Council

Appendix 1: 2023/24 Board Assurance Framework

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
Quality 1 – quality and safety of services	Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients and families, due to errors, or lack of care or lack of resources and insufficient quality improvement focus, results in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation	4	5	20	4	Chief Nurse / Medical Director
Quality 2 – capacity and activity delivery	Due to a lack of capacity, capability, and clinical attention and continuing pressures, there is an inability to meet elective recovery and clinical performance targets, resulting in a deterioration in service quality and patient care such as: • long delays in the emergency department and an inability to place patients to appropriate beds • patients not receiving the timely care they need across hospital and community health services • patients on a diagnostic and/or treatment pathway at risk of deterioration and the need for greater intervention at a later stage • rollout of the Covid-19 pandemic booster and winter flu vaccination programmes not being as successful as in previous years	4	5	20	4	Chief Operating Officer / Chief Nurse / Medical Director

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

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
Integration 1 – ICB/S and Alliance changes	Lack of system clarity, or specific changes brought about by national policy, a still maturing ICB, and an emerging provider alliance, (such as corporate services' rationalisations, Fuller report, community services review, "Start Well" review, and pathway reconfiguration), may result in unclear governance decisions and difficulty in strategic planning which impact adversely on patient services, particularly fragile ones, and the strategic viability of the Trust	4	3	12	8	Chief Executive / Director of Strategy & Corporate Affairs
Integration 2 – population health and activity demand	Local population health and wellbeing deteriorates, due to the impact of the pandemic, because of a lack of available investment in, or focus on, either ongoing care and prevention work or work to reduce health inequalities, and due to unsuccessful collaboration with local sector health and social care partners, results in continued high demand for services which is insufficiently met	4	3	12	8	Director of Strategy & Corporate Affairs
Sustainable 1 – control total delivery and underlying deficit	Adverse funding arrangements regionally or nationally; or failure to a) manage costs, b) reduce the run rate, c) properly fund cost pressures, due to poor internal control systems, or inability to transform services and deliver the cost improvement programme savings, or due to insufficient flexibility under a block contract along with North Central London system and provider alliance changes, result in an inability deliver the annual control	4	5	20	8	Chief Finance Officer

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
	total, a deterioration in the underlying deficit for the Trust, increased reputational risk and pressure on future investment programmes, or cancellation of key Whittington Health investment projects, and improvements in patient care and savings not being achieved					
Sustainable 2 – estate modernisation	The failure of critical estate infrastructure, or continued lack of high-quality estate capacity, due to insufficient modernisation of the estate or insufficient mitigation, results in patient harm, poorer patient experience, or reduced capacity in the hospital	4	4	16	8	Chief Finance Officer
Sustainable 3 – digital transformation and interoperability	Failure by the Trust to effectively resource and implement a digital strategy and resilient systems focussed on improving patient care through efficient, digitally enabled processes, and underpinned by a modern secure, standards-based infrastructure, will adversely impact on availability of clinical information, delivery of key transformation projects across the organisation and our ability to be an effective system partner and leader	3	3	9	6	Director of Strategy & Corporate Affairs

Appendix 2: 2022/23 Provider Licence self-certifications

Background

The NHS provider licence[2] forms part of the oversight arrangements for the NHS and sets out the conditions which providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future. The NHS provider licence was first introduced for NHS foundation trusts in 2013 and extended to NHS trusts from April 2023.

NHS trusts to self-certify on an annual basis whether or not they have met the two conditions outlined in the table below (foundation trusts have a third declaration to make which relates to training for governors):

NHS licence provider condition	Self-certification requirement
Condition G6(3)	The provider has taken all precautions necessary to comply with the Licence, NHS Acts and NHS Constitution
Condition FT4(8)	The provider has complied with required governance arrangements

NHS provider licence conditions

Condition G6 requires providers to:

- have effective processes and systems in place that identify risks to compliance with the conditions of the provider licence, any requirements imposed on it under the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services;
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring; and
- annually review, whether these processes and systems are effective.

The Board of Directors are invited to review the requirements of Condition G6 and confirm, or not confirm, the following self-certification statement:

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and has had regard to the NHS Constitution.

[2] PRN00191-nhs-provider-licence-v4.pdf (england.nhs.uk)

Condition FT4 requires providers to review whether their governance systems meet the standards and objectives in the condition; compliance requires effective Board and Committee structures, reporting lines and performance and risk management systems.

The following table (Table 1) outlines the requirements of Condition FT4. To self-certify, the Board are invited to confirm compliance, or otherwise, as at the date of the Board's review and for the future financial year. A proposed response to each requirement ('confirmed'/'not confirmed') is set out in Table 1, along with any identified risks and mitigating actions

Table 1 – Proposed self-certification responses

Condition FT4 key statement	Response	Risks/mitigating actions
1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust is implementing internal audit recommendations.
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	Confirmed	Minimal risk – see Board Assurance Framework (BAF)
3. The Board is satisfied that the Trust implements: a) Effective Board and committee structures b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c) Clear reporting lines and accountabilities throughout the organisation.	Confirmed	Minimal risk – see BAF
4. The Board is satisfied that the Trust effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board (now NHS England) and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	Confirmed	Minimal risk – see BAF

Condition FT4 key statement	Response	Risks/mitigating actions
e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.		
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Minimal risk – see BAF
6. The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Minimal risk – see BAF

Evidence and assurance in support of the positive confirmation for the G6 and FT4 licence conditions is shown below

Section 1: General licence conditions			
No.	**Licence condition**	**Explanation**	**Board assurance/evidence**
G1	Provision of information	Licensees are required to provide NHS Improvement with any information they may require for licensing functions	The Trust has robust data collection and validation processes and has a good track record of producing and submitting large amounts of accurate, complete and timely information to regulators and other third parties to meet specific requirements.
G2	Publication of information	Licensees have an obligation to publish such information as NHS Improvement may require, in a manner that is accessible to the public	The Trust is committed to operating in an open and transparent manner and is working to strengthen and develop this aspect of the Trust's governance as a corporate priority. The Board meets in public and will continue to undertake the vast majority of Trust business in public meetings; agendas, minutes and associated papers are published on our website. The Trust website contains a variety of information and referral point details providing advice to the public and referrers who may require further information about services. Copies of the Trust's Annual Report and Accounts and Quality Account are routinely published on the website.
G3	Payment of fees to NHS Improvement	The Health & Social Care Act (2012) gives NHS Improvement the ability to charge fees each financial year and licensees are obliged to pay them upon request	No decision has yet been made by NHS Improvement to charge fees, however, any obligation to pay fees and will be accounted for within the Trust's financial planning.

			The Trust does also pay fees to other parties such as the Care Quality Commission and NHS Resolution.
G4	Fit and proper persons	This condition prevents licensees from allowing unfit persons to become or to continue as directors	All Trust Directors are required to sign an annual declaration that they are a fit and proper person, in line with organisational policy and good evidence for compliance with well-led arrangements.
G5	NHS Improvement guidance	Licensees are required to pay due regard to any guidance issued by NHS Improvement	The Trust has had regard to NHSI guidance through submission of required annual and quarterly declarations, annual self-certifications and annual workforce race equality standard submissions and also when developing its annual operational and capital plans.
G6	Systems for compliance with licence conditions and regulated obligations	Licensees are expected to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements	The Trust has an approved risk management strategy in place which sets out its approach to identifying, managing and escalating risks. The strategy is reviewed annually. It also has a comprehensive and recently reviewed Board Assurance Framework. The effective management of risks is monitored by the Trust Management Group, respective Board Committees for relevant risks and by the Trust Board.
G7	Registration with the Care Quality Commission (CQC)	Providers are required to be registered with the CQC and to notify NHS Improvement if registration is cancelled	The Trust is registered with the CQC for the services it provides and has no current enforcement notices in place. The Trust's CQC rating remains as Good overall.
G8	Patient eligibility and selection criteria	Licence holders are required to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner	The Trust publishes descriptions of the services it provides on the Trust website. Eligibility is defined through commissioners' contracts and is clear the on choose and book electronic / referral system.
G9	Continuity of services	This condition applies to all licensees. It sets out the conditions under which a service will be designated as a Commissioner Requested Service.	Similar to the previous Mandatory Services, Commissioner Requested Services continue to be set within the contracts agreed with commissioners which are reviewed annually as part of the annual planning

		Licensees are required to notify NHSI at least 28 days prior to the expiry of a contractual obligation if no renewal or extension has been agreed. Licensees are required to continue to provide the service on expiry of the contract until NHSI issues a direction to continue service provision for a specified period or is advised otherwise. Services shall cease to be Commissioner Requested Services (CRS) if: • commissioners agree in writing that there is no longer a service need and the regulator has issued a determination in writing that the service is no longer a CRS; • three years have elapsed since the 1 April 2013 or one year has elapsed since the commencement of the license, whichever is the latter; or • the contract to provide a service has expired and the direction notice issued by NHSI specifying a further period of provision has expired. • Licences are required under this Condition, to notify NHSI of any changes in the description and quantity of services which they are under contractual or legal obligation to provide.	and contract negotiation process. No services are formally designated as Commissioner Requested Services under the terms of the License and the Trust commits to notifying NHSI as per this condition. The Trust has strong working relationships with its commissioning (and provider) partners within the local North Central London Integrated Care System. This was especially evidenced by collaborative working as part of the sector's response to the Covid-19 pandemic, and by the Trust playing a full role within its local health and care system, particularly through its membership of the University College London Health Alliance. The Board has a director responsible for leading on contract negotiations and Chair and executive team continually work on developing and improving stakeholder engagement. The Trust has a strong track record of delivering service transformation, efficiency and quality improvement to meet the needs of the local population to help them live longer, healthier lives.

Section 2: Pricing			
No.	**Licence condition**	**Explanation**	**Board assurance/evidence**
P1	Recording of information	Under this condition, NHSI may oblige licensees to record information, particularly information about their costs, in line with published guidance.	The Trust notes this condition. The Trust records all of its information about costs in line with current guidance and would comply fully with any new guidance.
P2	Provision of information	Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to NHSI.	The Trust notes this condition. The Trust intends to comply fully with any new requirements to submit information to NHSI.
P3	Assurance report on submissions to NHSI	When collecting information for price setting, it will be important that the submitted information is accurate. This condition allows NHSI to oblige licensees to submit an assurance report confirming that the information that they have provided is accurate.	The Trust would comply with this condition, as the requirement arose.
P4	Compliance with the national tariff	The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the national tariff for NHS health care services. This licence condition imposes a similar obligation on licensees, i.e. the obligation to charge for NHS health care services in line with the national tariff.	The Trust complies with this condition through either following national tariff guidance or local tariff arrangements, agreed with commissioners and reported appropriately.
P5	Constructive engagement concerning local tariff modifications	The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to NHSI for a modification.	The Trust complies with this condition and engages actively and constructively with its respective commissioners.

Section 3: Choice and competition			
No.	**Licence condition**	**Explanation**	**Board assurance/evidence**
C1	Patient Choice	This condition protects patients" rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice under the NHS Constitution, or where a choice has been conferred locally by commissioners.	The Trust complies with guidance through its policies and procedures and has made information available via the Choose and Book directory of services, NHS Choices and its website.
C2	Competition Oversight	This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct that has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	No compliance issues have been identified. All licensed provider organisations will be treated as "undertakings" under the terms of the Competition Act 1998. This means that all licensed providers will be deemed to be organisations engaging in an "economic activity" for which the provisions of the Competition Act will apply. Licensed providers therefore need to comply with the Competition Act. The Board and Executive Management team has access to expert legal advice to ensure compliance with this condition.

Section 4: Integrated Care			
No.	**Licence condition**	**Explanation**	**Board assurance/evidence**
IC1	Enable the provision of integrated care	The licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care	The Trust is an active participant in the local north central London health economy and is working in partnership with commissioners and providers to take forward models of integrated care such as the NCL STP. Integrated care remains a core element of the Trust's 2019/24 strategy and has a strong

			track record of working on integrated care pathways with other providers.

Section 5: Continuity of services			
No.	**Licence condition**	**Explanation**	**Board assurance/evidence**
COS1	Continuing provision of Commissioner Requested Services	This condition prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provides Commissioner Requested Services, without the agreement of relevant commissioners.	The Trust complies with this condition – see G9 above.
COS2	Restriction on the disposal of assets	This licence condition ensures that licensees keep an up to date register of relevant assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain NHSI"s consent before disposing of these assets when there are concerns about the ability of the licensee to carry on as a going concern.	The Trust maintains a capital asset register for all depreciable assets, a register of all its contracts and a property and property leases' register.
COS3	Standards of Corporate Governance and Financial Management	This condition requires licensees to have due regard to adequate standards of corporate governance and financial management. The Risk Assessment Framework will be utilised by NHSI to determine compliance	The Trust has an overarching corporate governance framework through its standing orders, standing financial instructions and reservation of powers to the Board and those it has delegated. The Trust has well developed systems of corporate and financial risk management as evidenced by the annual governance statement, head of internal audit opinion, CQC inspection (well-led), internal and external audit reports.
COS4	Undertaking from the ultimate controller	This condition requires licensees to put in place a legally enforceable agreement with their „ultimate controller" to stop ultimate controllers from taking any action that would cause	Not applicable – this licence condition does not apply as the Trust is a public benefit organisation and neither operates nor is

		licensees to breach the license conditions. This is best described as a „parent/subsidiary company" arrangement. **If no such controlling arrangements exist then this condition would not apply.** Should a controlling arrangement come into being, the ultimate controller will be required to put in place arrangements to protect the assets and services within 7 days.	governed by an ultimate controller arrangement
COS5	Risk pool levy	This licence condition obliges licensees to contribute, if required, towards the funding of the „risk pool" – this is like an assurance mechanism to pay for vital services if a provider fails.	The regulatory risk pool has not yet arisen. The Trust currently contributes to the NHS Resolution risk pool for clinical negligence, property expenses and public liability schemes.
COS6	Co-operation in the event of financial distress	This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with NHSI and any of its appointed persons in these circumstances in order to protect services for patients.	Financial performance is monitored by the Board, Finance & Business Development and Trust Management Committees and by NHS Improvement. The latter has assessed the Trust as in segment two of the Single Operating Framework.
COS7	Availability of Resources	This licence condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.	The Trust has forward plans and contract agreements with commissioners which cover this condition. A going concern assessment is made annually as part of the external audit review of the annual report and accounts.

Section 6: Foundation Trust conditions (NHS trusts are asked by NHSI to demonstrate how they would comply with this condition even if they are not yet Foundation Trusts)			
No.	**Licence condition**	**Explanation**	**Board assurance/evidence**
FT1	Information to update the register of NHS Foundation Trusts.	This licence condition ensures that NHS Foundation Trusts provide required documentation to NHSI. NHS Foundation Trust Licensees are required to provide NHSI with:	The Trust has a record of compliance with provided regulators with required information. Through the Audit & Risk Committee, the Board monitors the preparation and

		• a current Constitution; • the most recently published Annual Accounts and Auditor's report; • the most recently published Annual Report; and • a covering statement for submitted documents.	submission of the Annual Accounts, Auditor's report and the Annual Report.
FT2	Payment to NHSI in respect of registration and related costs.	If NHSI moves to funding by collecting fees, they may use this licence condition to charge additional fees to NHS Foundation Trusts to recover the costs of registration.	If NHSI required fees to be paid by the Trust, it would comply with such a condition.
FT3	Provision of information to advisory panel.	The Act gives NHSI the ability to establish an advisory panel that will consider questions brought by governors. This licence condition requires NHS Foundation Trusts to provide the information requested by an advisory panel.	Not applicable.
FT4	NHS Foundation Trust Governance arrangements.	This condition will enable NHSI to continue oversight of governance of NHS Foundation Trusts. In summary, licensees are required to: • have systems and processes and standards of good corporate governance; • have regard for the guidance published by NHSI; • have effective Board Committee Structures • have clear accountabilities and reporting lines throughout the organisation and maintain appropriate capacity and capability of the Board;	See COS3 above also. This Trust complies with this condition as demonstrated through the annual governance statement. See fuller details of assurance/evidence provided in appendix 2 overleaf.

		• comply with healthcare standards; • have effective financial management, control and decision making; and • maintain accurate information.	

Self-certification assurance evidence for condition FT4

Key statement	Evidence
1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• Achieved an overall 'Good' rating following the last full CQC service inspection (2019/20) • Annual review of Board Committee terms of reference, standing orders, standing financial instructions and scheme of delegation • Annual Report and Annual Governance Statement, approved by Audit Committee • Partial assurance from the annual Head of Internal Audit opinion • An unqualified external audit opinion on the 2022/23 financial accounts and clean opinions with regard to use of resources, the content of the Quality Account • The Board reviewed the content and structure of the Board Assurance Framework (BAF) and strengthened this to better align with strategic objectives highlighted in the revised 2019/24 Whittington Health strategy, with the focus of Board attention, clarify ownership of risks and enable increased transparency and assurance and communication of its risk appetite • Quarterly review of the Corporate Risk Register by the Quality Committee • Risk management training provided for all new starters and Trust-wide training needs analysis identifies risk management training requirements for specific staff groups (appropriate to grade, role and location) • Annual programme of internal audit – reflective of the risks identified on the Board Assurance Framework overseen by Audit & Risk Committee • Annual clinical audit programme overseen by Quality Committee

Key statement	Evidence
	• Compliance with the requirements of the Data Protection & Security Toolkit, as reported in the Annual Governance Statement and the Quality Account • Mechanisms in place for enabling sharing of lessons learned and review of Serious Incidents • Board of Directors' monthly review of Board Performance report, including performance against regulatory and contractual KPIs and compliance with mandatory training • Robust annual business planning process, including quality impact assessment of cost improvement plans and involvement of key stakeholders, and associated development of annual Operational Plan • Accountability framework for Integrated Clinical Service Units and corporate directorates is being introduced for this financial year
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	• As per Statement 1 above • Completion of well led self-assessment • Annual completion of provider self-certification • Compliance with provision B1.1.2 of the FT Code of Governance (at least half of the Board, excluding the chairperson, should comprise non-executive directors determined by the Board to be independent) • Regular reviews of progress in implementing recommendations for immediate and essential actions which arose from the Ockenden review • Annual Workforce Race Equality Standard and Disability Workforce Equality Standard submissions
3. The Board is satisfied that the Trust implements: a) Effective Board and committee structures b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	• Board of Directors meetings focus on strategy and policy, operational performance, governance and quality, workforce and organisational development • At least an annual review of Board Committee terms of reference • Detailed governance structure in place • Audit Committee's annual self-assessment, in line with Audit Committee Handbook recommendations • Board of Directors' development programme delivered by Deloitte focussed on the unitary Board, effectiveness, risk management, assurance and strategy

Key statement	Evidence
c) Clear reporting lines and accountabilities throughout the organisation	• Executive and Non-Executive Director annual appraisal process (including agreement of objectives and personal development plans). • Board of Directors', Quality Governance Committee and Audit Committee annual work plans • Chairs' assurance reports from Board committees are reviewed and at Board of Directors' meetings • Approval of Annual Governance Statement and wider Annual Report (also see Statement 1)
4. The Board is satisfied that the Trust effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board (now NHS England) and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	• 'Clean' external audit opinion on use of resources • Internal and external audit annual plan – review of completed audits by Audit & Risk Committee • Audit & Risk Committee's receipt of technical updates relating to the health sector from KPMG (external auditors) and other relevant briefings • Regular meeting of Board of Directors and Board committees, enabling timely reporting and sharing of information • Monthly performance reports to Board of Directors including performance against national and local targets, other regulatory requirements, workforce indicators, and patient and staff feedback (i.e. Friends and Family Test) • Monthly Finance reports to Board of Directors Board review of returns to NHS Improvement • Board of Directors' review and approval of annual capital expenditure plans with updates provided on progress • Updates to the Board on contract sign-off and future performance requirements from commissioners • Progress against delivery of Quality Account priorities is monitored by the Quality Committee Board development activities – see Statement 3 above • Local anti-fraud arrangements in place with reports on progress against annual work-plan and any ad hoc anti-fraud work received by the Audit & Risk Committee

Key statement	Evidence
e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.	
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	• Executive job descriptions with clearly defined remits/responsibilities, linked to the Trust's strategic objectives • Director appraisal process - including objective-setting and personal development planning • Board of Directors development activities. • Executive Director visible leadership service visits • Fit and Proper Persons Declarations for Board Directors • Board register of declared interests • Annual Complaints and Compliments Report reviewed by the Quality Assurance Committee • Annual Board reports on patient and staff survey outcomes and associated action plans • Patient Experience strategy agreed by Board with progress reported to the Quality Assurance Committee

Key statement	Evidence
c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	
6. The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	• As per Statement 5 above i.e. pre-employment checks, Fit and Proper Persons self-assessments, appraisals and personal development plans, recommendations from Remuneration and Terms of Service Committee • Medical and nursing revalidation processes • Six monthly safe staffing report to the Quality Assurance Committee • HR policies and procedure reflect legislative and regulatory requirements and best practice

Meeting title	**Trust Board in Public**	**Date:**	**24 May 2023**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item:**	**6**
Committee Chair	Amanda Gibbon, Non-Executive Director		
Executive director leads	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals, and Clare Dollery, Medical Director		
Report author	Marcia Marrast-Lewis, Assistant Trust Secretary		
Executive summary	The Quality Assurance Committee met on 10 May 2023 and was able to take significant or reasonable assurance from the following items considered: • Quarter 4 Quality Report • End of Life Care Report • Sickle Cell Report • Quarter 3 Learning from Deaths Report • Quarters 3 and 4 Maternity Board Report • Maternity Incentive Scheme Gap Analysis & CQC Report • Serious Incident Board report (Feb / Mar) Committee members took moderate assurance from the following agenda items: • Chair's assurance report, Quality Governance Committee • Elective recovery performance • Board Assurance Framework • Risk Register • The Committee also received verbal reports in relation to Complaints, Duty of Candour, Policies and Guidelines Committee noted limited assurance on the Annual Patient Lead Assessment of the Care Environment (PLACE) Report Following discussion, the following five key risks were identified to be reported to the Trust Board: 1. Maternity strategic risks and the rating of Requires Improvement in the recent CQC Report 2. Ongoing impact of industrial action on services 3. Sickle cell service 4. Backlog of waiting lists and admin issues.		

	5. Poor scores received under PLACE annual assessment.
Purpose	Approval
Recommendations	Board members are asked to note: i. note the Chair's assurance report for the meeting held on 10 May 2023
BAF	Quality strategic objective entries and the Integration 2 entry
Appendices	1. Q3 2022/23 Learning from deaths report 2. Q3 & 4 Maternity Board Report 3. Annual Patient Lead Assessment of the Care Environment (PLACE) Report

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	10 May 2023
Summary of assurance:	

1. The Committee confirms to the Trust Board that it took either significant or reasonable assurance from the following agenda items:

Emergency & Integrated Medicine – Better Never Stops Dementia service
The Committee welcomed and took significant assurance from a presentation delivered by Kelly Collins, Associate Director of Nursing, and Tisenia Alombro, Dementia Clinical Nurse Specialist, on progress of improvement work undertaken following the audit of the Dementia Service.

Committee members noted that the service was led by a Dementia Clinical Nurse specialist whose role was to oversee the quality of the dementia and delirium care plans across the service. In addition, they were required to work with the divisional management team to collect data to evidence the level of activity and impact of the role to provide evidence to support the development of dementia care, as well as ensure that adequate programs of education and training were in place and that staff had fulfilled their training expectations.

Committee members welcomed the positive outcomes being achieved in the service, which treated anywhere between 30 and 40 patients with dementia or delirium related conditions. For example, feedback from tier 1 and tier 2 dementia training was positive and staff appreciated the multi-disciplinary approach to the training in place. Anecdotal evidence also suggested that the service had provided patients, friends and family with a good patient experience which would be followed up by the collection of quantitative data.

The Committee was pleased to hear from the Clinical Nurse Specialist who stressed the importance of dementia training for all clinicians as this was key in the delivery of compassionate care and to support appropriate bed placement, particularly for patients with challenging behaviour. She highlighted the "What matters to me" patient passport which was a tool used to better understand the patients needs and which would form the basis of an individual care plan for patients with dementia.

End of Life Care Activity & Strategy Update – May 2023
The Committee considered a report on End of Life Care at the Trust over the previous 12 months. The Committee learned that the Specialist Palliative Care Team cared for 503 patients who died at the hospital during 2022 and that the numbers of referrals to the teams has consistently increased since 2013. The Trust participated in the National Audit for Care at the End of Life (NACEL) in 2021/22 which found that the Trust achieved scores broadly in line with the national average for clinical care, but the Trust was a significant outlier for specialist palliative care staffing. The audit also suggested a renewed focus on staff education and training in palliative and end of life care (PEOLC) was needed. The Committee noted that an appointment of a palliative care clinical nurse specialist had been made who as part of her remit had scheduled

educational study days, some medically led study days would take place later in the year.

The Committee was apprised of specific challenges within the Fast Track Continuing Care pathway where rapidly deteriorating patients or terminally ill patients were not discharged as quickly as they should to allow them to die at home or in their place of choice. A review of the processes around Fast Track would be undertaken so that the standard 12 hour process was facilitated.

Quarter three, 2022/23 Learning from deaths report
The Committee considered the report and noted that during the period 1st October to 31st December 2022 there were 116 adult inpatient deaths reported at Whittington Health (WH) versus 117 in Q2.

23 adult structured judgement reviews (SJRs) were requested for Quarter 3 and 9 of these have been completed and presented at department mortality meetings.

The Summary Hospital-level Mortality Indicator (SHMI) for the data period July 2022 to September 2022 at Whittington Health was 0.88.

A meeting was held in December, with the mortality leads to support teams in the recovery of the SJRs: however, the very significant operational pressures through the winter has continued to challenge teams. Colleagues would continue to be updated on outstanding reviews.

There were 22 deaths within 28 days of a positive COVID-19 test or with COVID-19 on the death certificates. This compares to 20 such deaths in Q2.

A new lead medical examiner had also been appointed as well as a new Medical Examiners Officer.

Maternity Services Board Report
Committee members took good assurance from the report and noted:

- a verbal update in respect of the publication of the Care Quality Commission's (CQC) report on Maternity Services which was assessed as requires improvement.
- The Trust has been written to by NHSR to ask if they would like to review and change the MIS submission in light of the CQC report.
- The Committee noted the Single Delivery Plan which was published in March 2023.
- Baby tagging equipment has now been acquired and would be implemented in due course.
- There were two cases for review under the Perinatal Mortality review tool related to staff access to mental health history, the process had been amended to enable doctors to access maternity medway and the other related to non-adherence of the low dose aspirin pathway.
- During 2022 the Trust recorded an induction rate which was below the national average but an increase in instrumental vaginal birth rate which was also associated with third degree tears which was also under review.

	Maternity Incentive Scheme Gap Analysis The Committee considered the outcome of a repeat internal review of the evidence supporting the Trust's year four Maternity Incentive Scheme (MIS) submission to NHS Resolution following the publication of the outcome of CQC's inspection of maternity services. The Committee were assured that following a gap analysis undertaken by the Director of Midwifery the Trust could demonstrate compliance of all safety actions within the timeframes as stipulated by MIS. **Quarter four, 2022/23 Quality report** The Committee welcomed a detailed report and was able to take good assurance from the quarterly Quality report and noted the following issues: • The committee was verbally updated that the latest SHMI release shows the Trust level SHMI in the statistically lower than expected range. • Extensive participation in clinical audits both local and national was noted- the committee noted that this level of detail gave assurance. • Pressure ulcer incidents increased by 15% (36) in January 2023 compared to December 2022. The number of recorded pressure ulcers decreased during February and March2023. • There was a temporary backlog of cancer harm reviews to complete. • The number of incidents recorded on Datix continued to rise (36% compared to the last quarter) with an increase in moderate harm incidents. • 21 cases of hospital onset C Diff against the trust trajectory of 14 • There were 204 incidents between Qtr1 2021/22 to Qtr4 2022/23 across the Trust that had outstanding Duty of Candour requirements. • Ongoing challenges exist in responding to complaints within national timeframes with actions in place to improve. • A number of outdated Trust policies that require review and ratification with proposed actions to reduce the back log. Committee members were also updated on: • Work that took place to clear 600 duty of candour letters related to an information governance breach in 2020 which is nearly been completed. • A data cleansing exercise is being undertaken by risk managers to ensure that all datix incidents were relevant to the number of pressure ulcer incidents.
2.	**Committee members took moderate assurance from the following agenda items:** **Chair's assurance report, Quality Governance Committee** The Committee noted the report of the items covered at the meeting held on 27 April 2023 where significant or reasonable assurance was taken from most of the items discussed. Committee members were updated on the moderate assurance taken from the Emergency and Integrated Medicine ICSU Report; Surgery and Cancer ICSU Report; The Annual Patient Led Assessment of Care in the Environment (PLACE) Report received limited assurance. Ongoing industrial action was also discussed as the impact on patient safety, services and morale across the hospital was a key area of concern.

Elective recovery update

The Committee discussed activity performance as of the week ending 16th April 2023 and noted the following information was undergoing validation and outcoming in some areas:

- Elective/day case surgery – 1,985 cases over the preceding four weeks representing 102% of the 2019/20 activity target.
- Outpatients – there had been 20,689 first appointments (101% of 2019/20 activity) and 11,057 follow ups (85% of 2019/20 activity)
- Compared to the previous 4 weeks there were 669 over 52-week waiters, an increase of 59. The number of patients over 78 weeks was at 9, a decrease of 23.
- Diagnostics – DMO1 performance for 2022/23 was 86.09%
- Community activity – there were 48,231 total contacts in February and 522 unoutcomed appointments.
- Cancer - GP referral 62-day backlog was ahead of plan with 76 patients against a target of 84, and 104 day backlog was behind plan with 23 patients against a target of 12

The Committee noted specific concerns around gynaecology cancer performance in which the Trust was an outlier. Assurance was provided that immediate investment in administrative resources had been employed to manage waiting lists in both cancer and surgery pathways. A recovery plan would also be finalised by the Trust Management Group in due course but immediate focus on remedial actions would be taken.

Committee members were also assured that focussed work to reduce numbers on referral to treatment (RTT) waiting lists and appointment slot issues (ASIs) was also in place, which should reduce the numbers of patients waiting over 78 weeks to zero and significantly reduce the number of patients without a confirmed appointment.

The Committee was apprised of continued high demand for accident and emergency pathways, with exceptionally high numbers of patients presenting at the front door. It was noted that high demand at A&E was consistent across London and that a System wide review of urgent and emergency care was needed to address the issues at hand and develop a sustainable way forward before the next winter season. Additionally, a data validation exercise would be undertaken to validate all patients with appointment slot issues to ensure that all referrals were current. It was agreed that a progress update would be reported at the next meeting of the Committee.

Quality Account Review of Draft Priorities

The Committee received the proposed Quality Account Priorities for 2023-2024, for inclusion in the Trust's Quality Account scheduled for submission by 30 June 2023. Priorities were developed through triangulation of data from patients, staff and external stakeholders and were focussed around:

- Reducing and avoiding harm from hospital acquired deconditioning.
- Improving care and treatment related to blood transfusions.
- Reducing health inequalities in the local population.
- Improving access and attendance for appointments.

	The Committee approved the proposal for Quality Account Priorities for 2023-2024 and agreed that additional focus on the management and treatment of pressure ulcers would also be incorporated as a main priority. **Board Assurance Framework (BAF)** The Committee reviewed the BAF and agreed the scores for both Quality and Integration entries. The Committee also welcomed discussion on the Integration 2 entry of the BAF which related to population health and activity demand and recommended that specific reference to address health inequalities should be incorporated into the risk descriptors. **Risk Register (Quality and COVID-19 risks)** The Committee reviewed and noted 24 fully approved quality high risks, with a further 14 awaiting approval. **Serious Incident Board Report** The Committee received an overview of Serious Incidents (SIs) declared during the months of February and March 2022/23 where: • Three Serious Incidents were declared in February 2023 and March 2023 • The Trust submitted five Serious Incident reports to the Integrated Care Board in February 2023. Lessons learned were shared with the committee and across the Trust. • Nine Serious Incidents which were declared by the Trust, were beyond the 60-day deadline for submission to the Integrated Care Board. The Committee was assured that measures to expedite closure of these SIs were in progress. The Committee were assured that lessons learned were shared across the Organisation accordingly.
	Committee members took limited assurance from the following agenda items: **Patient-Led Assessments of the Care Environment (PLACE) 2022** The Committee received the report on the PLACE inspection and noted the improvements needed. These were in relation to the fabric of the hospital buildings, cleanliness, privacy and dignity. They noted that some refurbishment was carried out in outpatients and maternity. Committee members noted their concerns around the cleanliness, privacy, dignity and wellbeing, where scores at the Trust fell below the national average. Committee members were apprised of remedial actions taken around cleaning which included additional training, and improved cleaning resources. An update on the action log would be reported to the Committee in due course and an interim 'PLACE lite' assessment would be undertaken internally to measure progress. It was agreed that a multidisciplinary approach should be taken to address the issues highlighted in the assessment. **Sickle Cell Report** The Committee was apprised of the progress made at the Trust against the Sickle Cell Improvement plan following the open letter from the patient group and 'No Ones Listening' – the SCTAPPG inquiry.

	The Committee noted that good progress had been made with engagement in ambulatory care and the emergency department however, a number of issues had yet to be resolved, notably: • Data set to monitor progress was still in development. • Time to analgesia in the emergency department (ED) and same day emergency care (SDEC) targets had not been met. • Minimal progress has been made on establishing an acceptable permanent haematology ward and as a result there has been no real improvement in inpatient care sickle cell patients. • Staffing remains a severe challenge. There was a risk that the service could be compromised as a result of staff attrition. The Committee agreed that significant investment was needed to finance the resources needed to improve the service. Chinyama Okunuga explained that the issues were well documented and that following a bed modelling exercise around eight beds were required for haematology/sickle cell patients, the precise location and ward configuration of the beds was yet to be agreed but would be reported through the Trust Management Group by the early autumn. In terms of resources, the Committee was advised that through the business planning round the Trust had committee £400k for haematology, thalassaemia and sickle cell. The Committee asked for a follow-up report on progress in the Autumn.
3.	**Present:** Amanda Gibbon, Non-Executive Director (Committee Vice Chair) Dr Clare Dollery, Medical Director Chinyama Okunuga, Chief Operating Officer Baroness Glenys Thornton, Non-Executive Director Sarah Wilding, Chief Nurse & Director of Allied Health Professionals **In attendance:** Mario Araujo, Head of Facilities Anne O'Connor, Interim Associate Director of Quality Governance Ihuoma Wamuo, Associate Medical Director for patient safety & learning from deaths Caroline McGirr, (*not sure of her title)* Kelly Collins, Associate Director of Nursing Emergency & Integrated Medicine Tisenia Alombro, Dementia Clinical Nurse Specialist Emma Drasar, Consultant Haematologist Anna Gorringe, Palliative Medicine Consultant. Helen Taylor, Clinical Director ACW ICSU Kat Nolan-Cullen, Compliance and Quality Improvement Manager Carolyn Stewart, Executive Assistant to the Chief Nurse Marcia Marrast-Lewis, Assistant Trust Secretary **Apologies:** Helen Brown, Chief Executive Naomi Fulop, Non-Executive Director (Committee Chair) Swarnjit Singh, Joint Director of Inclusion and Trust Secretary Tina Jegede, Joint Director of Inclusion and Lead Nurse, Islington Care Homes

Meeting title	**Quality Assurance Committee**	**Date: 10th May 2023**
Report title	**Quarterly Learning from Deaths (LfD) Report** Q3, 1 October to 31st 22	**Agenda item: 4.4**
Executive director lead	Dr Clare Dollery, Executive Medical Director	
Report authors	Dr Ihuoma Wamuo, Associate Medical Director for Patient Safety and Learning from Deaths Ruby Carr, Project Lead for Mortality	
Executive summary	During Quarter 3, 1st October to 31st December 2022 there were 116 adult inpatient deaths reported at Whittington Health (WH) versus 117 in Q2. 23 adult structured judgement reviews (SJRs) were requested for Quarter 3 and 9 of these have been completed and presented at department mortality meetings. A meeting was held in December, with the mortality leads, to support teams in the recovery of the SJRs however the very significant operational pressures through the winter has continued to challenge teams. The Summary Hospital-level Mortality Indicator (SHMI) for the data period July 2022 to September 2022 at Whittington Health is 0.88 which is as expected. A Mortality Review Group meeting took place on 22nd November 2022. The meeting reviewed the learning from death report. and considered the mortality review process including a review of the Learning from Deaths Policy. The April meeting has had to be rescheduled due to Industrial Action by BMA junior doctors.	
Purpose:	The paper summarises the key learning points and actions identified in the mortality reviews completed for Q3, 1st October to 31st December 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	QGC 27/04/23	
Appendices	Appendix 1: NHS England Trust Mortality Dashboard	

Quarterly Learning from Deaths Report, Q3 2022/23 1st October – 31st December 2022

1. Introduction

1.1 This report summarises the key learning identified in the mortality reviews completed for Quarter 3 of 2022/23. 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 review7s.
- 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 an 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 3, 2022/23

3.1 During Quarter 3, 2022/23 there were 116 adult inpatient deaths reported at Whittington Health versus 117 in Q2.

3.2 During Quarter 3, 2022/23 there were 0 child 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)	25
Cavell	13
Cloudesley	16
Meyrick	9
Critical Care Unit	16
Nightingale	17
Coronary Care Unit	3
Thorogood	0
Victoria	6
Coyle	8
Mercers	2
Theatres Recovery	1
Child/neonatal	0
Maternal	0
Total:	**Adults** 116

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	93	32	61
Paediatric Mortality Reviews	0	N/A	N/A
SJR	23	9	14

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

Table 3: *Reasons for deaths being assigned as requiring an SJR during Quarter 2, 2022/23*

Criteria for SJR	Number of SJRs identified	Completed SJRs	Comments
Staff raised concerns about care	2	0	
Family raised concerns about quality of care	1	0	
Death of a patient with Serious mental illness	4	2	
Death in surgical patients	1	0	
Paediatric/maternal/neonatal/intra-uterine deaths	0		
Deaths referred to Coroner's office without proposed cause of death	1	1	
Deaths related to specific patient safety or QI work e.g. sepsis and falls	3	1	
Death of a patient with a Learning disability	4	2	
Medical Examiner concern	4	1	
Serious Incident investigations			
Unexpected Death	0		
Concerns raised through audit, incident reporting or other mortality indicators	0		
Definite COVID-19 Health Care Acquired Infection (HCAI)	3	2	
Probable COVID-19 HCAI	0		
Intermediate COVID-19 HCAI	0		
Total including Neonatal Deaths	**23**	**9**	

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.

3.9 Plan for recovery of SJRs:

- A meeting took place in December 2022 in order to discuss and plan the recovery and completion of outstanding SJRs and to support with ongoing SJR requests.
- The Mortality Lead/s for each team were present and the meeting was chaired by the Associate Medical Director for Learning from Deaths & Patient Safety.

- A procedure by which to relocate, allocate and complete outstanding SJRs was agreed to be used going forward.
- The procedure for requesting, allocating and returning SJRs was also revised.

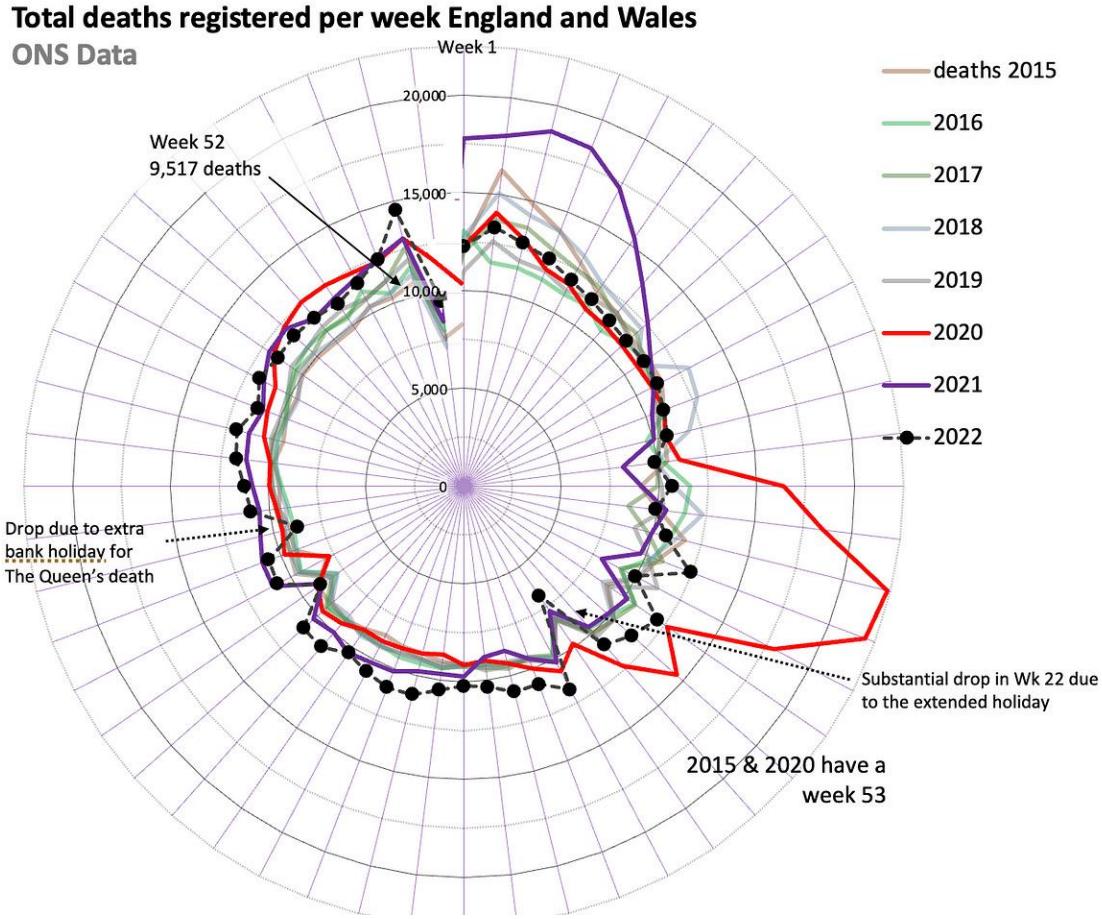
4. Mortality Dashboard

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 116 inpatient adult deaths recorded in Quarter 3, 2022/23 at Whittington Health.

4.3 In the week ending 30 December (Week 52), 9,517 deaths were registered in England and Wales This was 12.2% above the ONS 5-year average (2016 to 2019 and 2021). Of these deaths, 332 mentioned COVID-19 (2.4% of all deaths). The number of deaths was 23.3% above the five-year average in private homes (565 excess deaths), 23.3% in hospitals (403 excess deaths) and 9.7% above in care homes (162 excess deaths). This takes the total number of deaths in England & Wales to 576,896 for the year

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

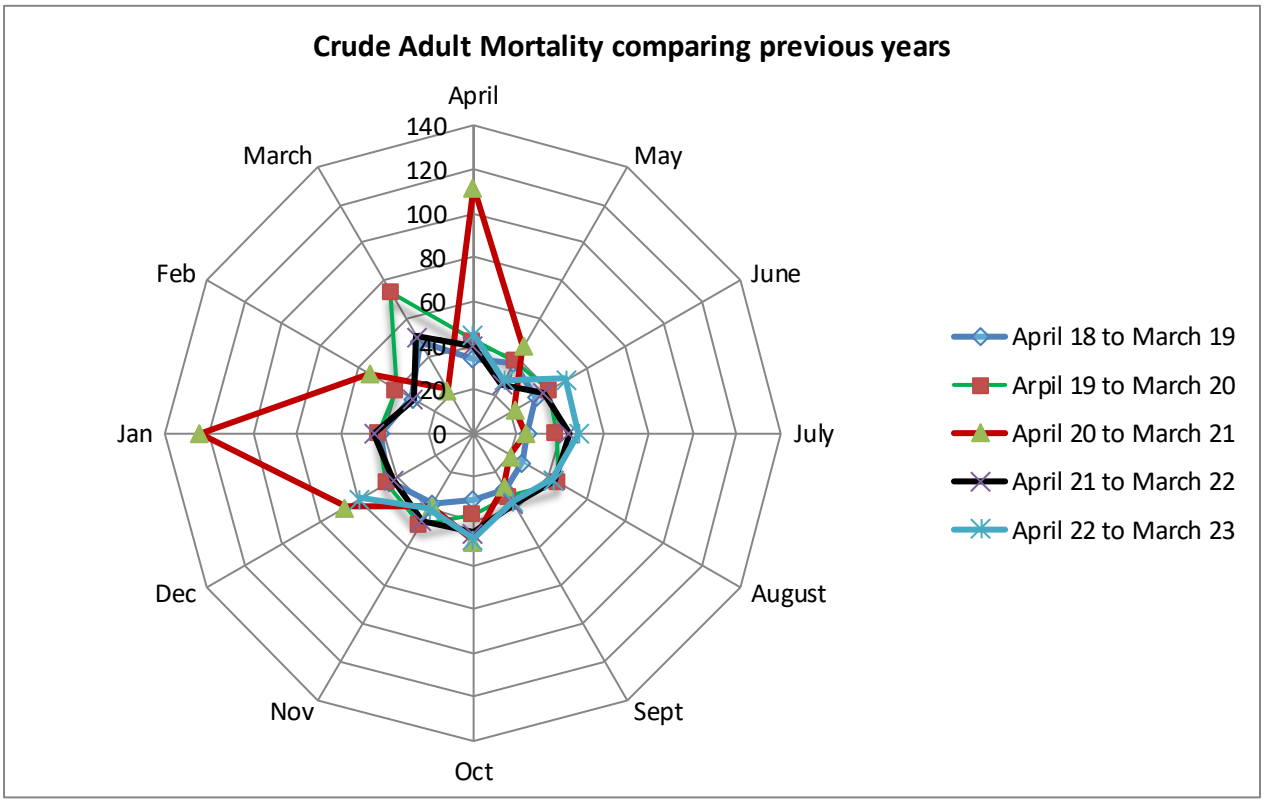


4.4 The radial graph below compares all causes of deaths (including ED deaths) in the Whittington hospital in 2018-19, 2019-20, 2020-21, 2021-22 with the year considered in this report 2022-23.

4.5 The number of inpatient and ED deaths in Q3 2022/23 was 157 which is 24 more than in the same quarter in the previous year.

4.6 There were 22 deaths in patients within 28 days of a positive COVID-19 test or with COVID-19 on the death certificates. This compares to 20 such deaths in Q2. Three of these deaths were definite Health Care Acquired Infection (HCAI). All of the deaths in Q3 had pre-existing medical conditions. 2 were under 70 years of age and the remainder between 71 and 98. 1 of these patients had a learning disability and 2 had a serious mental illness. None were homeless.

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



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

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

Month	April 18 to March 19	April 19 to March 20	April 20 to March 21	April 21 to March 22	April 22 to December 22
April	34	42	112	40	45
May	37	38	46	26	28
June	33	40	22	37	49
July	25	38	24	44	48
August	26	45	20	43	42
Sept	29	33	28	37	36
Oct	30	37	49	45	48
Nov	37	48	38	46	40
Dec	44	45	67	42	59
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 Summary Hospital-level Mortality Indicator (SHMI) for the data period April 2021 to March 2022 at Whittington Health is 0.88 which is as expected.

6. Themes and learning from mortality reviews Quarter 3 of 2022/2023

6.1 There were several examples of excellent End of life care. The following factors were identified as contributing to this: Respecting the wishes of patients who have capacity; consistent multiple iterative TEP conversations with relatives who find accepting their loved one is dying, challenging; a side room being available, despite bed pressures, was highlighted as benefit in two mortality meetings.

6.2 The nursing care and good communication from allied health professionals as well as the doctors was praised by some families.

6.3 One case highlighted the importance of early identification when a patient is dying, this allows early involvement with palliative care and gives families valuable time to spend with their loved one.

6.4 Patients with a Learning Disability (LD) must be identified early on admission and the LD team contacted. One review realised the LD team input was of value to the patient, in improved communication with the team and better quality of overall care. The patient's Learning Disability had no impact on their clinical course.

6.5 One review emphasised the risk of type 2 Respiratory failure in patients with chronic respiratory disease or an elevated bicarbonate. This was later discussed with several teams, including the respiratory team, to provide further understanding and learning.
The importance of recognising the need to adjust oxygen therapy targets to avoid toxicity was highlighted. The oxygen prescribing guidelines are available on the intranet for guidance. Oxygen alerts can be found on Careflow with the recommended target saturation.

6.6 It was highlighted that if an admitted patient is identified, to benefit from an oxygen alert, then a referral can be made on ICE (oxygen alert) to the respiratory team, who will create one.

6.7 The use of morphine for supporting breathlessness as treatment at the end-of-life care, was emphasised as beneficial. HFNO and oxygen are not indicated in this situation.

6.8 The benefits of returning a patient back to their previous ward, where they were well known, after an admission to the Critical care unit, helps with continuity of care for that patient. The previous team know the history and the patient well. It is accepted that this may not be possible but should be considered by discussion with the bed managers.

6.9 One mortality meeting highlighted that Necrotizing fasciitis carries a mortality of 15 to 30%. The acute management requires multiteam approach, with medical and surgical teams working alongside one another.

6.10 Ensure the documentation of notes is complete and not left in draft form, as notes can be altered and may not be a reflection of what was observed or done.

6.11 One meeting highlighted the importance of being alert to dual diagnosis presentations in frail elderly patients and ensure that both are addressed.

7. Dissemination of Learning

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

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

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

8. Mortality Review Group

8.1 An overarching Mortality Review Group meeting took place on 22nd November 2022. The meeting reviewed the learning from death reports and considered the mortality review process as a whole including a review of the Learning from Deaths Policy. The April meeting has had to be rescheduled due to Industrial Action by BMA junior doctors

9. Learning from Deaths Policy

The Learning from Deaths Policy was presented at the Policy Review Group on Monday 20th February and was approved.

10. Update on Medical Examiner Service

10.1 A new Lead Medical Examiner is leading the team and a second Medical Examiner Officer has been recruited and joined the team.

11. Conclusion and recommendations

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

Whittington Health: Learning from Deaths Dashboard - June 2022-23

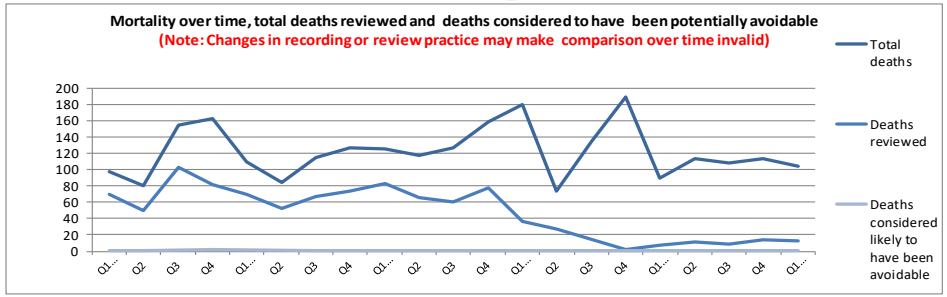
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
40	25	3	4	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
104	114	12	14	1	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
104	425	12	41	1	2

Time Series: Start date 2017-18 Q1 End date 2022-23 Q1



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	0	2	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	3	2	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	5	2	2	0	0

Whittington Health Maternity Services Board report, April 2023

This report provides a quarterly summary of the work being undertaken in the Whittington Health Maternity Unit.

1.0 Care Quality Commission Standards

Whittington Health Maternity services received the unannounced inspection of the Care Quality Commission (CQC) on the 23rd and 24th January 2023. The inspection had 3 parts to it: site visit on the 23rd of January, interviews of the Maternity Board Safety Champions, Maternity Triumvirate and the Maternity Voices Partnership co-chairs on the 24th of January, as well list of evidence and audits safety, audits and leadership.

The post-inspection feedback highlighted areas for improvement and positive findings. Areas for improvement were:

- Policies and guidelines were not always up to date or regularly reviewed.
- Assessment and prioritisation of women in triage was not consistent to ensure safety.
- Telephone cover in triage was not always sufficient.

Positive findings were:

- The culture of the service.
- Multi-disciplinary team working and staff engagement.
- Engagement with Maternity Voices Partnership with the service and the production of the "Kindness won't hurt" initiative.
  The final report is still yet to be received.

2.0 Maternity Incentive Scheme (IMS) – Year 4 (Previously Clinical Negligence Scheme for Trusts (CNST))

Obstetric incidents can be catastrophic and life-changing, with related claims representing the Clinical Negligence Scheme for Trusts' (CNST) biggest area of spend. Of the clinical negligence claims notified to NHS Resolution in 2021/22, obstetrics claims represented 12 per cent of clinical claims by number but accounted for 62 per cent of the total value of new claims; almost £6 billion.

The Maternity Incentive Scheme supports and rewards Trusts who have taken action to improve maternity safety. It sets out 10 Safety Actions for which Trusts have to evidence compliance with, in order to receive the financial rebate.

The Declaration Form for the submission was published by NHS Resolution on the 7th of December 2022, and the submission date was 12 noon on the 2nd of February 2023, which we submitted successfully.

The submission update for Whittington Health NHS Trust, with the details in Declaration Form attached as:

- Safety Action 1 (PMRT) : Fully Compliant
  - As a plan forward, the quarterly Perinatal Mortality Review Tool (PMRT) reports, updates will be part of the quarterly maternity report to the Quality Assurance Committee (QAC); and the quarterly learning points will be presented in the quarterly learning from deaths report.

- Safety Action 2 (MSDS): Fully Compliant
- Safety Action 3 (Neonatal Unit): Fully Compliant

  - As a plan forward, audits for transitional care and ATAIN are being embedded as quarterly reporting in a standing topic at the monthly Maternity Clinical Governance and Safety Champion meeting.

- Safety Action 4 (Clinical Workforce): Fully Compliant
  - As a plan forward, audit for criteria 1 & 2 to be made a standing item of the monthly Maternity Clinical Governance and Safety Champion meeting as part of the Obstetric Workforce.

- Safety Action 5 (Midwifery Workforce): Fully Compliant
  - As a plan forward, a consultation of the maternity workforce structure is planned for 2023 with the aim to increase the number of labour ward and flow coordinators to ensure appropriate cover for the unit. This will allow the presence of 2 senior midwives at all times and strengthen the supernumerary status of the coordinator.

- Safety Action 6 (SBLCB v2): Fully Compliant
  - Action Plan for Element 1 – as detailed in the spreadsheet provided to the committee.

- Safety Action 7 (MVP): Fully Compliant
- Safety Action 8 (Multi-Professional Training): Fully Compliant
- Safety Action 9 (Board Governance): Fully Compliant
- Safety Action 10 (HSIB & EN): Fully Compliant

3.0 Single Delivery Plan - NHSE

On the 30th of March 2023 NHS England published their Three-Year Delivery Plan for Maternity and Neonatal Services in England. The delivery plan is directed at frontline staff and leadership, describing the building blocks needed to ensure the needs of women, babies and families are at the heart of services. It summarises responsibilities for each part of the NHS including Trusts, Integrated Care Boards (ICB) and Systems including Local Maternity and Neonatal Systems and Operational Delivery Networks, and NHS England.

This plan aims to deliver change rather than set out new policy. It seeks to help each part of the NHS to plan and prioritise their actions by bringing together learnings and actions from a range of national reports and plans into one document. The plan is articulated around four themes:

1. Listening to, and working with, women and families with compassion.
Ensure care is personalised and that service users have informed choice. Voices of all women including those from diverse backgrounds must be heard, and services should work closely with all service users to collaboratively plan, design and improve care.

2. Growing, retaining, and supporting our workforce with the resources and teams they need to excel.
Ensure there are sufficient highly skilled staff across the whole maternity and neonatal team whilst combatting workforce inequalities. Staff should feel valued, with plentiful opportunity for skills and career development to facilitate a lifelong career in the NHS.

3. Developing and sustaining a culture of safety, learning, and support.
There should be a positive safety culture in every maternity and neonatal service, where everyone takes responsibility for safer care and learning, and leaders understand, and act based on how it feels for their teams to work at their organisation.

4. Standards and structures that underpin safer, more personalised, and more equitable care.
Best practice should be consistently implemented across the country, with timely, accurate data available to support learning and early identification of emerging safety issues. Women can access their records and interact with their plans and information to support informed decision-making.

Next steps:
The maternity department will develop a local action plan based on the themes and objectives outlined in the report. This will be monitored at the Maternity Clinical Governance and Safety Champions Meeting, ICSU's board, Maternity and Neonatal Transformation Programme Board, and the Trusts Quality Governance and Quality Assurance Committees.

4.0 Incidents and learning points from Serious Incidences (SIs)

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

In 2022 there were two serious incidents declared in maternity

Table 1: Serious Incidents

Datix Ref	Description	Target date of report completion
A90188 01/04/2022	Term admission to NICU – Hypoxic-ischaemic encephalopathy (HIE) – Therapeutic Cooling.	Completed
A87076 05/05/2022	Intrauterine death at 26 weeks and 5 days & ITU admission.	Completed
A99314 09/03/2023	Sickle Cell and Thalassemia Screening – Omission to counsel mother antenatally and to offer PND – 2 triplets diagnosed with sickle cell disease.	Draft report completed and circulated for review. Final report to be submitted 15/05/2023.

A90188 – This incident met HSIB criteria, as the family declined, SIEAG advised maternity to review using SI framework. The review has not identified any care and or service delivery problems that may have contributed to the outcome.

A87076 – This SI relates to a preterm intrauterine death and maternal admission to Intensive Care Unit. The investigation identified the need to review and change the maternity triage systems and guidelines; Further education is needed regarding recognising the severely unwell women.

A99314 - Between January and March 2023, one serious incident has been declared in maternity. The incorrect completion of the Family Origin Questionnaire (FOQ) and subsequent non-adherence of the failsafe process directly contributed to the failure to counsel a mother antenatally and to offer Pre Natal Diagnosis (PND) – 2 triplets were diagnosed with sickle cell disease.

Recommendations and actions that are still outstanding:

- Implementation of the electronic baby tagging system

- Undertake a full review of the processes and guidelines for the Maternity Assessment unit. Consideration for the implementation of BSOTS (Birmingham symptom specific obstetric triage system) or a modified BSOTs system to support staff in appropriately managing and escalating the unwell patient.
- SBAR audit
- Update the following guidelines: Modified Early Obstetric Warning Score (MEOWs) and The Severely Ill Obstetric Woman and include in ongoing education programmes.
- The swab counting guideline to be simplified and updated, in order to make it easier for staff to comply with the guidance. Various details i.e. swab counting as the procedure continues; and location of all swabs to be known at all times needs to be added. The guideline must detail that the whiteboards must be used for counting pre and post procedure.

5.0 Healthcare Safety Investigation Branch (HSIB) – Quarter 2 feedback

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

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

From 1 April 2022 to March 2023, Whittington Health referred five cases to the HSIB for investigation which met the criteria. The reasons for referral were potential hypoxic ischaemic encephalopathy (HIE) and intrapartum stillbirth. Two of the families declined for HSIB to review the care. One case was rejected by HSIB as on further review the case did not meet HIE criteria.

The two reviews by HSIB have now been completed. The finalised reports were presented to SIEAG in December 2022 and in February 2023. These reviews were for two intrapartum stillbirths.

For the case presented in December 2022, HSIB concluded that appropriate care was provided, and no safety recommendations have been made.

Regarding the case presented in February 2023, two safety recommendations were made by HSIB:

- First Safety Recommendation:
  - The Trust to ensure a consistent questioning approach for telephone triage is used in all clinical settings.
  - To complete this action, Maternity Triage service provision is currently under review and the intrapartum matron is leading on the implementation of the **Birmingham** Symptom Specific **Triage System** (BSOTS). This includes telephone triage.

- Second Safety Recommendation:

- Trust to ensure that staff are supported to undertake and record intermittent auscultation in line with national guidance.
- To complete this action, Maternity has implemented a fetal wellbeing mandatory study day. Intelligent Intermittent fetal monitoring auscultation is part of the programme, this involves a competency assessment. The Intelligent Intermittent fetal monitoring auscultation guideline is under review.

As of the March 2023, the Trust has no active investigations being undertaken by HSIB. Also, no new referrals have been made as no cases met HSIB criteria.

6.0 Perinatal Mortality Review Tool (PMRT)

Perinatal Mortality Review Tool (PMRT) supports systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and babies who die in the post-neonatal period having received neonatal care. PMRT provides a structured process of review, learning, reporting and actions to improve future care.

In 2022, ten cases met the eligibility criteria for PMRT review. The eligible cases were stillbirths. From those, seven reviews have been completed and three are ongoing. The progress is within the Maternity Incentive Scheme (MIS) timeframes. Following review for five of the cases there were no care and or service delivery problems identified. For two cases, care and service delivery problems were identified. For the first case, this was related to staff not accessing available information regarding the woman's mental health history. This, however, did not impact on the outcome. For the second case, the low dose aspirin pathway was not adhered too, the review panel found that this may have contributed to the outcome.

The department was able to secure external experts for five out of seven of the reviews. This continues to be an ongoing issue, and North Centre London Quality and Safety Group is aware and exploring options.

Families have been involved in the PMRT reviews.

7.0 Complaints and Compliments

Complaints
From October 22 to March 23 eight new formal complaints have been logged. From those 6 remain open, the key themes from the complaints are:

- Birth experience.
- Lack of communication.
- Staff attitude.

Update for the 6 opened ones:

- The oldest was opened in Nov 22 (50400)– this was logged as an out of time complaint. This requires input from
- 50569 – Draft submitted to PALS on the 13/04/2023. The delay in finalising the draft was due to the anaesthetist involved having left the Trust and her statement being required to complete the response.
- 50570 – Response in draft and with PALS for review – Delay with one of the leads completing the response.
- 50597 - very complex complaint – Draft received and shared with PALS –
- 50979 – Draft received and shared with PALS for review on 30/03/2023.

- 51404 – response due 28.04.23

Compliments

Here are some examples of compliments received:

- ""We had our 20 week anomaly scan with a doctor and she was absolutely amazing! She was very approachable and friendly. She really took the time to explain everything that she was doing during the scan. She made sure that we were comfortable for the duration of our scan and also ensured that she answered our questions thoroughly. We really appreciated this experience as first time parents. We are so happy that we have chosen Whittington Hospital for our pregnancy journey."
- "I was part of the Greenstone team throughout my pregnancy. The midwives were lovely and I couldn't fault the care that I received throughout pregnancy. My baby was breech and I went through two External Cephalic Version (ECV) procedures which were both unsuccessful. I then had a planned c-section. The hospital staff throughout these procedures were friendly, helpful and kept me really informed. Whilst on the postnatal ward the doctors picked up an infection in baby and we had to stay for 3 more days whilst they gave baby antibiotics. I found the first night very hard as baby wouldn't feed. Throughout all of this the staff were amazing, so kind and patient. I can't fault the care we received and just wanted to say thank you to everyone who performed my c-section and who worked on the collier ward 23-26 Feb."
- "I was extremely well looked after at every stage in my pregnancy. labour and recovery in hospital. Many thanks again to all those who looked after us in the months leading up to [baby]'s birth and in the days after. Your staff are a credit to the Whittington."
- "As many of your team know, I had two previous c sections - the second left me with postpartum PTSD and difficulty bonding with my second babe. So it was important for me to try and deliver this baby differently. From booking at 36 weeks, your team were fantastic. During my initial consultation with I, A and II was treated like an adult who could understand the risks and benefits of the decisions I was taking Amali - I loved your book."

8.0 Legal Claims

In Quarter 3, there was 1 new claim: preterm baby, born at 23 weeks, in poor condition in 2009. High risk. There is no documentation to be found in the electronic records as Datix was not implemented at that time.

In Quarter 4, there were 2 new claims and 1 closed claim. The 2 open claims are:

- Woman booked at RFL. She had a BBA (Born Before Arrival) in 2022 that was attended by the LAS who brought her to Whittington as was in our catchment area. Baby born at home in poor condition. Case being investigated by RF hospital. Family has declined HSIB investigation.
- High risk claim. Fetal In-Utero Death with maternal admission to ITU, in 2021. Reported as Serious Incident (2022.9194) and investigation was completed and closed.

The closed claim is:

- Never Event regarding a retained swab (2021.17265) in 2021. total costs paid £18,000.

9.0 Quality Improvement Projects

Dilapan update

Dilapan was implemented as the first line of induction of labour on Monday 6th February. 2023 Since then it has been used as first line for all inductions, including both in and outpatient. This launch was accompanied by an updated induction of labour guideline and new information leaflet for service users coproduced with the Maternity Voices Partnership.

Monthly meetings have been taking place in order to iron out any issues and we are working closely with the Dilapan representative to support training for all staff. As we approach 3 months since implementation, we will be auditing the use of Dilapan, patient experience and whether the pathway is effective.

Antenatal Education (AN)

The antenatal education in the maternity services is being assessed at Whittington Health by the Community team. Most of it had been postponed during the pandemic and the unit is looking into how to be restarting it.

Questionnaires have been distributed to staff and service users. 107 responses have been received from service users. The data is in the analysis phase currently and the target is for it to be completed by the 22nd of May 2023.

The AN education programme proposal has been completed and the next step is to hold a focus group with the providers (midwives) and service users (MVP) to co-produce the final programme. The target is for the completion of this to be done by 30.6.23.
The Launch of the standardised programme for all AN education provider to deliver has to be done for the beginning of September 2023.

Baby Tagging

Baby tagging is an electronic system where an electronic tag and disposable strap are put on the baby. This is to protect them from abduction. This is in response to learning from a SI The company installing the system, Xtag, have a site survey Monday 24th April for an implementation survey. NNU is now aligned with maternity to use this system.

Interpreters On Wheels (IOW)

WH Maternity services have trialled IOW, provided by Language Line, in November 2022 as a response to an SI. The trial was a success with service users and staff positive feedbacks. The Trust is procuring a new translation service that will include out of hours provisions and using the technology that has been trialled in the Language Line and is expected to start in the next 3 months.

In the meantime, the Trust IMT department is exploring whether equipment can quickly be procured to use the current Big Word out of hours provision on mobile iPads. Procurement is exploring the possibility of a short-term contract with Language Line until the outcome of the tender as the equipment is still on site and could be reactivated. NCL are currently trialling Card Medic.

10.0 Maternity Dashboard

Table 2: Maternity Dashboard

Measure	Goal	Red flag	Oct	Nov	Dec 2022	Jan 2023	Feb	March
Antenatal Referrals			380	341	326	410	339	409
Booking Scheduled			295	297	322	293	329	356

Measure	Goal	Red flag	Oct	Nov	Dec 2022	Jan 2023	Feb	March
Actual Births			254	259	231	248	221	227
Proportion of Vaginal births in a midwifery led unit Number of births			13.0% 19	23.5% 31	12.7% 15	20.3% 30	9.6% 12	14.5% 17
Induction of labour rate	< 32.1%	>41.2%	**33.2%**	**28.3%**	**28.9%**	**29.8%**	**27.8%**	**31.0%**
Robson Group 1 CS Rate	Nulliparous women with single cephalic pregnancy, ≥ 37 weeks gestation in spontaneous labour		6.8%	6.3%	4.8%	4.1%	5.0%	2.3%
Robson Group 2 CS Rate	Nulliparous women with single cephalic pregnancy, ≥ 37 weeks gestation who either had labour induced or were delivered by caesarean section before labour		10.4%	14.2%	16.3%	11.9%	12.3%	12.7%
Robson Group 2a CS Rate	As 2, induced		6.4%	9.5%	7.9%	5.3%	5.9%	7.2%
Robson Group 2b CS Rate	As 2, caesarean section before labour		4.0%	4.7%	8.4%	6.6%	6.4%	5.4%
Robson Group 3 CS Rate	Multiparous women without a previous uterine scar, with single cephalic pregnancy, ≥ 37 weeks gestation in spontaneous labour		0.8%	1.6%	1.3%	0.8%	0.0%	1.8%
Robson Group 4 CS Rate	Multiparous women without a previous uterine scar, with single cephalic pregnancy, ≥ 37 weeks gestation who either had labour induced or were delivered by caesarean section before labour		3.2%	2.8%	4.0%	2.0%	3.7%	2.7%
Robson Group 4a CS Rate	As 4, induced		1.2%	0.8%	1.3%	1.2%	2.3%	0.9%
Robson Group 4b CS Rate	As 4, caesarean section before labour		2.0%	2.0%	2.6%	0.8%	1.4%	1.8%
Robson Group 5 CS Rate	All multiparous women with at least one previous uterine scar, with single pregnancy, ≥ 37 weeks gestation.		11.2%	12.6%	14.0%	10.7%	14.6%	12.2%
Robson Group 5a CS Rate	As 5, with 1 previous CS		9.6%	9.1%	8.4%	8.2%	12.3%	10.4%
Robson Group 5b CS Rate	As 5, with more than 1 previous CS		1.6%	3.6%	3.1%	2.5%	2.3%	1.8%
Robson Group 6 CS Rate	All nulliparous women with a single breech pregnancy		2.4%	1.6%	2.2%	1.6%	0.9%	1.8%
Robson Group 7 CS Rate	All multiparous women with a single breech pregnancy, including women with previous uterine scars		2.0%	0.8%	0.4%	0.8%	0.9%	2.7%
Robson Group 8 CS Rate	All women with multiple pregnancies, including women with previous uterine scars		0.4%	2.4%	1.8%	1.2%	0.5%	2.7%
Robson Group 9 CS Rate	All women with a single pregnancy with a transvers or oblique lie, including women with previous uterine scars.		0.0%	1.2%	1.3%	0.8%	0.5%	1.8%
Robson Group 10 CS Rate	All women with a single cephalic pregnancy < 37 weeks gestation, including women with previous scars.		2.0%	2.4%	2.6%	2.0%	2.7%	4.5%
Overall Instrumental Vaginal Delivery	<12.3%	>15.5%	**14.0%**	**15.5%**	**19.0%**	**12.7%**	**17.1%**	**12.0%**

Measure	Goal	Red flag	Oct	Nov	Dec 2022	Jan 2023	Feb	March
Rate (Ventouse or Forceps)								
Failed instrumental delivery rate	N/A	N/A	5.4%	7.5%	4.8%	6.3%	2.8%	7.4%
Stillbirth rate	<3.93per 1000births after 23+6 weeks	> 4.8 per 1000 births after 23+6 weeks	**3.94**	**0.0**	**8.66**	**0.0**	**9.0**	**8.8**
Neonatal death rate	<1.71per 1000 live births	>1.81per 1000 live births	**0.0**	**0.0**	**0.0**	**0.0**	**4.6**	**4.4**
Term admissions to NICU (maternity dashboard data)	N/A		6.7%	6.3%	7.0%	7.4%	7.7%	8.8%

Antenatal referrals – There has been a progressive increase in the antenatal referral which correlates with the recruitment of administrative operational support in October 2022 for the antenatal areas. The numbers of referrals in January and March 2023 are comparable to the ones in 2021 (380 – 428).

Administration operational support at first point of contact throughout the maternity care pathway is crucial for good data capture and good data quality. Regarding the antenatal referrals, having appropriate administration operation support translates into appropriately capturing referrals and bookings.

Bookings scheduled – There has been a progressive increase in the scheduled booking, with 3 out of 6 months having similar numbers than in 2021 (306-366).
An introductory insight has been done for quarters 4 of 2021/2022 and quarter 1 of 2022/2023 in order to investigate the attrition rate between the booking and births: 50% of women who booked at WH transferred their care during pregnancy, 39% had a miscarriage, 7.5% had a termination, 1% birthed elsewhere and there were 2.5% of loss of contact. Regarding the transfer of care proportion, 25.4% moved outside of London, 24.4% to another North Central London Trust, 20.2% moved abroad, 17.6% to another area in London, 3.1% transferred their care to the private sector and 9.3% represent an unknown reason.

There is currently further work under way to investigate the transfers within the NCL sector.

Birth Centre – November 2022 is the month in 2022 with the highest proportion of vaginal births in the midwifery led unit. February 2023 is the month within the 6 months timeframe for which the proportion of vaginal births in the Birth Centre is the lowest. During this month, the birth centre was suspended for 5 shifts.

As per the national recommendations it should be the default place for birth and women referred to labour ward for choice or medical reasons. Women need to be reassured that they will be consistently offered the choice of the 3 options for birth places: Home, birth centre, labour ward. The ratification of the SOP for second on call midwife for homebirth being facilitated by the inpatient areas also supports consistent access to the Birth Centre. Within the past 6 months, the homebirth service was suspended 65 times which is open 82% of the time.

Current co-production work with the MVP's about creating a pathway of care for women and families requesting care outside of guidance will also impact and support the Birth Centre.

Induction of Labour – Although our overall induction rate is below the national average the failed induction rate for both primiparous and multiparous women is above the national average. To be able to draw further conclusions an insight in the reasons for induction of labour is needed. Also, Dilapan as the default mode of induction has been implemented in February 2023 and will need evaluation in the next quarter. When the induction of labour rate was compared with neonatal outcomes the number of terms admissions to NICU remained stable which provides assurance.

The metrics for caesarean section are now reported using the Robson classification:

- The highest caesarean section rate is, as in the previous quarter, for: Robson group 2 – Nulliparous women with single cephalic pregnancies, ≥ 37 weeks gestation who either had labour induced or were delivered by caesarean section before labour. Out of these the ones that had their labour induced were the ones that had a higher section rate.
- The second highest caesarean section rate is for: Robson group 5 – All Multiparous women with at least one previous uterine scar, with single cephalic pregnancy, ≥ 37 weeks gestation.
- The lowest caesarean section rates (<1%) are for:
    - Robson Group 9: All women with a single pregnancy with a transverse or oblique lie including women with previous uterine scars (over 6 months: 0.9%).
    - Robson Group 3: Multiparous women without a previous uterine scar with single cephalic pregnancy, ≥ 37 weeks gestation in spontaneous labour (over 6 months: 1.0%)

The overall instrumental vaginal birth rate for December is the highest of the year. Out of the 40 instrumental births in December, 33 were nulliparous women and 7 were multiparous. February 2023 has the second highest overall instrument vaginal birth rate for the 6 months timeframe. For both of the months, Reasons for instrumental births were for abnormal fetal heart rate monitoring reasons and for prolonged second stage of labour.

October had the highest rate of failed instrumental births for the 6 considered months. These 3 failed instrumental births were due to abnormal fetal heart rate monitoring and resulted in Caesarean sections. The obstetric consultant was in attendance for these 3 episodes.

More time is needed to explore and link with neonatal outcomes as no report provides this information combined.

During these 6 months, 13 women sustained a 3rd degree tear. There were no 4th degree tears. All 3rd degree tears were reviewed. Regarding the 3rd degree tears, 8 (61.5%) occurred during instrumental births for nulliparous women. Instrumental births are a risk factor for the occurrence of 3rd degree tears. The 5 other 3rd degree tears (38.5%) occurred during unassisted births regarding 2 nulliparous and 3 multiparous women. Further investigation into the unassisted birth is necessary to assess the causes.

The term admission rate to the neonatal unit remained stable. These admissions are reviewed by the Multi-Disciplinary Team, and they were all unavoidable. March 2023 saw the higher rate of term admission with 8.8%. This represents 18 babies. However, if the definition used for term admission is The London Neonatal Operational Delivery Network (ODN) ones which only counts term admissions for at least 24 hours and within the first 28 days of life. This total is 14.

Regarding the Stillbirth rates, the highest were in February and March 2023. These relates to 2 babies in each month. 3 of them had antenatal diagnosed abnormalities with very poor

prognosis. The 4th one was diagnosed with being small for gestational age and mother had felt reduced fetal movements for 2 weeks.

Regarding the neonatal death rates, they represent 1 baby in February and 1 in March 2023. 1 was a severe premature birth at 22 weeks and 1 day where baby gasped at birth with no further signs of life from 1h and 10 mi from birth. Neonatal team was in attendance. The second baby had a poor prognosis known since the antenatal period with structurally abnormal chromosome 7.

11.0 Workforce

11.1 Midwifery:

The Director of Midwifery has been appointment in the substantive role at the end of March 2023.

Birth Rate plus local review

A systematic, evidence-based process to calculate midwifery staffing establishment, Birth Rate Plus® (BR+), was published for Whittington Health in May 2022. BR+ is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years.

Whittington's most recent Birth Rate Plus report (*May 2022*) recommended an establishment in maternity of 184.04 WTE based on data from 2021 calendar year. Comparing against our current 177.81 WTE, this leaves a deficit of 6.23 WTE.

In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BR+ or equivalent calculations.

Following reductions to birthing rate figures seen in 2022 compared to 2021, a local review has been completed in January 2023.

The key conclusions noted are the reduction of births and antenatal referrals; and the suggestion that patient clinical complexity has increased.

The recommendations are:

- process of reviewing births and complexity to be in place ahead of next Maternity Establishment review (May 2023) and to be refreshed and reviewed every 6 months following this. *This will enable us to locally ensure we are in line with Birth Rate Plus suggested ratios between external reviews (2-3 years)*
- Retain current WTE (177.81 WTE) until above recommendations complete to both reduce risk of increasing establishment further above likely output of refreshed recommendations whilst also avoiding risk of reducing below as details of complexity changes not fully understood.

Supernumerary status of the labour ward coordinator:

This audit has been implemented in November 2022 as part of the Maternity Incentive Scheme compliance process for Safety Action 5 about Midwifery staffing.

Since January 2023, when auditing the maternity sitrep, 14 episodes have been noted where the supernumerary status of the labour ward coordinator was lost.

Out of the 14 episodes, 8 episodes are for unknown reasons (lack of documentation on the sitrep). This is being raised. As a result, the labour ward coordinator for the shift will have to attend the morning maternity operational huddle to have an overall insight of the maternity unit during her shift as well as supplying information about the sitrep documented. This is to start from May 2023.

Regarding the 6 other episodes, 4 were for providing 1:1 care to a labouring woman and 2 for providing care to a high-risk woman needing constant observation.

Recruitment and Retention:
A rolling advert has been ongoing since November 2022.

Band 5 Preceptee Midwife are to be recruited at the top point of the Band 5 pay scale from now on. This was agreed by the executive team in February 2023 and is in place for the next round of recruitment in May 2023. All preceptee midwives in post in February 2023 are having their pay scale readjusted and back paid from the start of their contract.

Since October, 11 midwives have started working at WH: 1 band 6 midwife and 10 band 5 preceptee midwives. Further 9 offers have been made throughout the rolling advert. 1 has declined without specifying any reasons. Therefore, 8 are currently in the pipeline. They are all Band 5 Preceptee midwives.

Regarding Maternity Support Workers (MSW), 12 have started since October 2022. 1 left after less than a week without specifying the reason.

Table 3: Vacancies at the end of March 2023

Role	Band	WTE- vacancy
Midwife	8	1.00
Specialist Midwife	7	1.00
Midwife	7	0
Midwife	6	28.54
Midwifery support workers	3	1.70

International Recruitment (IR):
Whittington Health is a member of the Capital Midwife International Recruitment Consortium and for which 10 places were approved for 10 WTE. Following interview processes, 10 offers were made, however 1 was declined. The next round of recruitment in order to achieve the 10 places is on 24/04/2023.

Since January 2023, 3 midwives have arrived and are awaiting their PIN. They will then be able to start as preceptee midwives (Band 5). All the others to arrive by end of December 2023.

Continuity of Care team:
1 team (Sunflower Team) operating in Islington that cares for women in area of higher social deprivation where Continuity of Care has been shown to greatest impact. The next team will be set up in Haringey again to support higher risk women, however this will be on hold until our recruitment is complete as directed Nationally.

11.2 Obstetrics:
The recruitment of substantive consultants is ongoing. The April interviews for a consultant with a special interest in fertility was not successful. A further post for an Obstetrician with special interest in Maternal Medicine is out to advert with interviews scheduled in June. The department has been successful in recruiting to the other posts and has locums to cover the gaps. This means the on-call rota of 1in 8 at the weekend will begin 1st June 2023. This will provide 8am-9pm consultant presence on the labour ward 7 days per week.

11.3 Junior Doctor Strike:
During the doctor strike the consultants worked collaboratively with the operational management team in developing a rota that would cover safely the services during the two strikes**.** Cover for the strikes was very challenging particularly the second strike due to holidays and other commitments, however the consultant body worked hard and supported the department in making sure the unit was safe.

In midwifery and additional midwife was booked for every shift on labour ward and triage and during the day and additional midwife was booked to carry out NIPE to support the neonatal team.

The department is very grateful to the teams for all they did in the strike to make it safe for our women and babies.

11.4 Funding:
NHSE has renewed the funding for another year for the 1.00 WTE midwifery role for recruitment and retention.

NCL has secured the funding for the 6 following months for 0.50 WTE midwifery specialist role for maternal medicine.

11.5 Culture Work:
The senior leadership team is on team building journey facilitated by the Organisation Development (OD) team. This allows the Midwifery Leadership team to address their current working relationship, build trust, explore ways to communicate effectively and to make improvements to build team effectiveness.

The OD team has explored with the midwifery team members what is required to support them. A development plan has been established consisting of a 6-month programme which is delivered in-house by the Organisational Development team. These, and any other ideas, can be used for discussion on the goals, to collaboratively create an appropriate plan to suit the needs of the Midwifery leadership team.

To improve the management skills of the operational members of the midwifery senior leadership team, a series of workshops are being put in place by the director of operations of the ACW ICSU, the Director of Midwifery and the HR business partner for the ACW ICSU.

In order to continue develop and keep and effective Multi-Disciplinary Teamwork and staff engagement the Ockenden cafes, initiated for the Ockenden Assurance visit in June 2022, are ongoing once a month. Donna Ockenden will be attending one in June 2023. Maternity dedicated Schwartz rounds are also taking place.

12.0 Maternity Digital Programme

The maternity digital programme and the Estates programme will be the focus of the Maternity and Neonatal Transformation programme over the next 12 months.

The team have worked hard in developing the first ad very complex Standard Operating Procedure (SOP) for women when they first interact with the maternity service. This has been a complex piece of work with the wider team and is a major step toward in digitising the service.

Using the learning from this work the team are setting out a plan to ensure all the remaining SOPs that required are completed.

Alongside this the IM&T team are working hard to address the connectivity issues in the community.

The next 12 months are crucial in pushing this project to completion.

13.0 Maternity and Neonatal Estates Programme

9.1 Birth Centre:
The upgrade of the centre is near completion and a small opening ceremony is planned for the end of April.

9.2 Phase 1:
The work on phase 1 has started and this includes removal of some parts of buildings and a survey of asbestos. The recruitment of a midwife to support the teams in working with the contractors while delivering clinical services is underway. A project board has been set up and this will manage the project. This group reports into the P22 Estates Programme Board as part of the wider estates programme and also into the Maternity and Transformation Program Board to ensure clinical oversight of the work.

9.3 Phase 2:
The development of Outline Business Case is underway and the 1:200 designs for this are being completed.

14.0 Maternity Voices Partnership (MVP) engagement

13.1 Annual Plan for 2023
The Co-chairs MVPs for the Maternity Unit write with the support of the NCL LMNS an annual plan which sets targets for the year.

For 2023, they have set 3 areas of focus:

- Co-Production of Projects to Improve Services. There are currently 4 co-production projects ongoing: Care Outside of Guidance pathway establishment, Induction of Labour pathway being service users centred, Infant Feeding and work towards BFi accreditation, Homebirth Service cover.
- Expand Service User Feedback Opportunities
- Grow Awareness of the Whittington MVP

13.2 Co-Production work - Care Outside Guidance
Women and families requesting care outside of guidance are increasing in number across the country and at the Whittington we are working hard to implement processes to ensure women feel supported in their choices within a safe framework.

When service users request care outside of the Trust guidelines, they are now referred for a one-to-one review with the consultant midwife, and obstetrician if appropriate. A full discussion on the service user's birth preferences takes place, recent evidence and

guidance is discussed and a personalised care plan is made together and shared with the service user.

In order to embed this practice, a guideline is in development and a series of four workshops have been commissioned for the full multidisciplinary team (including midwives, obstetricians and MVP) to discuss the wider importance of personalised care and how we can provide a safe pathway for all those in our care. Most recently, a workshop took place with Birthrights and we are planning a further visit by the Birthrights team to disseminate this learning widely within our maternity unit.

13.3 Doula's Meeting

Whittington maternity recently hosted their first workshop with local doulas and birth supporters. The event was well attended by both workers and midwives from the Whittington. Conversation focused on our shared passion for person centred care and positive experiences for women and birthing people.

Key discussion points included collaborative working, supporting out of guidance birth choices, and the strengths and challenges of the service. All in attendance agreed that this was a valuable opportunity and plans are in progress for a future meeting, as well as possible similar workshops with local independent midwives to enhance collaborative working.

15.0 Conclusion

The work in recruitment of Obstetricians and Gynaecologists has enabled the full on call rota to begin in June and supports the delivery of the safety actions for our women.
With the successful recruitment of the substantive Director of Midwifery Isabelle Cornet the next steps are a root and branch review of the midwifery structure. This work will take into account the Ockenden and CQC recommendations in supporting the Governance team, assessing the needs of the Digital team going forward to accelerate the digital work, improve the Safeguarding team and the sustainability of the Home birth Service. This will be done in the context of the Birth Rate Plus numbers and the financial need to provide efficient and high-quality services.
T
here has been a lot of developments in the Maternity Service, but we continue to work to improve what we provide to our women.

The committee is also asked to note the national publication by NHSE of the Maternity 3-year Single Delivery Plan.

The committee is asked to note the report.

Meeting title	**Quality Assurance Committee**	**Date: 10th May 2023**
Report title	Patient-Led Assessments of the Care Environment (PLACE) 2022	**Agenda item: 4.7**
Executive director lead	Mark Bateman, Deputy Director of Estates and Facilities	
Report author	Mario Araujo, Facilities Manager	
Executive summary	**<u>Background:</u>** Since 2019 the annual PLACE assessments, had been suspended, however, sites were advised to continue carrying out assessments, in a simplified version – PLACE Lite. Facilities have since December 2021, been carrying out PLACE Lite assessments, on regular basis, at ward level, during meal service. Whittington carried out their PLACE assessment on the 17th November and returns must be submitted by all Trust's by 16th December. Results are published to help drive improvements in the care environment. The results show how hospitals are performing both nationally and in relation to other hospitals providing similar services. Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. PLACE assessments will provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. The assessments involve local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness, and general building maintenance and, more recently, the extent to which the environment can support the care of those with dementia or with a disability. **<u>The Assessment Team:</u>** PLACE assessment teams must be made up of a minimum of 50% Patient Assessors (non-staff) Mario Araujo managed the assessment and was responsible for administrative matters before, during and after the assessment as well as submitting the results which are then published on the Health and Social Care Information Centre (HSCIC) website. This year's team of 12 was made up of: • 6 Patient assessors – Haringey Healthwatch, Volunteers and NHSE • 6 Staff Assessors	

This represented a good mix of auditors, and we are very grateful to both the local Healthwatch organisations in supporting us.

The Whittington Audit:

Was carried out on Thursday 17th November 2022, the following areas were assessed:

WARD	OUTPATIENT DEPARTMENTS	Emergency Departments	Food Assessments
Victoria Ward	Imaging	A&E PAEDS	Coyle Ward
Day Treatment Centre	Children's Clinic		Cavell Ward
Betty Mansell Ward	Clinic 3D		
SCBU	Clinic 3A		
Cloudesly Ward	Fracture Clinic		
Cavell Ward	Thalassemia Clinic		
Neo Natal	Eye Clinic		
Cearns Ward	TB Clinic		
Mary Seacole North	Clinic 3 B		
Mary Seacole South			
ITU			

Results:

The mixed age of the building showed different standards of cleanliness according to the age, condition and presentation of the building that was being viewed. It was acknowledged that in most areas cleaning was a challenge not due to the quality, but due to the poor fabric of the building, giving a negative impression, mainly floors.

The new national cleaning standards star ratings were not on display in some of the areas – although Facilities have confirmed all areas were issued with star ratings, as per our cleaning audit process. There is now an ask that ward/department managers ensure that both the cleaning standards and star ratings remain displayed, as per the guidance in line with the National Standards of Cleanliness 2021.

Clinical staff are caring, helpful and welcoming. The areas in general in the hospital are uncluttered.

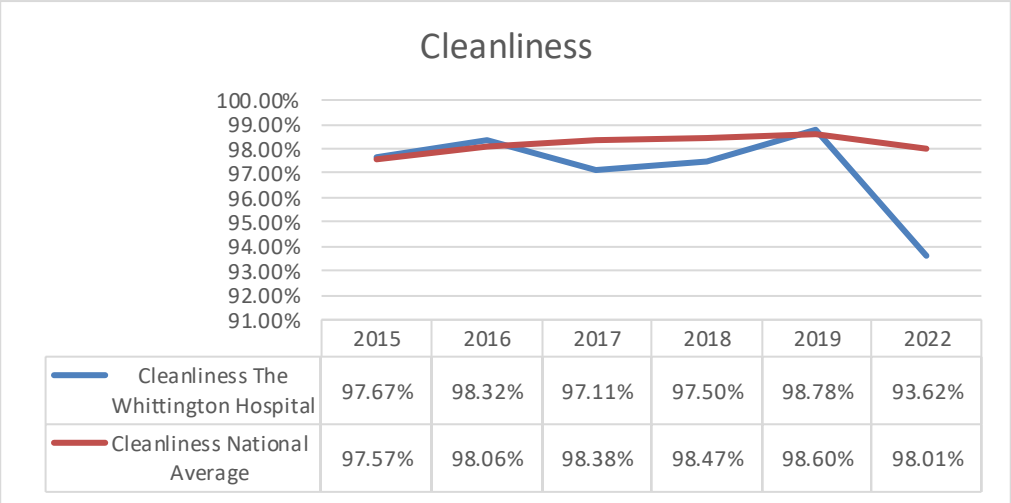
The wayfinding signage in the hospital is not so good or clear. Communications and Capital Projects are working on improving the wayfinding. Patient assessors showed a willingness to support further in a future project to provide feedback on ideas.

The internal decoration is drab with poor use of artwork or colour.

The group reflected that it was a good idea to have a dedicated note taker with them, part of the assessment team, as they had more time to audit and not have to worry about writing up the notes as they went along.

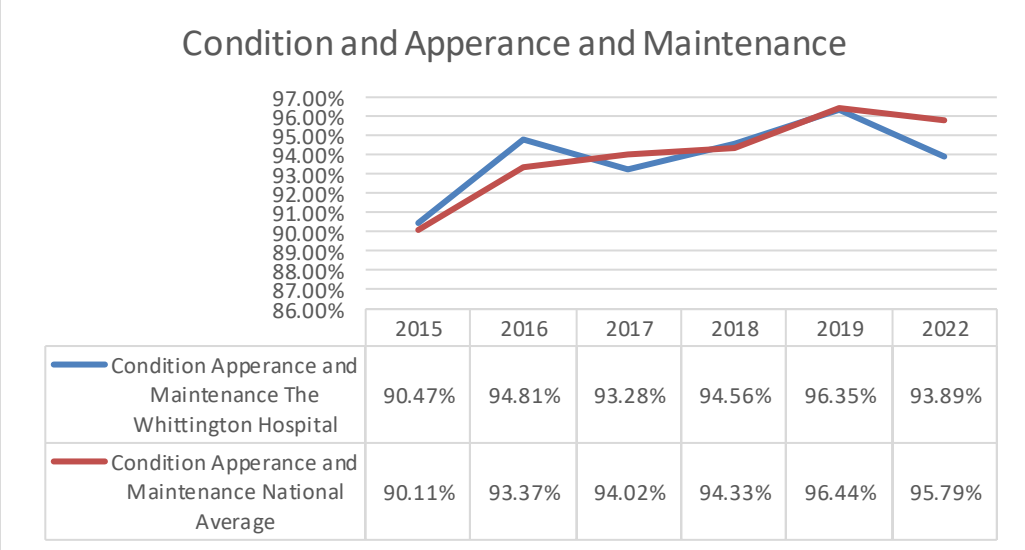
The results are shown below in the six graphs with comparisons against the National Average along with scores dating back to 2015 in each domain. The national averages for 2022 have not been included, as the closing date for submission is 16th December 2022.

Cleanliness



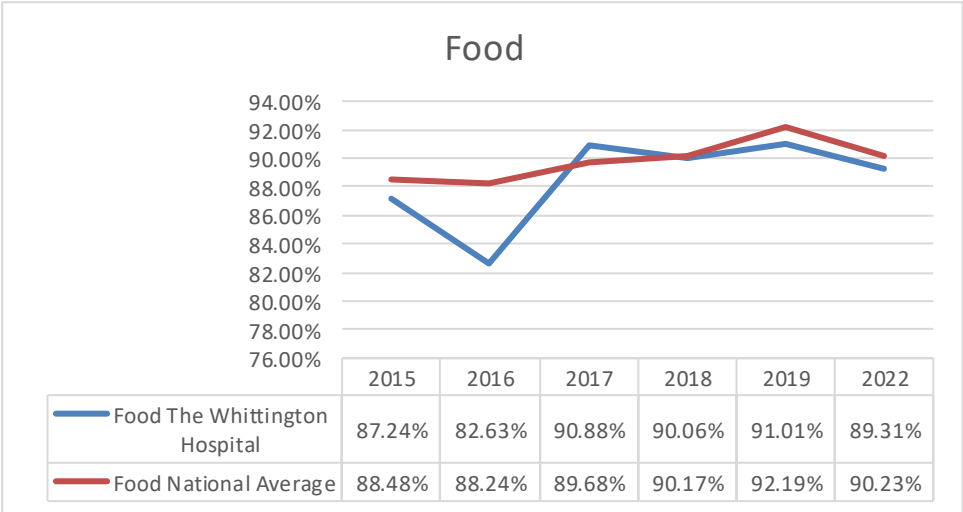
	2015	2016	2017	2018	2019	2022
Cleanliness The Whittington Hospital	97.67%	98.32%	97.11%	97.50%	98.78%	93.62%
Cleanliness National Average	97.57%	98.06%	98.38%	98.47%	98.60%	98.01%

Condition Appearance and Maintenance



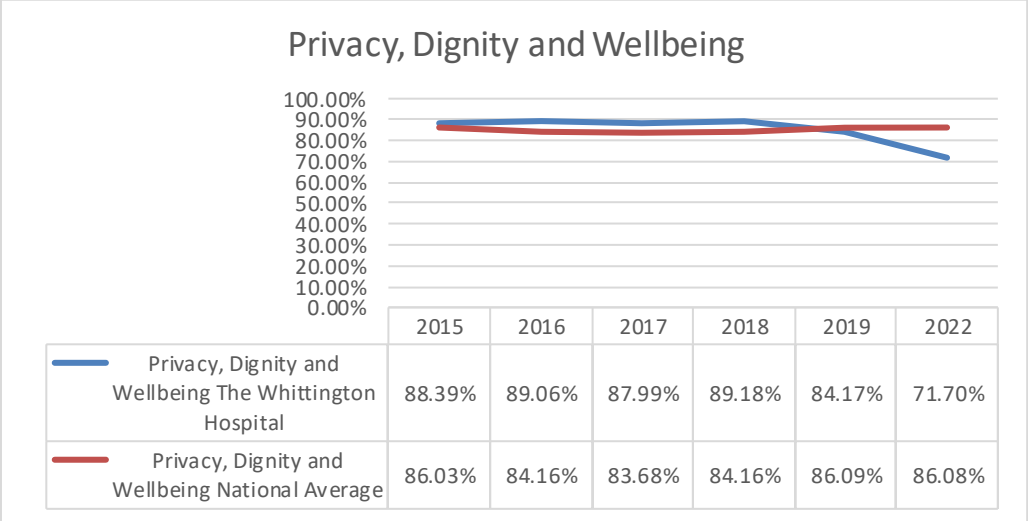
	2015	2016	2017	2018	2019	2022
Condition Apperance and Maintenance The Whittington Hospital	90.47%	94.81%	93.28%	94.56%	96.35%	93.89%
Condition Apperance and Maintenance National Average	90.11%	93.37%	94.02%	94.33%	96.44%	95.79%

Food



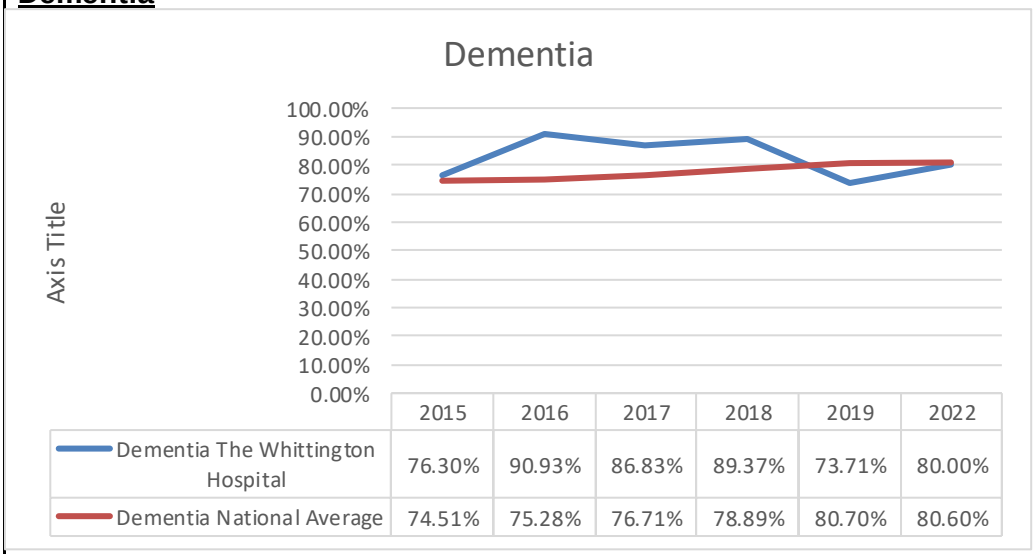
	2015	2016	2017	2018	2019	2022
Food The Whittington Hospital	87.24%	82.63%	90.88%	90.06%	91.01%	89.31%
Food National Average	88.48%	88.24%	89.68%	90.17%	92.19%	90.23%

Privacy, Dignity and Wellbeing



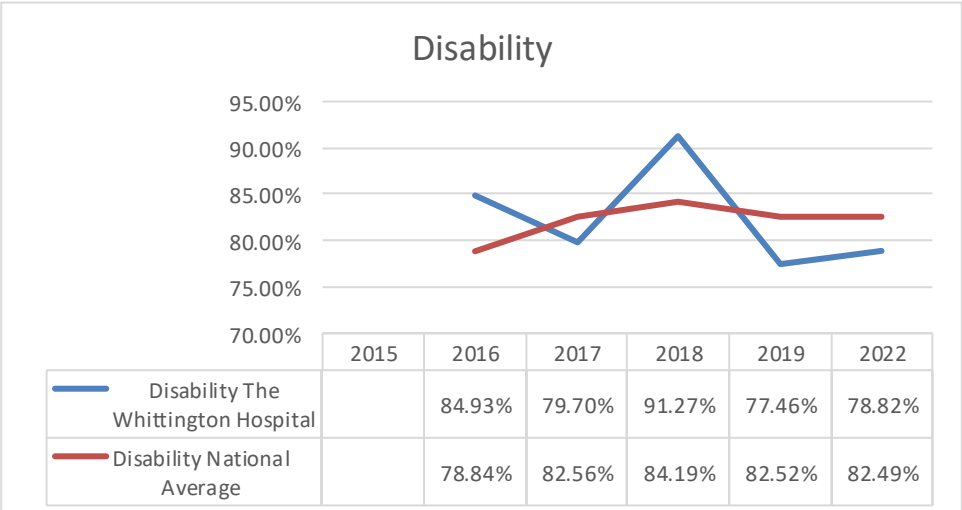
	2015	2016	2017	2018	2019	2022
Privacy, Dignity and Wellbeing The Whittington Hospital	88.39%	89.06%	87.99%	89.18%	84.17%	71.70%
Privacy, Dignity and Wellbeing National Average	86.03%	84.16%	83.68%	84.16%	86.09%	86.08%

Dementia



	2015	2016	2017	2018	2019	2022
Dementia The Whittington Hospital	76.30%	90.93%	86.83%	89.37%	73.71%	80.00%
Dementia National Average	74.51%	75.28%	76.71%	78.89%	80.70%	80.60%

Disability



	2015	2016	2017	2018	2019	2022
Disability The Whittington Hospital		84.93%	79.70%	91.27%	77.46%	78.82%
Disability National Average		78.84%	82.56%	84.19%	82.52%	82.49%

	There is no further definition of these results, the former PEAT ratings of Excellent/Food/Acceptable/Poor/Unacceptable no longer apply and there is now a Pass or Fail mark in this process. More information on PLACE available: https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place
Purpose:	*Information*
Recommendation(s)	The Quality Governance Committee is asked to review the quality assurance provided in this report and discuss concerns and review the targeted actions for improvement to ensure they are appropriate
Risk Register or Board Assurance Framework	*Quality entries on risk register*
Report history	*QGC 27/04/23*
Appendices	*Appendix 1: PLACE Report Whittington Health 2022* *Appendix 2: Area Scores Whittington Health 2022* *Appendix 3: Site scores Whittington Health 2022* *Appendix 4: PLACE action tracker 2022*

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2023**
Report title	**Integrated Performance Report**	**Agenda Item: 7**
Executive lead	Jonathan Gardner, Director of Strategy and Corporate Affairs	
Report owners	Paul Attwal, Head of Performance, Jennifer Marlow, Performance Manager	
Executive Summary	Board Members should note that all metrics are shown in summary, but only certain measures have been highlighted for further analysis and explanation based on their trajectory, importance, and assurance. **With regards to performance, areas to draw to Board members' attention are:** **Infection Prevention and Control** In April 2023 the Trust saw 1 case of C. Difficile against a yearly target of less than 13. **Emergency Department (ED)** All four of major ED metrics are showing signs of improvement in April 2023 compared to March 2023, however remain below national standards. During April 2023, performance against the 4-hour access standard was 68.1%, which is lower than the NCL average of 71.32%, and lower than the London average of 74.08% and the national average of 74.56%. There were 173 12-hour trolley breaches in April 2023. **12-hour trolley breaches show the numbers of patients who waited longer than 12 hours to be admitted to the ward following a decision to admit (DTA)* **Cancer** 28 Day Faster Diagnosis was at 68.8% in March 2023 against a standard of 75%, this is an improvement from February's performance of 67.9%. 62-day referral to treatment performance was at 57.7% for March 2023 against a target of 85%. Although this is still below national target it is a significant improvement of 25.1% from February's performance of 32.6%. At the end of April 2023, the Trust's position against the 62-day backlog was behind trajectory with 103 against a target of 110. **Referral to Treatment: 52+ Week Waits** Performance against 18-week standard for March was: 63.9%. The Trust position against the 52-week performance has worsened from 607 patients waiting more than 52 weeks for treatment in March 2023 to 627 in April 2023. Performance has declined as a result of strike action. The Trust has 10 patients over 78 weeks at the end of April 2023. The 78-week target has now moved to have 0 patients over 78 weeks by the end of June 2023. This is as a result of the impact of the strike action.	

	Workforce Following realignment of targets inline with national standards the Trust is now compliant with mandatory training targets. Well Led People Pulse Survey ran throughout the month of April 2023 with a total of 526 respondents. The engagement score is 6.56 which is slightly higher than the national average.
Purpose:	Review and assurance of Trust performance compliance
Recommendation	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan
Risk Register or Board Assurance Framework	The following BAF entries are linked: Quality 1; Quality 2; People 1; and People 2.
Report history	Trust Management Group

Whittington Health NHS Trust

Performance Report

May 2023
Month 1 (2023-2024)

Safe

Indicator	Target	Last Reported Month	Latest Month	Previous Month	2023-2024	Variation	Assurance
Admissions to Adult Facilities of pts under 16 yrs of age	**0**	**Apr**	0	0	0		
HCAI C Difficile	**<13**	Apr	1	3	1		
Actual Falls	**400**	**Apr**	27	29	27		
Category 3 or 4 Pressure Ulcers	**0**	Apr	8	10	8		
Medication Errors causing serious harm	**0**	**Apr**	0	0	0		
MRSA Bacteraemia Incidences	**0**	**Apr**	0	1	0		
Never Events	**0**	**Apr**	0	0	0		
Serious Incidents	**N/A**	**Apr**	2	2	2		
VTE Risk Assessment %	**>95%**	**Apr**	95.3%	95.8%	95.3%		
Mixed Sex Accomodation Breaches	0	Apr	9	11	9		
Summary Hospital Level Mortality Indicator (SHMI)	1.14	Apr					

Category 3 or 4 Pressure Ulcers - *Target 0*

April Performance Category 3 – 8 (2 hospital, 6 community)

April Performance Category 4 – 0

Issues: Staff accessing available training, inaccurate skin assessment on admission to emergency care, delays in implementing plans of care and equipment remain the key themes.

Actions:

- Development of new Trust Action Plan to address key themes
- Increased access to PU training, including planned CSW Skills day on 14/7/23
- Review of trolley and mattress provision in ED

HCAI C. Difficile

April Performance C. Difficile - 1

Issues:

- Delays in sending samples for testing.
- Poor documentation and management of isolation protocols.
- Infection status not being correctly handed over during ward transfers.
- Bowel management plans not being followed.

Actions:

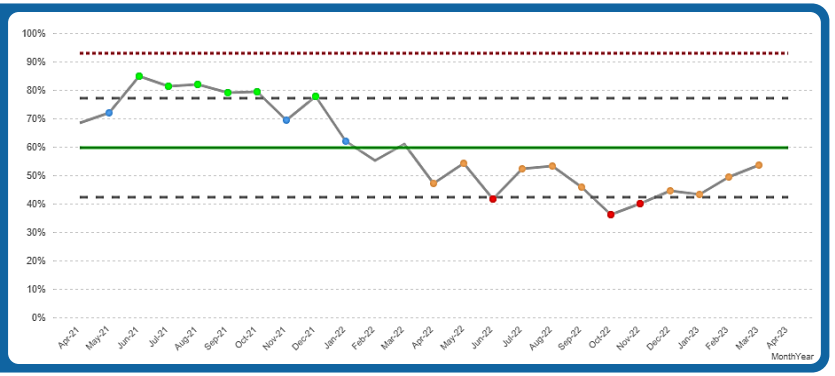
- Introduced MDT incident meeting to review each case.
- Trust wide shared learning of 2022/23 C. difficile infections.
- External audit of point of care cleaning plus supported training.
- Proposed antimicrobial stewardship rounds for C. difficile.

Responsive (Access)

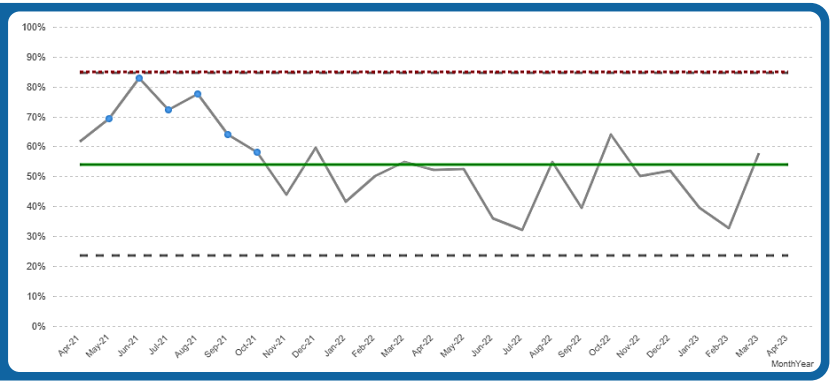
Whittington Health NHS Trust

Indicator	Target	Last Reported Month	Latest Month	Previous Month	2023-2024	Variation	Assurance
Cancer - 14 days to first seen	>93%	Mar	53.6%	49.3%		L	F
Cancer - 14 days to first seen - breast symptomatic	>93%	Mar	5.6%	4.5%		L	F
Cancer - 62 days from referral to treatment	>85%	Mar	57.7%	32.6%		L	F
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%	Mar	56.4%	31.3%		L	F
Cancer ITT - % of Pathways sent before 38 Days	>85%	Mar	16.7%	16.7%		L	F
Cancer - % Pathways received a Diagnosis within 28 Days of Referral	>75%	Mar	68.8%	67.9%		L	F
Cancer - 31 days to first treatment	>96%	Mar	90.4%	91.2%			F
Cancer - 31 days to subsequent treatment - surgery	>94%	Mar					
Cancer - 62 Day Screening	>90%	Mar	50.0%	100.0%			F
DM01 - Diagnostic Waits (<6 weeks)	>99%	Apr	79.86%	83.95%	79.86%		F
RTT - Incomplete % Waiting <18 weeks	>92%	Apr	63.9%	62.4%	63.9%	L	F
Referral to Treatment 18 weeks - 52 Week Waits	0	Apr	627	607	627	H	F
% seen <=48 hours of Referral to District Nursing Service	>95%	Apr	91.6%	85.8%	91.6%		F
Haringey New Birth Visits - % seen within 2 weeks	>95%	Mar	91.8%	93.0%			F
Islington New Birth Visits - % seen within 2 weeks	>95%	Mar	93.7%	93.2%			F
% of Rapid Response Urgent referrals seen within 2 Hours of Referral		Apr	81.6%	79.8%	81.6%		

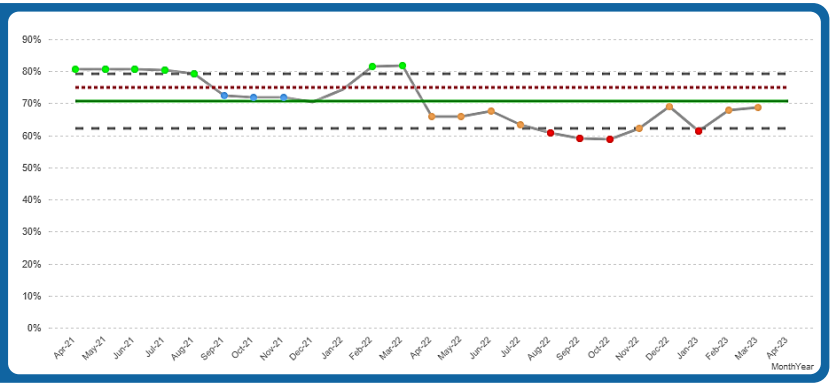
Cancer - 14 Days to First Seen



Cancer - 62 Day Performance



Cancer - 28 Day FDS



Responsive (Access)

Whittington Health NHS Trust

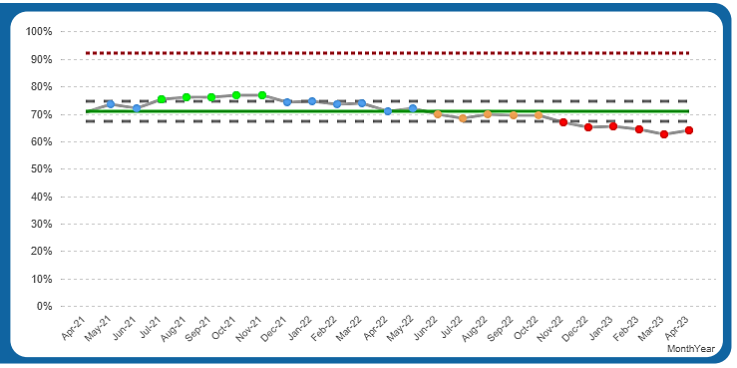
What the Data Tells Us	Issues	Actions and Mitigations
Cancer: 14 Days to First Seen - *Target >93%* *No. of pts first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer.* **March Performance – 53.6%** This is an improvement of 4.3% from February's performance of 49.3% and a gradual improvement trend.	Significant number of patients breaching the target within Breast One Stop (13.1%), Dermatology Outpatients (31.7%), and Gynaecology Rapid Access Outpatients (34.4%).	• Overall improvement plan for Cancer performance within the Trust has been established, and is monitored weekly by the Chief Operating Officer. • Working with each service using a recent audit to identify the specific capacity issues that needs to be addressed. • Recalculating the Capacity and Demand modelling for each service. • Addressing capacity shortfalls with each service until in equilibrium.
Cancer: 62 Day Performance - *Target >85%* *No. of pts receiving their first treatment for cancer within 62 days of GP referral for suspected cancer.* **March Performance – 57.7%** This is an improvement of 25.1% from February's performance of 32.6%.	Significant number of patients breaching the target within Breast (8 breaches from 11 patients), and Urology (6 breaches from 14 patients).	**Breast:** • Improve pathway coordination including treatment scheduling through super tracking twice per week. **Urology:** • Improve pathway coordination including treatment scheduling through super tracking twice per week.
Cancer: 28 Day Faster Diagnosis Standard (FDS) - *Target >75%* *% Pathways Received a Diagnosis within 28 Days of Referral.* **March Performance – 68.8%** This is an improvement of 0.9% from February's performance of 67.9%.	Significant number of patients breaching the target within, Gynaecology (43.2%), and Urology (44.3%)	**Gynaecology:** • Focus on improving histology turnaround times. • Gynaecology triaging patients straight to outpatient hysteroscopy. • Additional hysteroscopy sessions to increase capacity levels. • Urology to review of Haematuria Pathway. • Urology to ensure that prostate pathway is running to previously agreed plan

Responsive (Access)

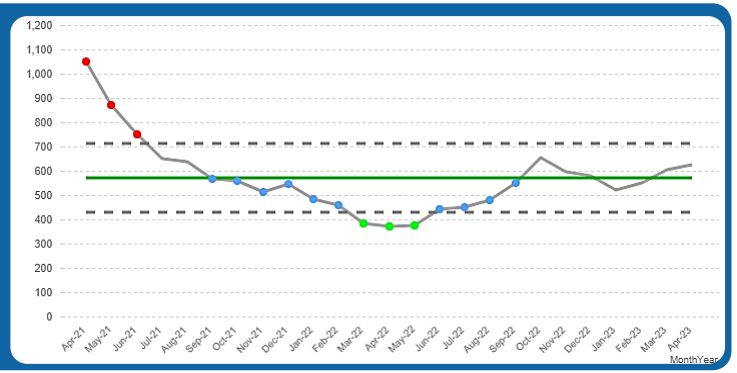
Whittington Health NHS Trust

What the Data Tells Us	Issues	Actions and Mitigations
Referral to Treatment Incomplete % Waiting <18 week – ***Target 92%*** **April Performance – 63.92%** This is an improvement of 1.54% from March's performance of 62.38%. The gradual downward trend is a concern.	• Impact of the doctors strike has effected capacity across elective pathways. • Bed availability continues to have an impact on the delivery of elective pathways. • The Trust was 10 patients away from achieving the target of 0 over 78 weeks for April. Due to impact of strike action nationally the target of 0 has now been moved to the end of June 2023 • Key risk service for the Trust to be compliant with the 78 week target is Vascular Surgery. There are known issues within the Vascular services across the whole of NCL due to capacity constraints.	• Mitigations for Vascular is to use Mutual Aid and Independent sector support to ensure compliance by the end of June. • Performance 78 target is being reviewed weekly by Chief Operating Officer. • Regular review of 52 week position at the weekly waiting list review meeting.
Referral to Treatment 18 weeks - 52 Week Waits – ***Target 0*** **April Performance – 627** This is a worsening of 20 from March's performance of 607. There were 10 Patients waiting over 78 weeks.		
DM01: Diagnostic Waits <6 weeks – Target 99% *Percentage of patients waiting less than 6 weeks for 15 key diagnostic tests and procedures.* **April Performance – 79.86** This is a worsening of 4.09% from March's performance of 83.95%. The downward trend is a cause for concern against variation and assurance.	• Impact of the doctors strike has effected capacity across elective pathways including Diagnostics. • Key diagnostics with underperformance are Audiology Assessments, Echocardiography, and Sleep Studies. • Capacity constrains in Audiology Assessments, and Outpatient Cardio Testing continue to impact performance.	• The Audiology service are producing a recovery plan to be presented to the Trust Management group for implementation. • Outpatient Cardio capacity review underway, with improvement plan to be set up in May.

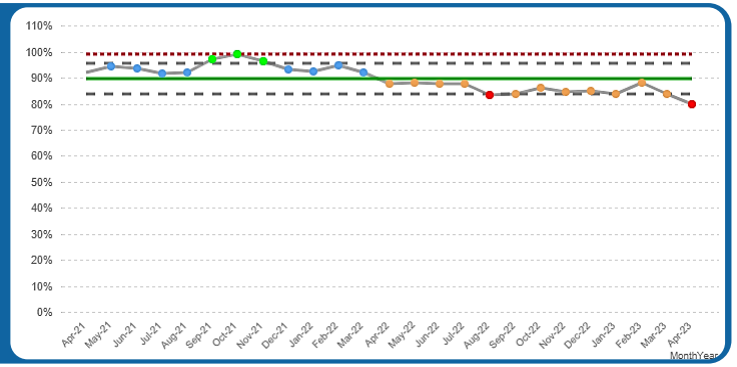
18 Weeks RTT



52-Week Waiters



DM01



Responsive (Emergency Department)

NHS Whittington Health NHS Trust

Indicator	Target	Latest Month Reported	Latest Month	Previous Month	2023-2024	Variation	Assurance
LAS Patient Handover Times - 30 mins	**0**	Apr	69	84	69	H	F
LAS Patient Handover Times - 60 mins	**0**	Apr	24	69	24	H	F
% streamed to an onsite service	**>7.5%**	Apr	2.2%	2.0%	2.2%		F
Median Wait for Treatment (minutes)	**< 60 min**	Apr	90	107	90	H	F
% of ED attendance seen by clinician within 60 mins of arrival		Apr	41.1%	35.8%	41.1%	L	
Median time from Arrival to Decision to Admit		Apr	04:15	04:28	04:15	H	
12 Hour Trolley Waits in ED	**0**	Apr	173	296	173	H	F
Total ED Attendances in dept for more than 12 hours (arrival to dept)		Apr	508	756	508	H	
% of ED Attendances over 12 hours from Arrival to Departure	**<2%**	Apr	6.4%	8.0%	6.4%	H	F
Emergency Department waits (4 hrs wait)	**>95%**	Apr	68.1%	65.5%	68.1%	L	F
% left ED before being seen		Apr	9.5%	10.9%	9.5%	H	
% ED re-attendance within 7 days		Apr	10.3%	10.2%	10.3%		

LAS Handovers - *Target 0*

Number of Ambulance Handover delays of greater than 30 minutes and 60 minutes.

April Performance (30 mins) – 69
This is an improvement of 15 from 84 in February.

April Performance (60 mins) – 24
This is an improvement of 45 from 69 in February.

Issues: The process for Rapid Access Triage is in review due to physical and capacity constraints that are causing delays in handovers.

Actions: Observation of the current processes to be undertaken followed by a workshop with ED and Local Ambulance Service staff

Mitigations: Maintain patient safety and regular checks with any patients waiting in the back of ambulances.

Median Wait for Treatment - *Target <60*

Time from arrival to seeing a doctor or nurse practitioner.

April Performance – 90 minutes
This is an improvement of 17 minutes from 107 in March

Issues: Overcrowding in ED reducing capacity to assess patients.

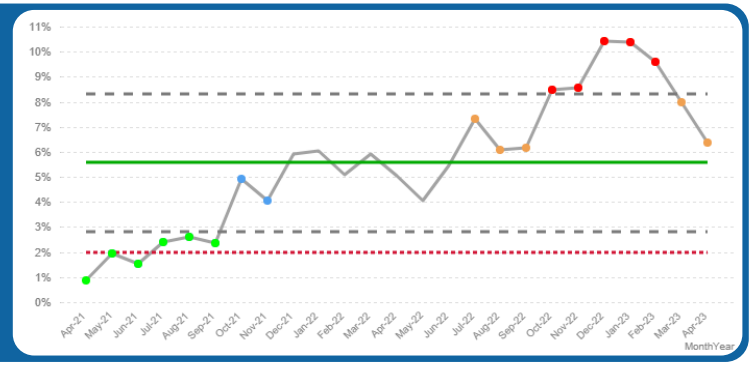
Actions: Demand and capacity review with recommendations to be submitted for consideration. Further development with the Trust Flow programme will continue with wards and site team to improve the number of discharges before midday.

Responsive (Emergency Department)

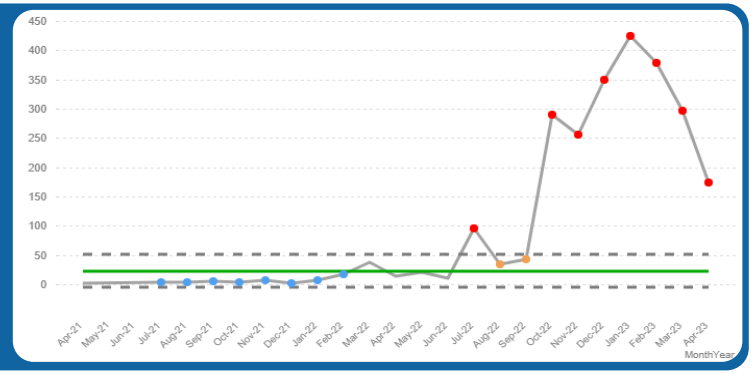
Whittington Health NHS Trust

What the Data Tells Us	Issues	Actions and Mitigations
% Of ED Attendances Over 12 Hours - *Target <2%* *Percentage of patients in ED for more than 12 hour.* **April Performance – 6.4%** This is an improvement of 1.6% from March's performance of 8%.	• Long wait to be seen delaying patient journey due to overcrowding in the department • Bedding overnight of patients in Same Day Emergency Care • Continued increase in length of stay for mental health patients within ED • Late discharges from ward delaying movement of patients awaiting admission out of ED • Patients requiring less than 23hrs care being discharged directly from ED	• Ward managers to attend the 3pm Bed meeting to discuss discharges for the following day, encouraging all necessary medication, transport and care to be in place for earlier discharge • New ED dashboard reporting tool with live updates being trialled prior to roll out within the next month. This will provide clear oversight of patient flow within ED • Demand and capacity review of staffing to be completed and recommendations submitted for consideration following the changes in attendance patterns post COVID • Review of effective use of SDEC (Same Day Emergency Care) including clinical teams regularly reviewing patients in ED for appropriate transfer to service • ED, police, mental health teams and Local Ambulance Service now meeting regularly to identify alternative appropriate care for mental health patients to reduce inappropriate attendance to ED • Refresh of the multi agency High Intensity User group
12-Hour Trolley Waits in ED - *Target 0* *No. of patients who waited longer than 12 hours to be admitted to the ward following a decision to admit.* **April Performance – 173 (Average 5.8 per day)** This is an improvement of 123 (41.6%) from March's performance of 296.		
Emergency Department Waits (4 hrs wait) - *Target >95%* *No. of patients treated within 4 hours of arrival in ED.* **April Performance – 68.1%** This is an improvement of 2.6% from March's performance of 65.5%.		

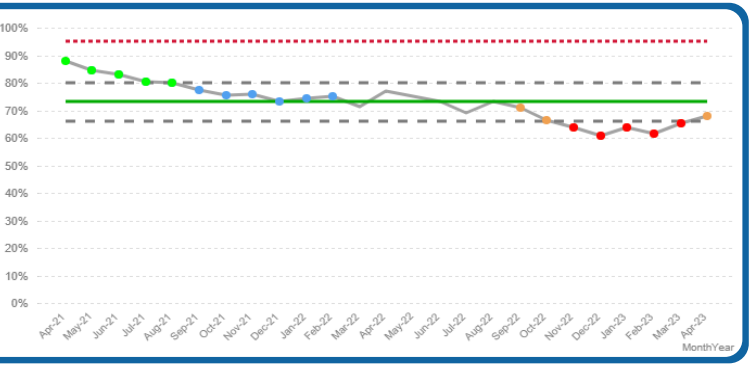
ED Attendances Over 12 Hours



12-Hour Trolley Waits in ED



ED 4 hour Waits



Activity

Whittington Health NHS Trust

Current performance level is below trajectory due to impact from doctors strikes

Indicator	Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
ED Attendances		9742	9387	9117	8081	8383	9392	9324	9287	8309	7891	8762	7988
ED Admission Rate %		9.8%	9.5%	10.2%	10.6%	10.1%	9.0%	9.0%	10.3%	10.9%	9.9%	10.4%	10.6%
Community Face to Face Contacts		45655	43453	41198	37831	40764	42817	46681	35140	44183	41086	46094	37168
Elective and Daycase		2090	2081	2178	2020	2303	2317	2393	1826	2234	2010	2152	1872
Emergency Inpatients		1707	1717	1674	1686	1563	1626	1577	1631	1605	1467	1619	1396
GP Referrals to an Acute Service		8384	7675	7648	7465	7392	8089	7249	6296	7825	6963	8061	6297
% of GP Referrals that were completed via ERS		81.9%	81.0%	82.7%	82.8%	81.4%	82.1%	81.5%	77.5%	74.6%	71.2%	71.5%	64.3%
% e-Referral Service (e-RS) Slot Issues	<4%	33.0%	32.6%	30.1%	31.5%	32.5%	31.8%	38.5%	38.3%	34.3%	35.3%	38.5%	48.0%
Maternity Births	320	244	262	264	271	237	254	259	231	248	221	227	192
Maternity Bookings	377	388	284	327	277	262	295	297	322	293	327	356	313
Outpatient DNA Rate % - New	<10%	10.5%	10.5%	11.5%	12.7%	13.3%	12.8%	12.0%	13.6%	11.2%	11.4%	11.6%	11.8%
Outpatient DNA Rate % - FUp	<10%	9.9%	10.3%	10.9%	10.7%	10.5%	10.6%	10.4%	11.7%	9.8%	10.5%	10.1%	9.8%
Outpatient New Attendances		10208	9931	9324	9403	9475	9890	11488	9928	12338	11533	12166	10444
Outpatient FUp Attendances		18008	17201	15858	16460	18120	17333	18439	15403	17843	16369	17745	14480
Outpatient Procedures		6337	5893	5988	6169	6285	6386	6490	5505	6457	5789	6566	5417

ED Attendances

April 2023 – 7988

This is a decrease of 774 compared to 8762 in March 2023.

This is also a decrease of 799 compared to 8787 in April 2022.

GP Referrals

April 2023 – 8384

This is an increase of 368 from 8016 in March 2023.

This is also an increase of 1605 compared to 6779 in April 2022.

Maternity Births

April 2023 – 192

This is a worsening of 35 from 227 in March 2023.

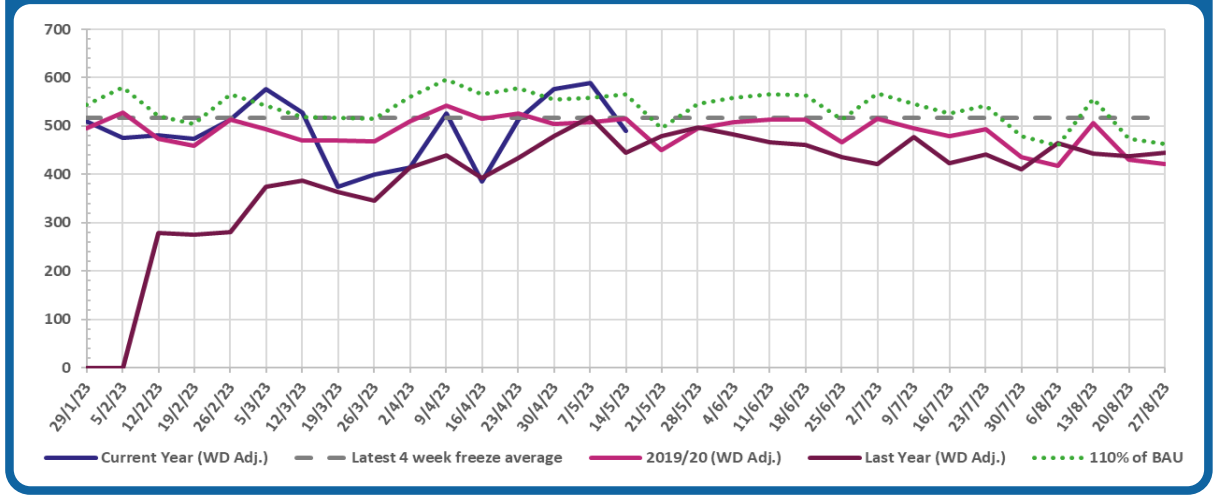
This is also a worsening of 73 compared to 265 in April 2022.

Maternity birth rates have seen a reduction of below target by almost 40%, however maternity bookings are only down by 17%.

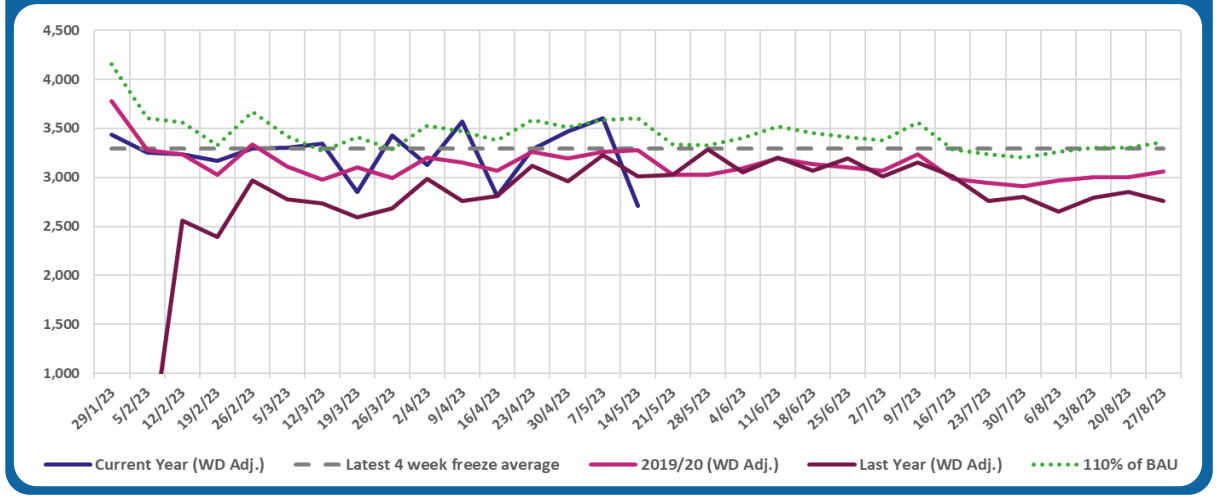
Activity - Forecasts

Whittington Health NHS Trust

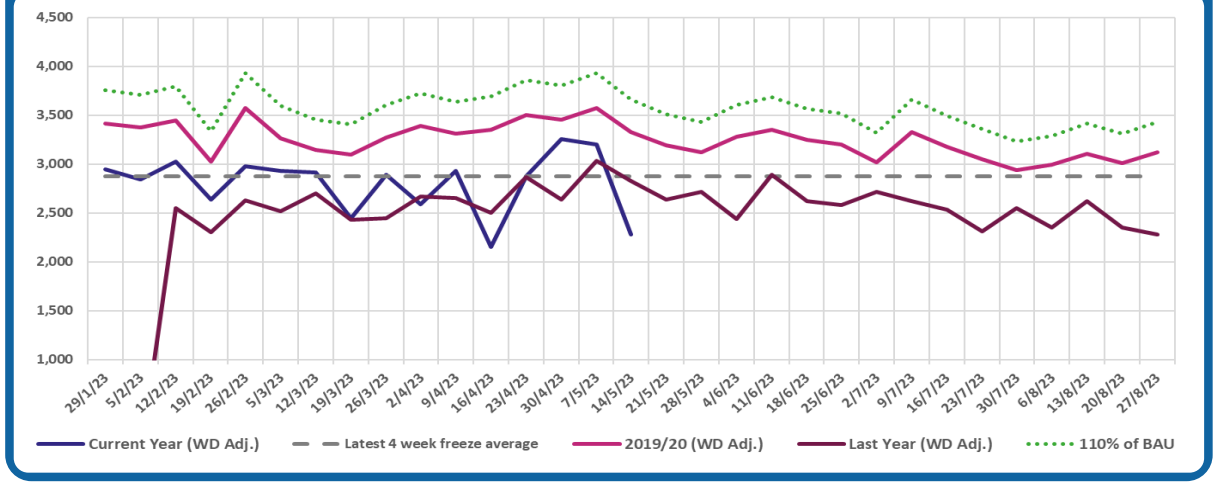
Weekly Elective Activity Trajectories



Weekly Outpatient First Attendances Trajectories



Weekly Outpatient Follow-up Attendances Trajectories



Forecasts Commentary

Current performance level is below trajectory due to impact from doctors strikes.

Weekly Elective Activity Trajectories:
Flex position week ending 30/04/23 was at 96% of 19/20 levels.

Weekly Outpatient First Attendances Trajectories:
Flex position week ending 30/04/23 was at 103% of 19/20 levels.

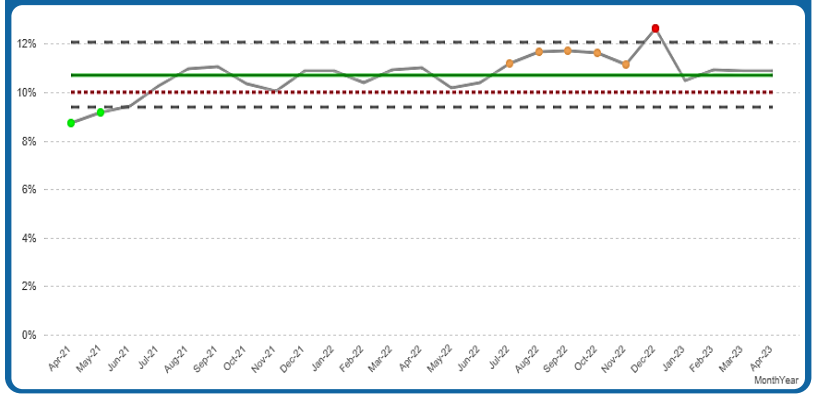
Weekly Outpatient Follow-up Attendances Trajectories:
Flex position week ending 30/04/23 was at 80% of 19/20 levels.

*All figures are subject to change

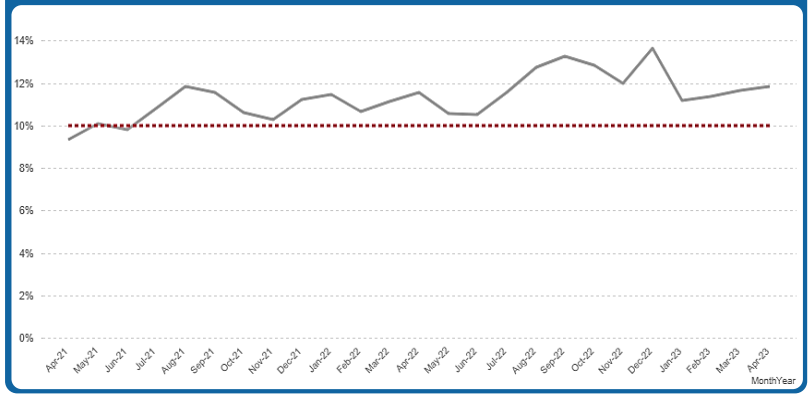
Activity

Whittington Health NHS Trust

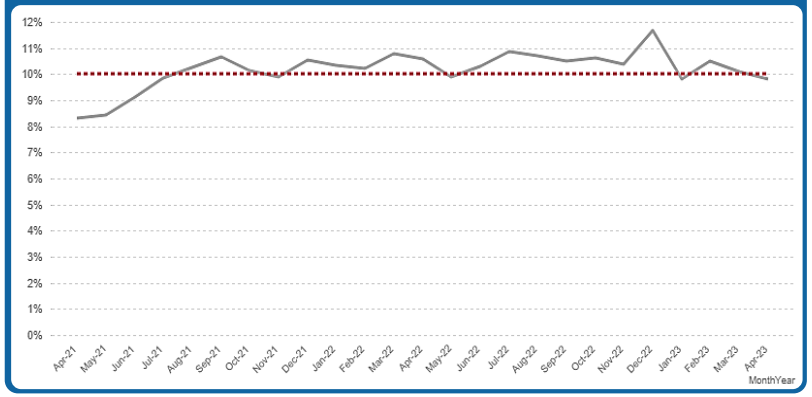
Acute DNA % Rate



Outpatient DNA % Rate - New



Outpatient DNA % Rate – Follow-Up



Activity Highlights

Community Activity: There were 43,591 total contacts in April and there were 612 unoutcomed appointments.

Elective/Day Cases: There were 1,910 cases in the last four weeks of April March (91% of 19/20 activity)

Outpatients: In the last 4 weeks of April there were 12,956 Firsts Appointments (102% of 19/20), and 10,720 Follow-Ups (79% of 19/20)

DNA Rates: Acute DNA rate for April was 10.7 which has had a slight decrease from March rate of 10.9%

Outpatient DNA rate for new appointments was 11.6 April this has stayed the same from March. Outpatient DNA rates for Follow-up appointment was 9.8% this has decreased from Marchs position of 10.1%.

Issues: DNA rates continue to breach Trust target of 10%. Outpatient Transformation working group intends to dedicate workstream plans to reduce DNA below 10% sustainability

Actions: This is part of the Outpatient Transformation working group on the 17th May 2023.

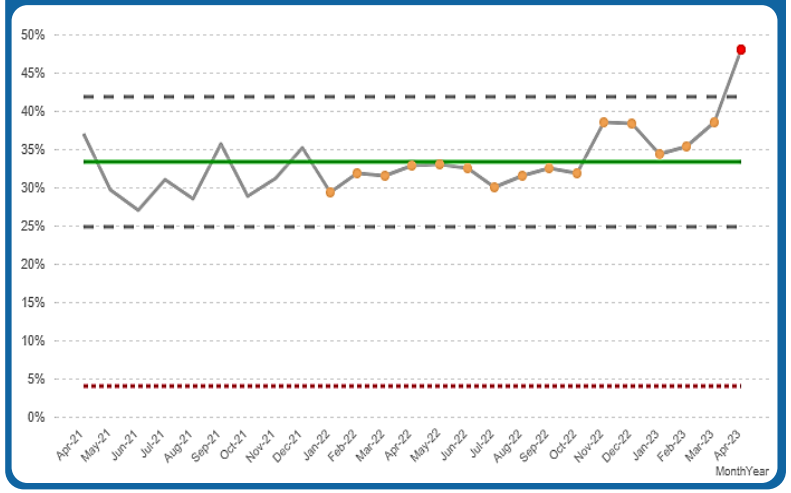
- DNA deep dive Packs are being provided and worked on in the outpatient working group, actions plans for the Specialities above 15% DNA rate will be in place before next outpatient board 14th June 2023.
- Quality checks to be undertaken to review standard of coding outcome and mitigate DNA.
- Services to ensure compliance with trust access policy. Particularly 'reasonable notice' when scheduling.

Effective

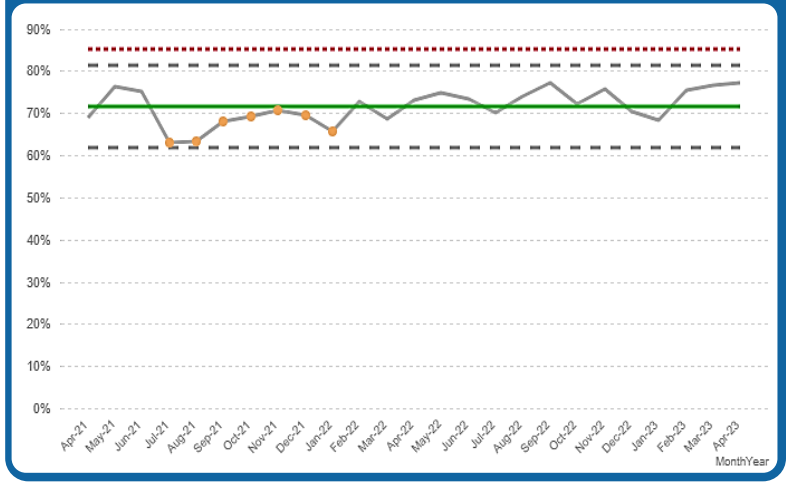
Whittington Health NHS Trust

Indicator	Target	Last Reported Month	Latest Month	Previous Month	2023-2024	Variation	Assurance
Cancelled Ops not rebooked <28 Days	**0**	**Mar**	11	11	0	H	
Hospital Cancelled Operations	**0**	Mar	3	7	0		
Theatre Utilisation	**>85%**	Apr	77.17%	76.60%	77.17%	H	
Community DNA % Rate	**<10%**	**Apr**	7.9%	8.1%	7.9%	H	P
Acute DNA % Rate	**<10%**	**Apr**	10.9%	10.9%	10.9%	H	F
% e-Referrals Service (e-RS) Slot Issues	**<4%**	**Apr**	48.0%	38.5%	48.0%	H	F
Outpatients New:Follow Up Ratio	**2.3**	**Apr**	1.39	1.46	1.39	L	L
Non Elective Re-Admissions within 30 days	**<5.5%**	**Apr**	3.73%	3.07%	3.73%	L	P
Rapid Response - % of referrals with an improvement in care		**Apr**	75.2%	73.0%	75.2%	H	

% e-Referrals Service (e-RS) Slot Issues



Theatre Utilisation



Effective

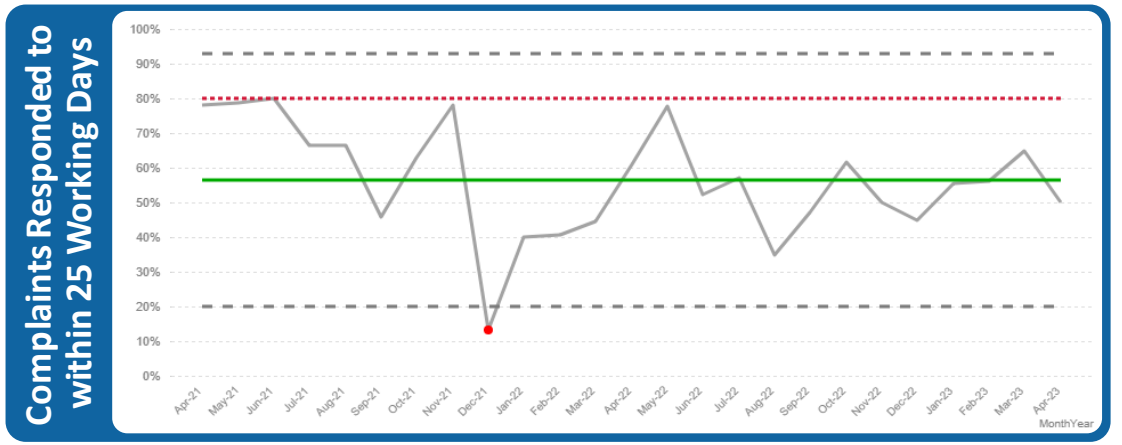
Whittington Health NHS Trust

What the Data Tells Us	Issues	Actions and Mitigations
% e-Referrals Appointment Slot Issues - *Target <4%* *Number of electronic referrals unable to be booked (due to no slots available) via e-RS (e-referral system).* **April Performance – 48%** This is an increase/a worsening of 9.5% from March's performance of 38.5%.	• Specialties experiencing higher than planned ASI issues sit within Surgery and Cancer ICSU. • Management of available capacity. • Capacity constraints across the surgical specialities continues to impact slot availability.	• From improvement work within the Surgery ICSU the overall backlog of ASI is starting to reduce and will be reflected in Mays figures. • Additional support from the Access team is reducing the tail end of the backlog of longer waiters as a result long waiters are starting to reduce. • ASIs are being monitored weekly at the PTL meeting.
Theatre Utilisation - *Target 85%* *Percentage of available Theatre time used for elective procedure.* **April Performance – 77.17%** This is an improvement of 0.57% from March's performance of 76.6%.	• Variance in utilisation between specialities and consultants. • Focus on optimising case mix which can have an impact on utilisation of Theatre time. • There have been issues with Radiography cover which is causing late starts.	• Theatres to collaborate with service managers to support services and where necessary specific clinicians to implement booking rules appropriately. • Review lists case by case at 6-4-2 for weeks 1 and 2 to ensure cases adequately booked for early finishing lists. • Meet with imaging leads to discuss and agree start times. • Focus on early finishing lists
Hospital Cancelled Operations - *Target 0* *No. of patients who have had their operation cancelled.* **March Performance – 3** This is a decrease of 4 from 7 in February 2023.	• There has been an increase in the number of patients who are unfit for surgery, causing cancellation issues in Pre-Assessment, which has been further impacted by capacity within the department. • Bed issues from last month highlighted inaccurate classification of point of delivery.	• Proforma for cancellations completed for every request ensures targeted mitigation. • Theatres to collaborate with services to use information from proforma to offer targeted support to specialities/ clinicians • Services to focus on supporting junior doctors to accurately complete ICE requests to ensure correct point of delivery. • Implementation of Life Box and Pre-Assessment dashboard to support redesign of clinic templates balancing Telephone/ F2F contacts.

Caring

Whittington Health NHS Trust

Indicator	Target	Last Reported Month	Latest Month	Previous Month	2023-2024	Variation	Assurance
ED - FFT % Positive	>90%	Apr	84.0%	75.4%	84.0%		F
ED - FFT Response Rate	>15%	Apr	11.9%	11.5%	11.9%		F
Inpatients - FFT % Positive	>90%	Apr	93.9%	89.7%	93.9%	L	P
Inpatients - FFT Response Rate	>25%	Apr	16.7%	19.6%	16.7%		F
Maternity - FFT % Positive	>90%	Apr	95.6%	98.7%	95.6%		P
Maternity - FFT Response Rate	>15%	Apr	5.9%	8.6%	5.9%		F
Outpatients - FFT % Positive	>90%	Apr	94.9%	90.5%	94.9%		P
Outpatients - FFT Response Rate	400	Apr	177	200	177		F
Community - FFT % Positive	>90%	Apr	96.7%	95.4%	96.7%		P
Community - FFT Response Rate	1500	Apr	844	943	844	H	P
Complaints responded to within 25 or 40 working days	>80%	Apr	50.0%	65.0%	50.0%	L	F
Complaints (including complaints against Corporate division)		Apr	28	20	28		



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

April Performance - 50% This is a worsening of 15% from 65% in March

33 complaints required a response in April 2023 - 5 were de-escalated leaving 28.

Responses due in December and January remain unchanged from last month - Of the 38 responses due, 1 remains outstanding.

Complaints Team continue to work with ICSUs to support the completion of all complaint investigations. In the meantime, all urgent issues have been actioned.

Severity of Complaints: 46% were designated 'low' risk, 50% were 'moderate' risk, and 4% were 'high' risk

Themes: A review of the complaints due a response in April 2023 shows that 'Medical Care' 29%, 'Communication' 21% and, 'Attitude' 18% were the main issues for complainants.

Of the 14 complaints that have closed, 3 were 'upheld', 8 were 'partially upheld' & 3 were 'not upheld' meaning that 79% of the closed complaints were upheld in one form or another.

Well Led

Whittington Health NHS Trust

Indicator	Target	Last Reported Month	Latest Month	Previous Month	2023-2024	Variation	Assurance
Appraisals % Rate	**>85%**	**Apr**	71.4%	74.4%	71.4%	H	F
Mandatory Training % Rate	**>85%**	Apr	85.9%	85.8%	85.9%	H	P
Permanent Staffing WTEs Utilised	**>90%**	**Apr**	89.8%	90.0%	89.8%		F
National Quarterly Pulse Survey (NQPS)	**800**	Apr	0	0	0		
NQPS Staff % recommended work	**>50%**	Apr					
Staff Sickness abscence %	**<3.5%**	**Mar**	3.67%	4.09%			F
Staff Turnover %	**<13%**	**Apr**	13.7%	14.2%	13.7%	H	F
Vacancy % Rate against establishment	**<10%**	**Apr**	10.2%	10.0%	10.2%		F
Average Time to Hire	**<=63**	**Apr**	59	63	59		P
Safe Staffing Alerts - Number of Red Shifts		**Apr**	1	2	1		
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		**Apr**	10.3	9.9	10.3		

Mandatory Training % Rate - Target >85%

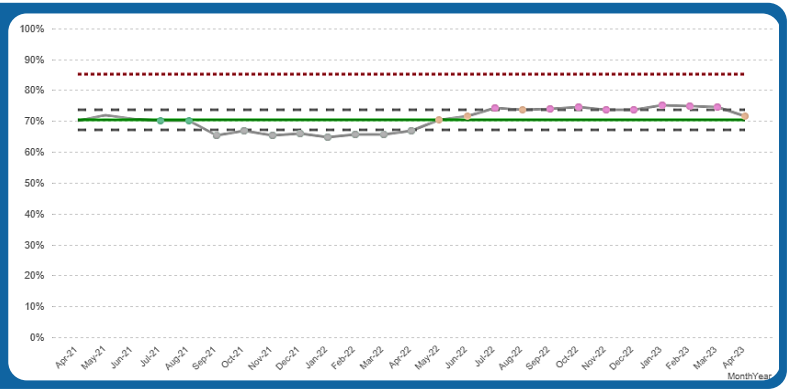
April Performance – 85.9%

This is an improvement of 0.1% from 85.5% in March.

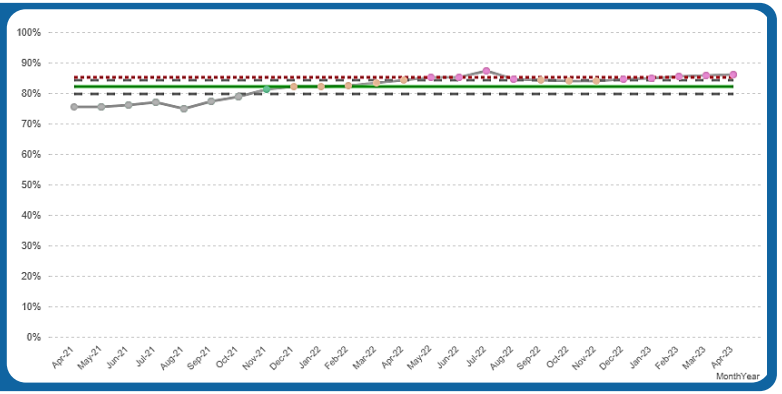
The Trust target for Mandatory Training has been reduced to 85% to fall in line with the national target.

For the last three months the Trust has achieved over 85%.

Appraisals %



Staff Turnover %



Well Led - People Pulse Survey

Whittington Health NHS Trust

Summary of Quarterly People Pulse Survey – April 2023

The national quarterly pulse survey ran throughout the month of April 2023 with a total of 526 respondents:

- The engagement score is 6.56 which is slightly higher than the national average.
- 50.5% of respondents said they would recommend the organisation as a place to work which is slightly higher than the national average of 46%.
- Respondents were asked to describe their mood, 63.6% chose positive descriptions and 36.4% chose negative descriptions.
  - The three highest results for mood showed that 19.4% were coping, 16.2% were calm and 13.4% felt demotivated.
  - The top three reasons for positive moods were down to manageable workload, general positivity and having breaks.
  - The top three reasons for negative moods were down to high workloads, management and colleagues not supporting them or are difficult to work with and short staffing.
- Under the core metrics theme, 72.2% felt the team support each other which has decreased by 4.1% from January 2023.
- In addition, 52.3% felt that they are well-informed about important changes taking place in the organisation which was a decrease of 2.8% from January.
- There has been an increase of 2.4% since January on the view that the organisation is proactively supporting health and wellbeing which is now at 51.3%, however this is still below the national average.
  - When asked if a conversation about health and wellbeing had taken place, 53% said yes and 47% said no. Of those that had saidyes, 73% found the conversation to be supportive.
- This quarter respondents were asked about their commute to and from work as well as what would encourage them to uptake walking/cycling or public transport.
  - The main mode of transport for 35.3% of respondents was train and the underground, 34.6% also said that having discounted orsubsidised public transport tickets for the NHS would encourage them to take public transport or use it more regularly.

Community Performance Dashboard

NHS
Whittington Health
NHS Trust

Indicator	Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	2023-2024	Performance
IAPT Moving to Recovery	>50%	52.1%	50.2%	48.7%	48.3%	47.1%	53.8%	50.7%	49.0%	53.1%	50.7%	52.5%			
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	92.6%	95.2%	93.3%	90.5%	94.1%	95.0%	92.0%	91.9%	92.9%	92.0%	93.3%			
Haringey - 8wk Review % carried out before child aged 8 weeks	N/A	71.5%	62.8%	64.3%	72.8%	65.2%	69.2%	67.9%	66.5%	63.9%	68.9%	71.1%			
Haringey - HR1 % carried out before child aged 15 months	N/A	68.9%	75.8%	75.5%	74.3%	69.8%	77.4%	74.2%	75.9%	71.1%	75.4%	73.3%			
Haringey - HR2 % carried out before child aged 30 months	N/A	55.0%	68.1%	74.3%	66.1%	75.5%	74.7%	72.6%	66.0%	71.4%	68.4%	69.9%			
Islington - 8wk Review % carried out before child aged 8 weeks	N/A	72.7%	77.4%	77.3%	70.8%	70.9%	59.7%	68.3%	61.6%	71.4%	82.7%	76.0%			
Islington - HR1 % carried out before child aged 15 mths	N/A	78.3%	78.8%	86.8%	85.2%	80.4%	79.0%	86.6%	82.8%	80.8%	84.0%	84.0%			
Islington - HR2 % carried out before child aged 30 mths	N/A	73.7%	78.5%	77.2%	81.1%	87.8%	79.6%	83.1%	87.6%	83.3%	84.1%	82.8%			
% of MSK pts with a significant improvement in function (PSFS)	>75%	73.5%	83.3%	88.6%	87.7%	87.9%	92.5%	87.5%	93.9%	90.7%	74.4%	91.5%	81.7%	81.7%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%			100.0%	60.0%	77.8%	82.4%	100.0%	80.0%	90.9%	88.2%	87.5%	83.3%	83.3%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	74.4%	73.5%	70.8%	72.7%	71.7%	80.2%	81.5%	71.3%	70.1%	72.8%	75.3%	77.4%	77.4%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	90.6%	93.4%	95.2%	96.4%	93.9%	94.2%	95.9%	88.4%	92.7%	94.7%	95.5%	87.7%	87.7%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%			100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	85.7%	75.0%	75.0%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 weeks	>45%		52.0%			41.2%			49.6%						
Islington Self-Management - Average Increase in PAM Score	>=9														
Haringey Self-Management - Average Increase in PAM Score	>=9														

Community Waiting Times

Whittington Health NHS Trust

Community Waiting Times Dashboard - Routine Referrals

SERVICE	% Threshold	Target Weeks	Mar-23	Apr-23	May-23	Avg Wait (May)	No. of Pts Seen
Bladder and Bowel - Children	>95%	12				-	0
Community Matron	>95%	6	93.3%	100.0%	100.0%	0.8	4
Adult Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	2.2	26
Community Rehabilitation (CRT)	>95%	12	52.5%	67.2%	52.1%	23.8	48
ICTT - Other	>95%	12	86.8%	95.7%	100.0%	2.8	64
ICTT - Stroke and Neuro	>95%	12	22.2%	38.1%	21.4%	12.4	14
Home-based Intermediate Care Service	>95%	6	86.4%	70.7%	62.5%	4.6	32
Community Bed-based Intermediate Care Service	>95%	6	100.0%		100.0%	0.7	1
Paediatric Wheelchair Service	>95%	8	100.0%	100.0%		-	0
Bladder and Bowel - Adult	>95%	12	37.4%	36.0%	54.1%	14.8	61
Musculoskeletal Service - CATS	>95%	6	30.6%	30.9%	29.4%	12.4	228
Musculoskeletal Service - Routine	>95%	6	26.2%	31.2%	25.7%	15.2	561
Nutrition and Dietetics	>95%	6	97.9%	97.9%	99.1%	2.9	117
Podiatry (Foot Health)	>95%	6	22.3%	21.5%	21.5%	21.3	340
Lymphodema Care	>95%	6	100.0%	92.3%	100.0%	2.8	10
Tissue Viability	>95%	6	98.1%	100.0%	100.0%	1.1	23
Cardiology Service	>95%	6	93.9%	86.3%	100.0%	2.5	30
Diabetes Service	>95%	6	91.0%	75.0%	68.3%	4.9	41
Respiratory Service	>95%	6	95.8%	93.5%	96.4%	3.0	28
Spirometry Service	>95%	6	89.8%	71.1%	63.3%	4.5	30

Community Waiting Times Dashboard - Urgent Referrals

SERVICE	% Threshold	Target Weeks	Mar-23	Apr-23	May-23	Avg Wait (May)	No. of Pts Seen
Bladder and Bowel - Children	>95%	-				-	0
Community Matron	>95%	2				-	0
Adult Wheelchair Service	>95%	2	100.0%	100.0%	100.0%	0.1	3
Community Rehabilitation (CRT)	>95%	2	15.4%	33.3%	42.9%	11.3	14
ICTT - Other	>95%	2	17.4%	0.0%	0.0%	6.7	3
ICTT - Stroke and Neuro	>95%	2	27.3%	0.0%	0.0%	4.0	3
Home-based Intermediate Care Service	>95%	2	83.6%	81.8%	66.7%	1.6	36
Community Bed-based Intermediate Care Service	>95%	2	60.0%	85.7%	100.0%	1.1	1
Paediatric Wheelchair Service	>95%	2				-	0
Bladder and Bowel - Adult	>95%	2				-	0
Musculoskeletal Service - CATS	>95%	2	0.0%	7.1%	12.5%	8.5	8
Musculoskeletal Service - Routine	>95%	2	35.3%	12.5%	24.3%	3.7	70
Nutrition and Dietetics	>95%	2	100.0%	100.0%	100.0%	0.0	1
Podiatry (Foot Health)	>95%	2	100.0%	0.0%		-	0
Lymphodema Care	>95%	2				-	0
Tissue Viability	>95%	-				-	0
Cardiology Service	>95%	2	0.0%	50.0%	100.0%	0.0	1
Diabetes Service	>95%	2				-	0
Respiratory Service	>95%	2				-	0
Spirometry Service	>95%	2				-	0

Community Waiting Times

Whittington Health NHS Trust

Adult Community Waiting Times - Commentary and Action Plan

Podiatry:

Efficiencies in productivity are now embedded and showing improvements in waiting times, particularly for follow ups. This will in turn have an effect on new patients with 667 patients waiting over 18 weeks apposed to 1408 patients 6 months ago. This improvement continues month on month. The service will be completing a demand and capacity review to ensure there is sufficient capacity within the service to meet demand.

Islington Community Neuro-Rehabilitation (ICRT):

Waiting times for neuro and stroke rehabilitation have grown in the last few months, a hangover effect of the pandemic but also very long length of stay (LOS). Patients waiting for Physiotherapy (PT) and Occupational Therapy (OT) are the main areas of concern due to, less than optimal productivity. Kingsgate have been supporting the service manager with a demand and capacity review. Weekly MDT meetings, led by the service manager were introduced in May to provide senior oversight and check and challenge to optimise appropriate discharge and reduce LOS. There is an action plan to which is monitored monthly by the Director of Operations.

Bladder and Bowel Service:

Waiting lists had been growing due to the increase in referrals from the General Practitioner Federation Community Gynaecology direct access women's health physiotherapy referrals. In addition, the only clinician able to see paediatric patients retired at the beginning of the calendar year. Kingsgate have supported the clinical lead to complete a demand and capacity review and re-introduce group sessions. These started in April. The effect on waiting times have yet to be seen but increases have stabilised. The service will get back to business as usual by the end of the calendar year with the capacity to take on more activity as appropriate in discussion with commissioners.

Musculoskeletal (MSK):

MSK has completed a series of six super Saturdays which has had a impact on waiting times for physiotherapy waits only. Self-management portal was introduced in April and will enable the service to reduce waiting times and see 95% of patients within 6 weeks The effect of the self management portal will not be seem for 4-6 months.

Children's Community Waits Performance

Whittington Health NHS Trust

Children's Community Dashboard - Routine Referrals

SERVICE	% Threshold	Target Weeks	Feb-23	Mar-23	Apr-23	Avg Wait (Apr)	No. of Pts Seen
CAMHS	>95%	8	56.8%	60.2%	57.3%	21.5	75
Community Children's Nursing	>95%	2	52.9%	68.2%	61.1%	2.7	54
Community Paediatrics - Haringey	>95%	18	92.4%	97.6%	97.7%	4.7	43
Community Paediatrics - Islington	>95%	18	84.6%	88.2%	88.0%	5.9	25
Family Nurse Partnership - Islington	>95%	12				-	0
Haematology Service - Islington	>95%	12	100.0%	100.0%		-	0
Haringey - SCT	>95%	20	0.0%	0.0%	0.0%	48.9	19
IANDS - SCT	>95%	20	0.0%	18.8%	9.1%	47.9	11
IANDS	>95%	18	72.7%	100.0%	80.0%	6.1	5
Looked After Children - Haringey	>95%	4				-	0
Looked After Children - Islington	>95%	4	100.0%	87.5%	66.7%	3.1	3
Occupational Therapy - Barnet	>95%	18	72.9%	69.8%	80.6%	22.9	31
Occupational Therapy - Haringey	>95%	18	60.0%	85.7%	82.4%	14.7	17
Occupational Therapy - Islington	>95%	18	50.0%	30.0%	25.0%	24.9	4
Paediatrics Nutrition and Dietetics - Haringey	>95%	12	90.0%	83.3%	71.4%	11.3	7
Paediatrics Nutrition and Dietetics - Islington	>95%	12	100.0%	100.0%	100.0%	6.1	9
Physiotherapy - Barnet	>95%	18	86.5%	96.6%	93.0%	6.3	43
Physiotherapy - Haringey	>95%	18	100.0%	100.0%	100.0%	7.0	33
Physiotherapy - Islington	>95%	18	100.0%	100.0%	100.0%	5.1	52
PIPS	>95%	12	100.0%	100.0%	100.0%	4.1	6
SALT - Barnet	>95%	18	47.1%	29.2%	25.0%	37.0	92
SALT - Haringey	>95%	13	19.6%	26.6%	40.3%	17.4	62
SALT - Islington	>95%	13	94.1%	92.9%	87.5%	8.8	16
SALT - MPC	>95%	18	76.7%	91.2%	90.9%	7.2	22
School Nursing - Haringey	>95%	12	84.3%	90.8%	70.0%	10.7	50
School Nursing - Islington	>95%	12	100.0%	91.5%	100.0%	2.4	30

Children's Community Dashboard - Urgent Referrals

SERVICE	% Threshold	Target Weeks	Feb-23	Mar-23	Apr-23	Avg Wait (Apr)	No. of Pts Seen
CAMHS	>95%	2	100.0%	94.7%	76.9%	1.4	13
Community Children's Nursing	>95%	1	100.0%	100.0%	100.0%	0.1	5
Community Paediatrics - Haringey	>95%	1				-	0
Community Paediatrics - Islington	>95%	1				-	0
Family Nurse Partnership - Islington	>95%	-				-	0
Haematology Service - Islington	>95%	-				-	0
Haringey - SCT	>95%	2				-	0
IANDS - SCT	>95%	2				-	0
IANDS	>95%	2				-	0
Looked After Children - Haringey	>95%	2				-	0
Looked After Children - Islington	>95%	2				-	0
Occupational Therapy - Barnet	>95%	6				-	0
Occupational Therapy - Haringey	>95%	2				-	0
Occupational Therapy - Islington	>95%	2				-	0
Paediatrics Nutrition and Dietetics - Haringey	>95%	2				-	0
Paediatrics Nutrition and Dietetics - Islington	>95%	2				-	0
Physiotherapy - Barnet	>95%	6				-	0
Physiotherapy - Haringey	>95%	2	100.0%			-	0
Physiotherapy - Islington	>95%	2				-	0
PIPS	>95%	-				-	0
SALT - Barnet	>95%	6				-	0
SALT - Haringey	>95%	2		33.3%		-	0
SALT - Islington	>95%	2				-	0
SALT - MPC	>95%	2				-	0
School Nursing - Haringey	>95%	2				-	0
School Nursing - Islington	>95%	2				-	0

Children's Community Waits Performance

Whittington Health NHS Trust

Children's Community Waiting Times - Commentary and Action Plan

Therapy Services:

Barnet Speech Language Therapy - Waiting times are rising as demand increases for assessment and therapy. Transformation work and additional investment in 23/24 aims to address this

Islington Speech and Language Therapy - Additional funding from family hubs will focus on early identification and intervention for young CYP with speech, language and communication needs and it is hoped will reduce overall need for targeted support. The Occupational Therapy (OT) service continues to find it challenging to meet demand. One off funding in 2022/23 linked to recovery helped address this pressure and we are working with NCL commissioners on a proposal for further investment in 23/24.

Haringey Speech and Language Therapy - Waiting times have seen slight improvements. This is due to some additional temporary staff supporting reduction in waits in the early years service. OT waits are stable as agency staff are covering vacant posts. The therapy service is finalising plans for new recurrent investment which will strengthen universal provision.

Dietetics: Dietetics waiting times in Haringey are increasing due to staff shortages. A new dietitian has been recruited, shortages of temporary staff mean the wait will not improve quickly

Looked After Children: Initial health assessments in Islington have been delayed due to an increase in unaccompanied asylum seeking children and a number of young people who have declined assessments. Following an increase in funding from the ICB the team are increasing nursing support for looked after children leaving care.

Community Children's Nursing: Waiting times are mainly due to a new Bladder and Bowel caseload that has transferred from adult services. Clinics started 2 weeks ago so there should be a reduction in waiting times as the service becomes established.

Social Communication: It continues to be challenging to address waiting times for autism and ADHD assessments in Haringey and Islington due to increasing demand. The Islington under 5s service have 380 children waiting and have launched a new assessment pathway. The service aims to deliver up to 30 assessments per month (an increase from 19). New investment in Haringey will be used to improve the quality of provision and increase the number of assessments provided.

Islington Community CAMHS: The CAMHS management team is currently looking at throughput in the service. The service had a successful away day in April focused on endings of therapy. Investment from the System Development Funding has been confirmed from the ICB for additional resource to support the CAMHS Therapies team for interventions for CYP with complex mental health presentations. This will provide additional resource alongside demand and capacity modelling and a quality improvement project to redesign the service model in Continuous Treatment Team.

Meeting title	**Trust Board -Public**	**Date: 24.5.2023**
Report title	Finance Report April (Month 01) 2023/24	**Agenda item: 8**
Executive director lead	Kevin Curnow, Chief Finance Officer	
Report author	Finance Team	
Executive summary	The Trust is reporting a deficit of £3.52m at the end of April which is £0.77m worse than plan. The planned deficit for April was £2.75m. The year-to-date adverse financial performance to plan is mainly driven by • Non-delivery of savings on Cost Improvement Programmes (CIP) • Elective recovery fund (ERF) underperformance • Other expenditure overspends Cash position at the end of April was £67.9m **Planning Update** Following the requirement for North Central London Integrated Care System (NCL ICS) to submit a balanced plan, Whittington Health has been asked to submit a surplus plan of £2m for 2023-24. Due to the timing of this resubmission, this change is not reflected in the April financial position but will be in month 2. The Trust is yet to identify schemes to deliver this required improvement.	
Purpose:	To discuss April performance.	
Recommendation(s)	To note April financial performance, recognising the need for improve savings delivery.	
Risk Register or Board Assurance Framework	BAF risks S1 and S2	
Report history		
Appendices		

CFO Message **Finance Report M01**

April performance is £0.8m worse than plan

At the time of writing the Trust was planning a surplus of £5k for 2023-24. This included expected savings delivery of £17.9m and non-recurrent benefits of £13.3m.

At end of April the Trust is reporting a deficit of £3.52m which is £0.8m worse than in month plan.

Key drivers for April financial performance are.

- The continued opening of winter ward (Thorogood) and Endoscopy 4th room, agency premium and additional payment to cover the junior doctor's strike.
- The Trust spent £1.63m on agency staff in April against a planned target of £1.64m. The Discretionary Spend Scrutiny panel is continuing work with the ICSUs to control and monitor agency spend.
- Activity in April was significantly lower than plan (strikes being a major contributory factor). Though the Trust is awaiting further guidance on the in-year monitoring of the variable contract (Elective Recovery Fund) an estimated claw back of £0.8m has been included within April performance.

Due to the lateness in agreeing the financial plans, there still further validation required on April's performance. There is no external reporting requirement on April's performance.

Cash of £67.9m as at end of April

Cash balance at end of April was £67.9m, down from £72.9m at Month 12. Payment of capital and revenue creditors formed a significant component of this reduction. Interest received on cash balances was £245k against plan of £160k.

Internally funded capital plan of £12.2m for 2023-24

The Trust has submitted an Internally funded capital programme of £12.2m for 2023-24.

Also, within the capital programme for 2023-24 is £12.1m of nationally funded projects. This includes Community Diagnostic Centre, Targeted Investments Fund (TIF) and other digital interoperability work streams.

Trust submits a surplus plan of £2m for 2023-24 on 16th of May

Planning Update - Following NCL requirement to submit a balanced plan, Whittington Health has been asked to submit a surplus plan of £2m for 2023-24. Due to the timing of this resubmission, this change is not reflected in the April financial performance. The Trust is yet to identify schemes to deliver this required improvement. This change will be reflected in month 2 reporting.

1. Summary of Income & Expenditure Position – Month

	Plan	Actual	Variance	Plan	Actual	Variance	Annual Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income							
NHS Clinical Income	24,618	24,763	144	24,618	24,763	144	295,907
High Cost Drugs - Income	787	778	(10)	787	778	(10)	9,569
Non-NHS Clinical Income	2,072	2,209	137	2,072	2,209	137	24,869
Other Non-Patient Income	2,057	2,084	27	2,057	2,084	27	24,690
Elective Recovery Fund	4,064	3,294	(770)	4,064	3,294	(770)	54,690
	33,600	**33,128**	**(472)**	**33,600**	**33,128**	**(472)**	**409,725**
Pay							
Agency	0	(1,631)	(1,631)	0	(1,631)	(1,631)	0
Bank	(440)	(2,652)	(2,212)	(440)	(2,652)	(2,212)	(5,442)
Substantive	(25,094)	(21,559)	3,536	(25,094)	(21,559)	3,536	(283,422)
	(25,534)	**(25,841)**	**(307)**	**(25,534)**	**(25,841)**	**(307)**	**(288,864)**
Non Pay							
Non-Pay	(8,043)	(8,155)	(111)	(8,043)	(8,155)	(111)	(86,433)
High Cost Drugs - Exp	(852)	(778)	74	(852)	(778)	74	(10,222)
	(8,895)	**(8,932)**	**(37)**	**(8,895)**	**(8,932)**	**(37)**	**(96,655)**
EBITDA	**(830)**	**(1,646)**	**(816)**	**(830)**	**(1,646)**	**(816)**	**24,206**
Post EBITDA							
Depreciation	(1,516)	(1,554)	(38)	(1,516)	(1,554)	(38)	(18,749)
Interest Payable	(79)	(85)	(5)	(79)	(85)	(5)	(952)
Interest Receivable	104	245	141	104	245	141	1,250
Dividends Payable	(429)	(479)	(50)	(429)	(479)	(50)	(5,750)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(1,920)	**(1,872)**	**48**	**(1,920)**	**(1,872)**	**48**	**(24,201)**
Reported Surplus/(Deficit)	**(2,750)**	**(3,518)**	**(768)**	**(2,750)**	**(3,518)**	**(768)**	**5**
Impairments	0	0	0	0	0	0	0
IFRS & Donated	(8)	(4)	3	(8)	(4)	3	(92)
Reported Surplus/(Deficit) after Impairments and IFRIC12	**(2,758)**	**(3,522)**	**(765)**	**(2,758)**	**(3,522)**	**(765)**	**(87)**

- The Trust financial position as at the end of April is a deficit of £3.52m (excluding donated asset depreciation and impairments) against a planned deficit of £2.75m. This is £0.77m worse than planned.

- The adverse variance on CIP delivery and other expenditure overspends in month is offset by slippage on other planned investment (£0.6m adverse variance on CIP).

- Included within the position is an accrual to cover the funded portion of April 2023 pay uplift (2.1%).

2. Income and Activity Performance

The internal income plan for 2023-24 is based on recurrent outturn (for non-clinical income) and aligned to agreed activity plans for clinical income. Payment for ICS and NHSE patient care activity income will be on the basis of aligned payment and incentive (API) fixed and variable elements. Elective activity and outpatient (first & procedures) will be paid on a variable basis at 100% of national tariff. ICB income under £0.5m is classed as low value activity (LVA) and paid on a block basis.

Income by ICB is detailed below

	£000's
Nhs Icb North Central London	305,520
NHS England	33,745
Nhs Icb North East London	8,668
Nhs Icb North West London	3,558
Nhs Icb Hertfordshire & Wessex	1,122
Nhs Icb South East London	692
LVA	2,243
ICB/NHSE patient care income	355,548

The North Central London ICB target for elective recovery is 113%. Whittington Health has been set an elective recovery target of 102.88% of 2019-20 activity for NCL ICB target.

ICB	Target 2019/20 level	£000's	Secondary Dental	Total ERF Target
NHS North Central London ICB	102.88%	49,217	374	49,591
NHS England	124.00%	3,318	0	3,318
NHS North East London ICB	104.99%	1,634	7	1,641
NHS North West London ICB	102.88%	1,409	291	1,700
NHS Hertfordshire and West Essex ICB	129.45%	419	1	420
NHS South East London ICB	108.88%	202	0	202
LVA		0	0	0
		56,199	673	56,872

There are ongoing discussions with NCL ICS around funding of unbundled high-cost drugs, devices and Imaging. The ICBs have yet to confirm how this activity will be funded in 2023-24. Current income allocation from NCL ICB for high cost drugs and devices is £1.3m lower than actual spend in 2022-23.

There is a significant risk to the Trust is not achieving the £57m ERF target. The costed electivity activity plan is £54.7m which is £2.1m less than the target.

2.1 Income Performance – April

Income	Annual Plan	In Month Income Plan	In Month Income Actual	In Month Variance
	£000's	£000's	£000's	£000's
A&E	20,156	1,652	1,569	(83)
Elective	25,278	1,964	1,561	(403)
Non-Elective	56,828	4,660	4,174	(485)
Critical care	5,947	487	374	(113)
Outpatients	52,839	4,098	3,603	(495)
Ambulatory	7,075	580	507	(72)
Direct access	13,809	1,071	1,292	221
Community	77,985	6,499	6,499	0
Other clinical income NHS	45,557	4,395	5,961	1,566
NHS Clinical Income	**305,476**	**25,406**	**25,540**	**135**
Non NHS clinical income	24,869	2,072	2,209	137
Elective recovery fund (ERF)	54,690	4,064	3,294	(770)
Income From Patient Care Activities	**385,035**	**31,542**	**31,044**	**(498)**
Other Operating Income	**24,690**	**2,057**	**2,084**	**27**
Total	409,725	33,600	33,128	(472)

- Income was £0.5m under plan in month, driven by ERF underperformance £0.8m.

- 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.

- £0.1m NHS clinical income overperformance relates to overperformance on drugs. Annual drugs plan does not include £1m non recurrent NCL ICB or 2023/24 growth.

- £0.1m Non NHS clinical Income driven by £0.1m neurodevelopment Attention deficit hyperactivity disorder (ADHD) hub. This is non recurrently funded and expected to be £1.2m for the year. This is offset by additional expenditure.

- Other operating income is on plan.

- There is significant underperformance in elective, non-elective outpatients and A&E. Lower activity performance in critical care and ambulatory. Overperformance in direct access, critical care and ambulatory

2.2 Elective recovery fund (ERF) – April

- ERF £0.8m underperformance is an estimate based on an annual target £56.9m. The target is an estimate based on published ERF calculations which used 2022/23 values. Current plan of £54.7m is based on costed internally agreed activity plans. The level of underperformance is a prudent estimate due to lack of guidance on in-year monitoring.

- ERF underperformance is significant across both admitted (17%) and non- admitted (21%). The cause of the underperformance is suggested to be the impact of strikes and increased annual leave.

Admitted/Non-Admitted	POD Group	Annual Plan	In Month Income Plan	In Month Income Actual	In Month Variance	In Month Variance
		£000's	£000's	£000's	£000's	%
ADM	Daycases	17,621	1,300	1,189	(111)	(9%)
	Elective	7,891	582	379	(203)	(35%)
ADM Total		**25,512**	**1,882**	**1,568**	**(314)**	(17%)
NADM	First attendance	23,488	1,762	1,252	(510)	(29%)
	Outpatient procedures	5,690	420	474	54	13%
NADM Total		**29,178**	**2,182**	**1,726**	**(456)**	(21%)
Total		54,690	4,064	3,294	(770)	(19%)

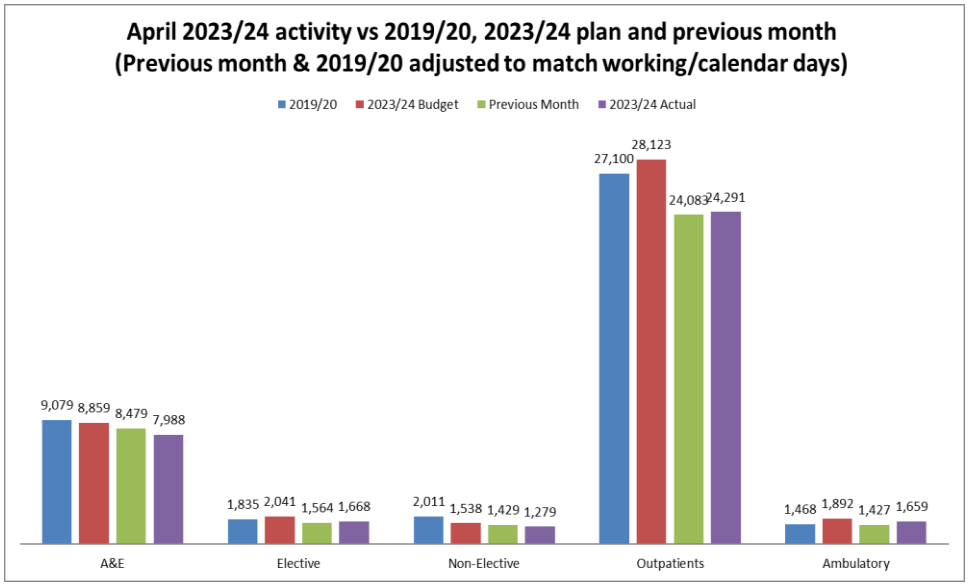
- The largest underperformance is in bariatric surgery (93%), general surgery (40%), general medicine (33%), cardiology (35%) and spinal surgery (46%). With overperformance in gastroenterology (15%), neurology (10%) and gynaecology (3%)

2.3 Activity Performance – April

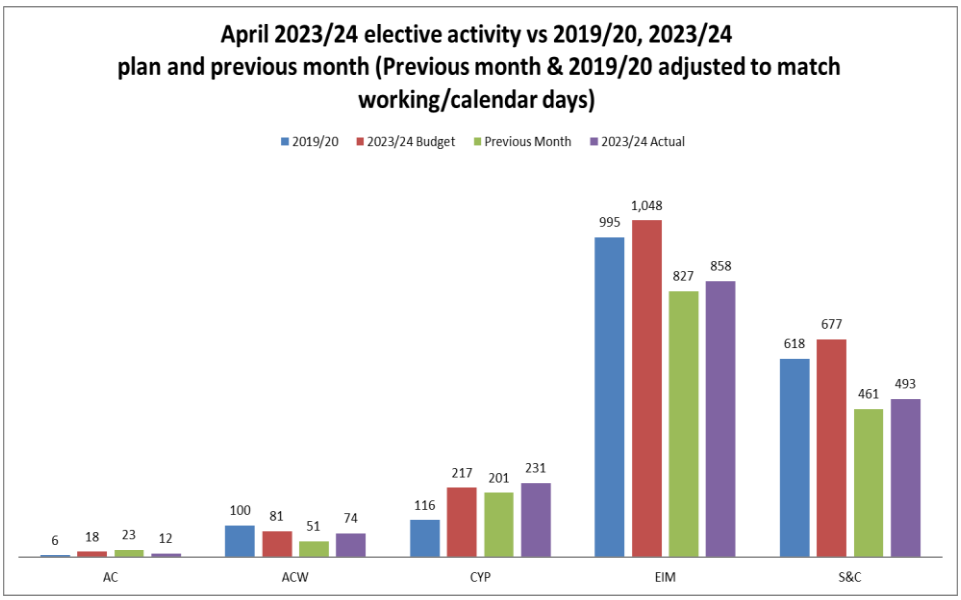
Activity	In Month Activity Plan	In Month Activity Actual	In Month Variance	In month Activity Diff%	YTD Activity Plan	YTD Activity Actual	Activity Diff	YTD Activity Diff%
A&E	8,859	7,988	(871)	(10%)	8,859	7,988	(871)	(10%)
Elective	2,043	1,692	(351)	(17%)	2,043	1,692	(351)	(17%)
Non-Elective	1,538	1,281	(258)	(17%)	1,538	1,281	(258)	(17%)
Critical care	304	294	(10)	(3%)	304	294	(10)	(3%)
Outpatients	28,126	24,550	(3,576)	(13%)	28,126	24,550	(3,576)	(13%)
Ambulatory	1,892	1,659	(233)	(12%)	1,892	1,659	(233)	(12%)
Direct Access	89,283	109,890	20,606	23%	89,283	109,890	20,606	23%

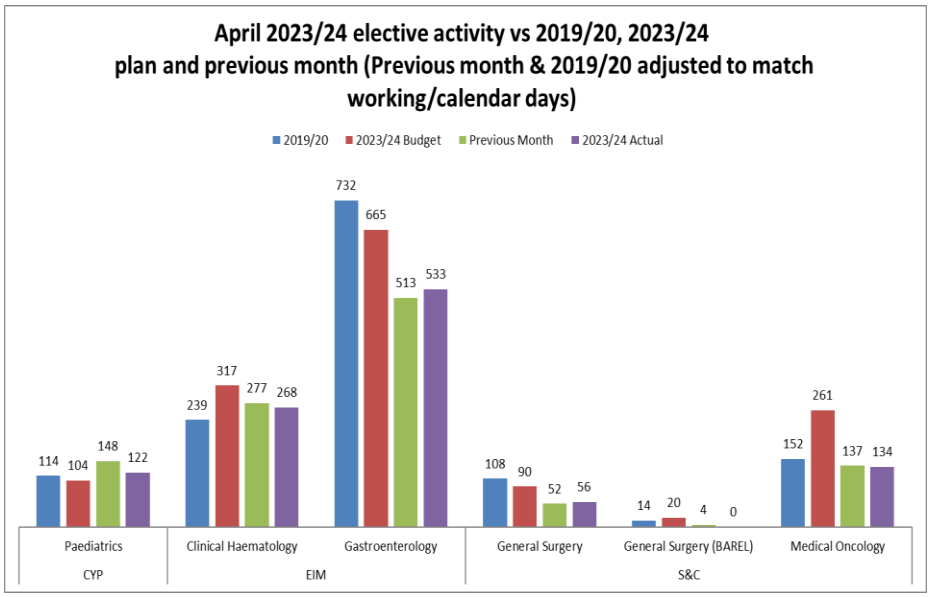
- Activity across inpatients and outpatients continues to be under plan.

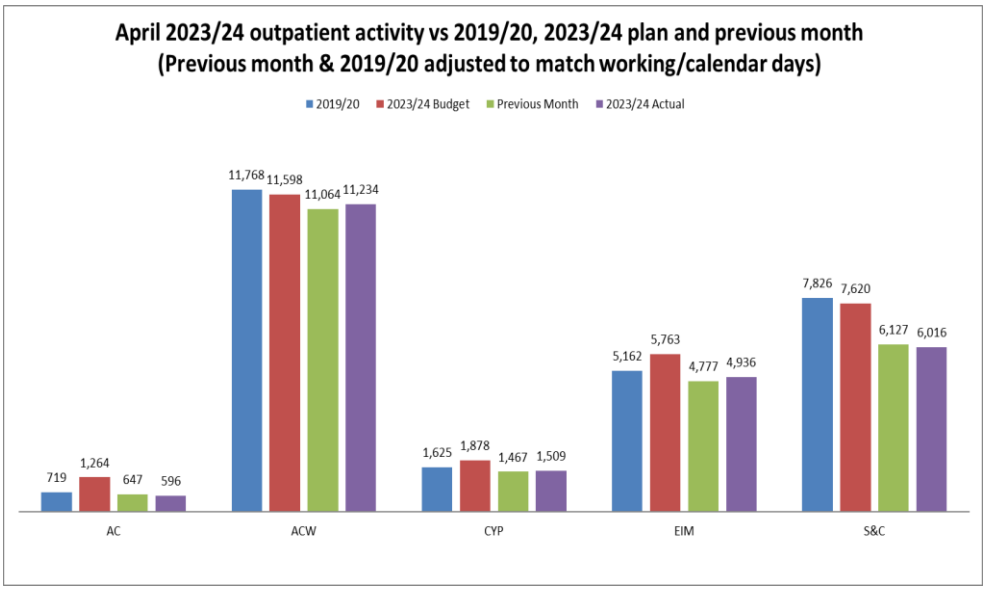
- Activity increased in elective and outpatients compared to previous month adjusted for calendar/working days. Decreased in A&E, non-elective and ambulatory activity.

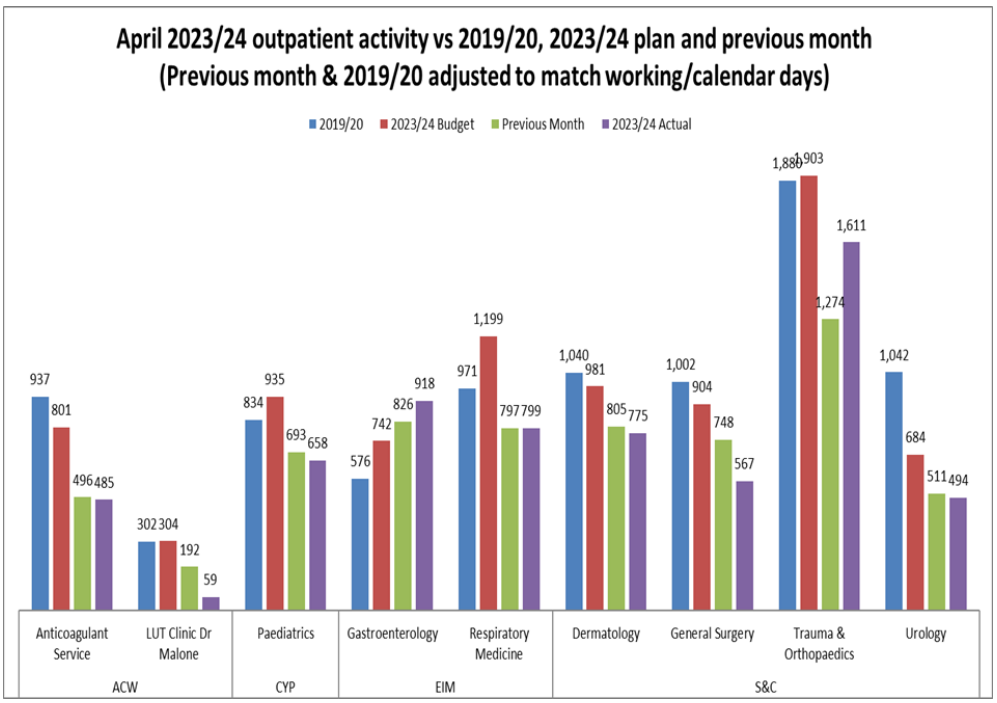


17% underperformance in total elective activity driven mainly by general surgery-bariatric (100% under plan), medical oncology (49%), general surgery (38%), gastroenterology (20%) and clinical hematology (15%). Offset by pediatrics (17% over plan).









13% underperformance in outpatient activity driven mainly by LUTS (81% under plan), anticoagulant (39%), general surgery (37%), respiratory medicine (33%), paediatrics (30%), urology (28%), dermatology (21%) and trauma & orthopaedics (15%). Offset by overperformance in gastroenterology (24% over plan).

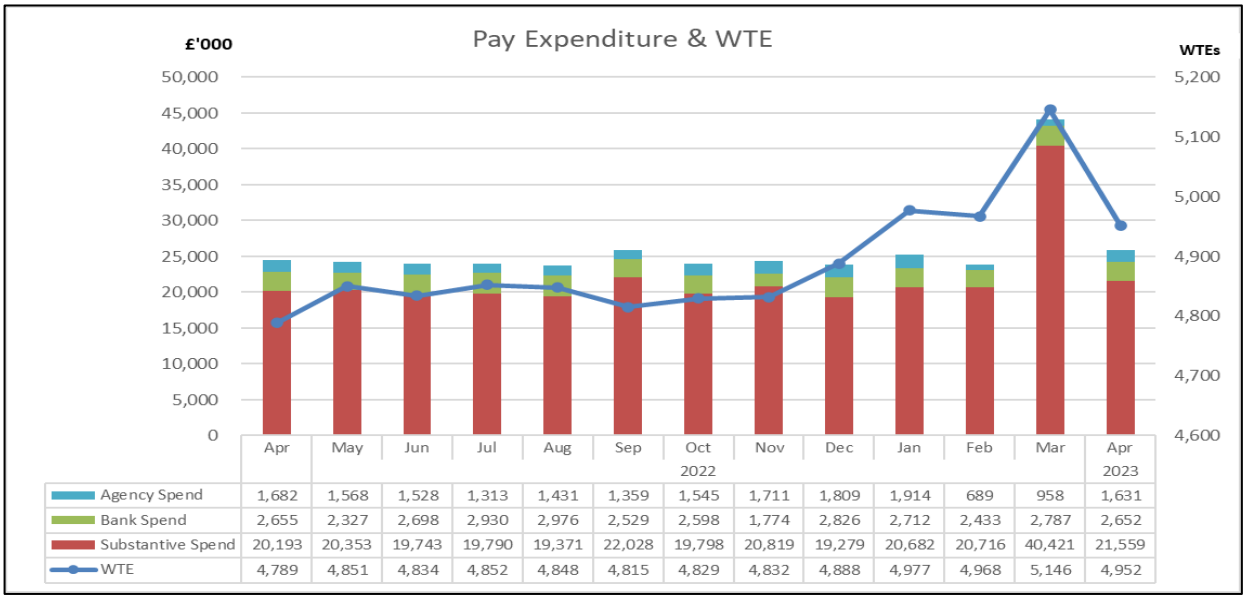
3. Expenditure – Pay & Non-pay

3.1 Pay Expenditure

Pay expenditure for April was £25.84m. Included in the pay spend is the cost of Thorogood ward remaining opened during the month (£0.150) and additional cost due to junior doctor strike actions (£0.2m). Other operational movements are from unachieved CIPs across all ICSUs part of which are currently being offset by vacancies and slippages in some of the planned investments.

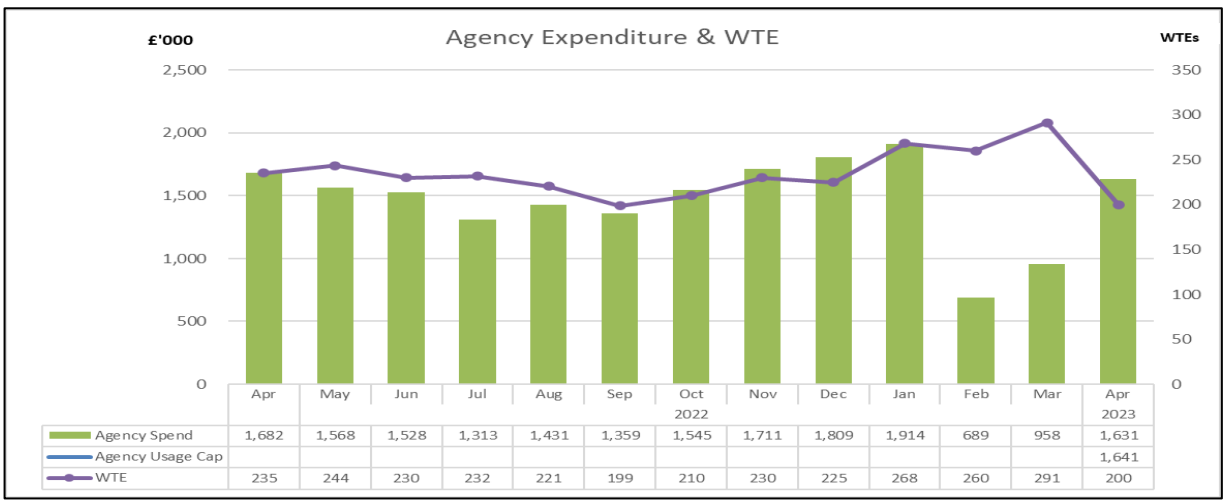
Non-operational costs include an estimate for April 2023 pay uplift which will be paid out in June salary.

	2022-23				2023-24	
	Jan	Feb	Mar	Average	Apr	Mov^t
Agency	1,914	1,895	2,496	2,102	1,631	(471)
Bank	2,709	2,729	3,648	3,029	2,651	(378)
Substantive	20,638	20,711	20,666	20,671	20,561	(111)
Total Operational Pay	**25,261**	**25,335**	**26,809**	**25,802**	**24,842**	**(959)**
Non Operational Pay Costs	47	(1,498)	17,357		999	
Total Pay Costs	**25,308**	**23,837**	**44,166**		**25,841**	**(959)**



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
							2022						2023
Agency Spend	1,682	1,568	1,528	1,313	1,431	1,359	1,545	1,711	1,809	1,914	689	958	1,631
Bank Spend	2,655	2,327	2,698	2,930	2,976	2,529	2,598	1,774	2,826	2,712	2,433	2,787	2,652
Substantive Spend	20,193	20,353	19,743	19,790	19,371	22,028	19,798	20,819	19,279	20,682	20,716	40,421	21,559
WTE	4,789	4,851	4,834	4,852	4,848	4,815	4,829	4,832	4,888	4,977	4,968	5,146	4,952

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
							2022						2023
Agency Spend	1,682	1,568	1,528	1,313	1,431	1,359	1,545	1,711	1,809	1,914	689	958	1,631
Agency Usage Cap													1,641
WTE	235	244	230	232	221	199	210	230	225	268	260	291	200

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

3.2 Non-pay Expenditure

Non-pay spend for April was £8.16m. In month expenditure includes the transfer of Histopathology service to UCL, increase usage of apheresis service from NHS Blood and Transport, increased surgical consumables, increased insulin pumps cost use of independent sector (£0.024m) and unachieved CIPs. The overspent of £0.1m against budget is mitigated by slippage in planned investment.

	2022-23				2023-24	
Non-Pay Costs	**Jan**	**Feb**	**Mar**	**Average**	**Apr**	**Mov^t**
Supplies & Servs - Clin	3,373	3,450	5,711	4,178	3,112	(1,066)
Supplies & Servs - Gen	301	305	588	398	333	(65)
Establishment	327	245	412	328	263	(64)
Healthcare From Non Nhs	288	(230)	58	39	95	57
Premises & Fixed Plant	1,281	2,239	4,596	2,705	2,286	(420)
Ext Cont Staffing & Cons	538	717	698	651	193	(458)
Miscellaneous	1,671	536	(8,221)	(2,005)	1,821	3,825
Chairman & Non-Executives	11	11	9	10	9	(1)
Non-Pay Reserve	14	(140)	0	(42)	42	84
Total Non-Pay Costs	**7,804**	**7,132**	**3,852**	**6,263**	**8,155**	**1,892**

Excludes high-cost drug expenditure and depreciation.

Miscellaneous Expenditure Breakdown

	2022-23				2023-24	
Non-Pay Costs	**Jan**	**Feb**	**Mar**	**Average**	**Apr**	**Mov^t**
Supplies & Servs - Clin	3,373	3,450	5,711	4,178	3,112	(1,066)
Supplies & Servs - Gen	301	305	588	398	333	(65)
Establishment	327	245	412	328	263	(64)
Healthcare From Non Nhs	288	(230)	58	39	95	57
Premises & Fixed Plant	1,281	2,239	4,596	2,705	2,286	(420)
Ext Cont Staffing & Cons	538	717	698	651	193	(458)
Miscellaneous	1,671	536	(8,221)	(2,005)	1,821	3,825
Chairman & Non-Executives	11	11	9	10	9	(1)
Non-Pay Reserve	14	(140)	0	(42)	42	84
Total Non-Pay Costs	**7,804**	**7,132**	**3,852**	**6,263**	**8,155**	**1,892**

Included in miscellaneous is CNST premium, Transport contract, professional fees, and bad debt provision

4.0 Statement of Financial Position (SoFP)

The net balance on the Statement of Final Position as of 30th April 2023 is £242.9m, £3.5m lower than March 2023, as shown in the table below.

Statement of Financial Position as at 30th April 2023	2022/23 M12 Balance	2023/24 M1 Balance	Movement in Month
	£000	£000	£000
NON-CURRENT ASSETS:			
Property, Plant And Equipment	230,044	229,085	959
Intangible Assets	7,051	6,802	249
Right of Use Assets	36,444	36,094	350
Assets Under Construction	32,776	33,647	(871)
Trade & Other Rec -Non-Current	584	567	17
TOTAL NON-CURRENT ASSETS	**306,899**	**306,195**	**704**
CURRENT ASSETS:			
Inventories	942	1,026	(84)
Trade And Other Receivables	25,881	25,796	84
Cash And Cash Equivalents	72,991	67,941	5,049
TOTAL CURRENT ASSETS	**99,813**	**94,764**	**5,050**
CURRENT LIABILITIES			
Trade And Other Payables	(81,636)	(77,867)	(3,769)
Borrowings: Finance Leases	(808)	(723)	(85)
Borrowings: Right of Use Assets	(4,370)	(4,370)	0
Borrowings: Dh Revenue and Capital Loan - Current	(116)	(116)	0
Provisions for Liabilities and Charges	(1,774)	(1,714)	(60)
Other Liabilities	(2,701)	(4,705)	2,004
TOTAL CURRENT LIABILITIES	**(91,404)**	**(89,495)**	**(1,909)**
NET CURRENT ASSETS / (LIABILITIES)	**8,409**	**5,268**	**3,141**
TOTAL ASSETS LESS CURRENT LIABILITIES	**315,308**	**311,463**	**3,845**
NON-CURRENT LIABILITIES			
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,624)	(1,624)	0
Borrowings: Finance Leases	(3,011)	(3,011)	0
Borrowings: Right of Use Assets	(32,250)	(31,915)	(335)
Provisions for Liabilities & Charges	(31,963)	(31,976)	12
TOTAL NON-CURRENT LIABILITIES	**(68,848)**	**(68,525)**	**(323)**
TOTAL ASSETS EMPLOYED	**246,460**	**242,938**	**3,522**
FINANCED BY TAXPAYERS EQUITY			
Public Dividend Capital	120,707	120,707	0
Retained Earnings	25,454	21,931	3,522
Revaluation Reserve	100,300	100,300	0
TOTAL TAXPAYERS EQUITY	**246,460**	**242,938**	**3,522**

Cash and Interest Received
The Trust closed April 2023 with cash of £67.9m, down from £72.9m at Month 12. Plan £73.4m. Payment of capital and revenue creditors formed a significant component of this reduction. Interest received on cash balances was £245k against Plan of £160k. Plan was set with an anticipated peak to interest rates around Month 6-7 of the financial year.

Trade and Other Payables
Reduction of £3.8m in month, as noted in the Cash paragraph above.

5.0 Capital Expenditure

Capital expenditure as 30th April was £1.73m, of which £221k related to PDC-funded and the balance to internally funded projects. The Month 1 expenditure was inflated in both plan and actual by the UK Power Networks project component of £859k which completed in April as anticipated. All capital expenditure incurred in month related to prior-year projects, and a significant allocation was awarded to these in the Capital Plan.

In-month planned capital expenditure was £1.236m. The Capital Plan is due for Capital Monitoring Group discussion and approval on 18th May.

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2023**
Report title	**Workforce Assurance Committee Chair's report**	**Agenda item: 9**
Committee Chair	Rob Vincent, Non-Executive Director	
Executive director lead	Norma French, Director of Workforce	
Report authors	Marcia Marrast-Lewis, Assistant Trust Secretary, and Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary	
Executive summary	Trust Board members are presented with the Workforce Assurance Committee Chair's report for the meeting held on 26 April 2023. **Areas of assurance:** • Quarter 4 corporate workforce information report • Workforce key performance indicators • National Staff Survey 2022: results overview • Gender pay gap report • Board Assurance Framework The Committee also received: • an update on Equality Diversity & Inclusion; and • the annual review of committee's self-assessment of effectiveness and its terms of reference • a staff story from the Freedom to Speak Up Guardian • WRES and WDES equality standard submissions	
Purpose	Approval	
Recommendation(s)	Board members are invited to: i. note the Committee Chair's report, particularly areas of significant assurance; ii. approve the revised Committee terms of reference; iii. note the outcomes for the race and disability equality standard submissions which are being submitted to NHS England; and iv. note the annual gender pay gap report outcomes.	
BAF	People 1 and 2 entries	
Appendices	1: Committee terms of reference 2: WRES and WDES equality standard submissions 3: Annual gender pay gap report 4: NHS Staff survey outcomes.	

Committee Chair's assurance report

Committee name	Workforce Assurance Committee
Date of meeting	26 April 2023
Summary of assurance:	

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

"No case to answer analysis"
Committee members considered a report which summarised analysis carried out on the number of formal disciplinary cases at the Trust that had an outcome of "no case to answer" between April 2019 and March 2023. The analysis found that a total of 10 cases were identified as having no case to answer, with six of the 10 cases occurring in 2022. The Committee was assured that steps had been taken to reduce the number of formal disciplinary cases that result in a "no case to answer" outcome following investigation. The Committee welcomed the implementation of the Restorative Justice process and Fair Treatment Panels which would also greatly improve the experience of staff and impact positively on organisational culture.

Industrial action
The Committee was appraised of latest developments in relation to industrial action taken by NHS staff including nurses and junior doctors. Planning for junior doctor strikes was managed through the Trust emergency planning processes supported by Medical Director's office, operational and other healthcare professional colleagues. No future dates for strikes had been confirmed however junior doctors continued to hold a mandate to strike and more dates were expected. Negotiations to settle a pay award for staff on Agenda for Change pay structure were still ongoing.

Review of Committee effectiveness and terms of reference
The Committee reviewed the amended terms of reference which highlighted changes to the membership and that the Committee would continue to meet quarterly and extend the length of each meeting. It was agreed that the Committee would have oversight of the people strategy which is being developed. The Committee approved the terms of reference for onward ratification by the Trust Board.

Changes to workforce key performance indicators
The Committee received a breakdown of workforce key performance indicators (KPIs) which had been benchmarked against NCL hospital trusts. It was agreed that while the majority of Whittington Health's workforce KPIs are in line with those of NCL, it was recommended that the Trust targets for both appraisal and mandatory training be revised to 85%. It was also agreed that bank and agency KPIs would continue to be reported to the Finance & Business Development Committee.

2022/23 Quarter four workforce report
The Committee received the report which reported on key workforce issues for the fourth quarter of 2022/23, notably:

- Vacancy rates had decreased to 10.6% at the end of March.
- Sickness absence continued to reduce to 4.4%
- Appraisal and mandatory training increased by 1% to 86% with appraisal compliance remaining static at 74%. HR Business Partners would continue to work with Integrated Clinical Support Units (ICSUs) and corporate directorates to increase compliance.
- Employee Relations (ER) continued to see that some cases were not resolved within the 90-day target, with an increase of four cases at the end of quarter four bringing the total number of cases not resolved within the 90 day target to 36.
- Recruitment time to hire was at 63 days which was in line with the Trust's target.

The Committee was assured that focussed work would continue with Estates and Facilities. Additional appraisal training has been carried out with managers with the aim of increasing engagement and compliance and embedding team appraisals.

National Staff Survey 2022: adequate materials

The Committee considered the outcome of a deep dive into the result of the National Staff Survey question related to "satisfaction around adequate material, resources and equipment to do their role" which scored 46.5%, which was 2.9% above the worst in the acute and community category and left the Trust 10th out of 11 trusts in NCL. Some of the feedback received indicated issues with procurement of materials where there were national shortages of materials, issues with the procurement processes and governance. The Committee was assured that appropriate mitigating actions had been taken in response to the risks raised that related to patient safety and quality of care. Additional resources would also be deployed to respond to issues raised through the national staff survey.

Annual workforce race and disability equality standard submissions

The Committee received a summary of the outcome of the annual workforce disability (WDES) and race equality standards (WRES) submissions to NHS England.

The Committee noted the improvement in several indicators including:

- bullying & harassment (from staff)
- equal opportunities for career progression
- discrimination and
- board representation
- a significant improvement in the relative likelihood of BME staff entering into the disciplinary process (3.75 in 2022 to 0.6 in 2023) compared to white staff.

The Committee noted a deterioration in WRES indicator 5 (bullying and harassment (from patients) and a slight deterioration in indicator 2 (recruitment). The 2023 WDES results showed that there continued to be a very low level of disclosure of disabilities in the electronic staff record (ESR)

system. The results over the ten metrics showed that staff with a disability fared less well in comparison with staff with none. The Committee accepted the submissions and noted that it would be approved at the Trust Board before the final submission to NHS England at the end of May 2023.

Gender pay gap report
The Committee considered the report which provided an overview of the Trust's position in relation to a gender pay gap and which was required to be reported annually as a public sector organisation since 2017. The Committee noted that the mean average hourly gap had closed by 1.2% from 7.6% in March 2021 to 6.3% in March 2022. In addition, it noted that the average gender pay gap as a median average had also closed by 4.9%, from 6.5% in 2021 to 1.7% in 2022. The Committee also welcomed assurance that Whittington Health benchmarked favourably against other provider organisations in the North Central London sector.

Board Assurance Framework and Trust Risk Register – People entries
The Committee noted the Board Assurance Framework and Trust Risk Register.

Staff Story: A testimonial from the Freedom to Speak Up Guardian.
The Committee was introduced to Ruben Ferreira, the Trust's Freedom to Speak Up Guardian, who had been invited to the meeting to talk about his role and career at the Trust. He explained that he had qualified as a social worker in his native country Portugal but was unable to secure a job so re-trained as a family mediator and teacher. Ruben enjoyed his work in Portugal but felt that there were greater opportunities to progress in the UK. He began his career at the Whittington Hospital eight years ago in a Band 2 administration role in the Community which built a solid foundation on which to develop a career in the NHS, after two years he was promoted to a lead admin role in the Community. Ruben's skills and drive did not go unnoticed, his aptitude as an artist was harnessed by the Organisational Development team and together they developed a workshop to help staff achieve their potential by building on their individual skills and talents.

Ruben did not hesitate to apply for the position of Freedom to Speak Up Guardian, he was confident that he possessed all the necessary skills and qualities needed for the role. His enthusiasm and abilities were recognised at interview, and he was appointed shortly thereafter. Ruben has been in the role for four years and continues to enjoy his work immensely. He felt that working as closely as he does with staff, listening to their stories, supporting and advising where he could was a privilege that he would not take for granted. Ruben recognised that the role could feel quite isolated but was confident that he could draw on the support of his management team when needed. He expressed his gratitude for the support that he has received in developing the role and making sure that the service was visible across the Organisation.

2.	**Present:** Rob Vincent, Non-Executive Director (Committee Chair) Glenys Thornton, Non-Executive Director Norma French, Director of Workforce Kevin Curnow, Chief Finance Officer Tina Jegede, Joint Director of Inclusion and Lead Nurse, Islington Care Homes Swarnjit Singh, Joint Director of & Inclusion and Trust Company Secretary Eliana Chrysostomou, Associate Director, Learning & Organisational Development Charlotte Pawsey, Deputy Director of Workforce Rowena Welsford, Associate Director, Workforce **In attendance:** Helen Brown, Chief Executive Officer Mark Livingstone, Deputy Director, Allied Health Professionals Astrid Von Volckamer, Acting Assistant Director, Learning & Organisational Development Mala Shaunak, Acting Head of Organisational Development Marcia Marrast-Lewis, Assistant Trust Secretary Kate Green, Executive Assistant to Director of Workforce

Appendix 1: Committee terms of reference

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

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

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

8.	**Reporting**
8.1	Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.
8.2	The draft minutes of Committee meetings shall be formally recorded and a Chair's assurance report presented at the next meeting of the Trust Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure, or executive action.
8.3	The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.
8.4	The Committee shall receive reports from the following Trust fora: • People Committee • Trust Partnership Group • Multidisciplinary team Recruitment & Retention Group • Health & Wellbeing Group • Junior doctor forum • Education Committee • Staff equality networks • Medical Staff Negotiating Committee (MNSC) • #Caringforthosewhocare programme
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.
9.3	These terms of reference were approved by the Board of Directors in May 2023 and will be reviewed, at least annually.

Meeting title	**Trust Management Group and Workforce Assurance Committee**	**Dates: 9 May 2023 and 26 April 2023**
Report title	**Annual Workforce Race and Disability Equality Standard submissions**	**Agenda item:**
Executive director	Norma French, Director of Workforce	
Report authors	Simon Anjoyeb, Equality, Diversity and Inclusion Lead, Tina Jegede and Swarnjit Singh, Joint Directors of Inclusion	
Executive summary	This report presents the outcome of the annual workforce disability (WDES) and race equality standards (WRES) before submission to NHS England. This year the deadline for these submissions has been brought forward from 30 July to 31 May 2023. The outcomes from both the WRES and WDES (see tables 1 and 3) will also be publicised on our intranet and on our external web pages. Headlines from the current WDES and WRES results this year show some improvements in several indicators (bullying & harassment (staff), equal opportunities, discrimination and board representation) and significant improvement in the relative likelihood of BME staff entering into the disciplinary process (3.75 in 2022 to 0.6 in 2023) compared to white staff. However, there has been a deterioration in WRES indicator 5 (bullying and harassment (patients) and a slight deterioration in indicator 2 (recruitment). The 2023 WDES results show that there continues to be a very low level of disclosure of disabilities in our electronic staff record (ESR) system. Our results over the ten metrics show that staff with a disability fare less well in comparison with staff with none; although there have been some improvements in many metrics, the gap in experience appears to be widening.	
Purpose	Noting	
Recommendation(s)	The Board is asked to: i. note the outcomes from this year's WRES and WDES which will be submitted to NHS England and publicised on our external webpages; and ii. continue to support the ongoing work arising from these results.	
BAF	People 1 and People 2 entries	
Report history	Annual equality submissions to NHS England	
Appendices	1: 2017/22 WRES outcomes summary	

Annual Workforce Race and Disability Equality Standard submissions

1. Workforce Race Equality Standard (WRES)

1.1 Collecting data on diversity and inclusion enables organisations to focus on specific areas for improvement to create and sustain a more inclusive culture. The Trust has accumulated eight years of data, and some parameters and reporting requirements have changed over that period (for example, for indicators nine and seven). However, seeing the data together provides an overview of progress.

1.2 The WRES outcomes are drawn from data held in the Trust's Electronic Staff Record (ESR) and other systems, such as those held on Trust human resources systems for indicators 2, 3, and 4 for the financial year 2022/23. Information for indicators 5, 6, 7 and 8 are taken from the 2022 Annual NHS Staff Survey, undertaken in the Autumn of 2022, with results published in the Spring of 2023.

1.3 Table 1 overleaf summarises the Trust's WRES results since 2017. More detailed data, including a gap trend, is available in Appendix 1.

Table 1: Summary of WRES Indicators, 2016-2022

WRES Indicator			2017	2018	2019	2020	2021	2022	2023
1	Workforce Ethnicity	BME	45.0%	43.0%	41.6%	40.2%	40%	38.2%	41.5%
		White	-	-	42.6%	37.8%	37%	37.7%	37.4%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		2.17	2.14	1.65	1.55	1.64	1.42	1.51
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		2.41	1.18	1.44	0.85	1.57	3.75	0.68
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development compared to BME		-	-	0.94	0.91	1.26	1.01	0.93
5	Percentage of staff experiencing harassment, bullying or abuse from the public in last 12 months	BME	28.6%	29.1%	35.9%	32.5%	30.3%	28.6%	29.3%
		White	30.3%	28.4%	30.5%	30.6%	28.9%	27.9%	30.4%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	31.9%	32.5%	36.2%	31.9%	29.7%	27.7%	25.4%
		White	24.6%	26.7%	31.4%	29.9%	24.2%	25.7%	24.3%

WRES Indicator			2017	2018	2019	2020	2021	2022	2023
7	Percentage of staff who believe that trust provides equal access to career progression or promotion	BME	70.0%	39.8%	35.8%	39.7%	39.7%	39.9%	41.2%
		White	86.6%	59.5%	56.2%	58.2%	56.4%	54.4%	57.5%
8	Percentage of staff who experience discrimination at work from a manager or other colleagues	BME	16.6%	17.1%	20.3%	16.1%	16.9%	15.2%	15.0%
		White	6.6%	8.2%	9.5%	7.8%	8.2%	8.3%	9.4%
9	Percentage membership of Board		13.3%	20.0%	20.0%	16.7%	16.5%	17.6%	26.7%
	Relative representation of BME in Board membership		-45%	-23%	-21.8%	-23%	-16.5%	-20.6%	-14.8%

1.4 Commentary on the results and trends follows below for each of the nine WRES indicators.

Indicator 1 (Trust profile: white, black, and minority ethnic (BME) staff at different pay bands)

1.5 In many NHS trusts, including Whittington Health, a typical workforce representation shows white staff increasing with bandings and BME staff decreasing the higher the pay bands. At Whittington Health, band 7 (clinical) and band 8a (non-clinical) is the point where BME underrepresentation first becomes evident to a statistically significant degree. It is hoped that the Trust will be able to use these analyses to focus ongoing efforts on making career progression more equitable for BME employees in specific roles and pay bands where significant disparities exist.

1.6 This was one of the key drivers for the London Race Strategy setting Model Employer targets for individual providers. The targets are to appoint ethnic staff at senior levels (band 8A and above) over ten years (2018-28), to help achieve equity and to demonstrate that they are an employer more reflective of the communities served at all organisational levels.

1.7 The table below shows that the suggested targets are not fully being met, and whilst some pay bands exceed targets, others are falling behind, as shown in Table 2 (below). This data will continue to be reviewed to ensure accurate information is available on senior staff bandings in integrated clinical service units and corporate departments.

Table 2: Progress against the Model Employer targets

	2018 Actual	2019 Actual	2019 Goal	2019 Gap	2020 Actual	2020 Goal	2020 Gap	2021 Actual	2021 Goal	2021 Gap	2022 Actual	2022 Goal	2022 Gap	2023 Actual	2023 Goal	2023 Gap
Band 8A	58	56	64	-8	60	70	-10	62	75	-13	80	81	-1	101	87	+14
Band 8B	20	22	22	0	24	24	0	21	25	-4	29	27	+2	34	29	+5
Band 8C	3	5	4	+1	6	6	0	5	7	-2	8	9	-1	9	10	-1
Band 8D	2	2	2	0	4	3	+1	3	3	0	5	3	+2	6	3	+3
Band 9	1	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
VSM	0	0	0	0	0	1	-1	0	1	-1	3	1	+2	1	1	0

1.8 To further understand the impact of race equity on specific groups; during 2023/24 the EDI Team will further granulate the WRES results into specific ethnicities. This in-depth look into the indicators may inform more targeted actions to improve performance (particularly in relating to indicators 1 and 2).

Indicator 2 Relative likelihood of being appointed)

1.9 In 2022, the relative likelihood was 1.42, which indicates that white candidates are more likely to be appointed from shortlisting than BME candidates. In 2023, it increased to 1.51, indicating a slight decline in this indicator's performance.

Indicator 3 (Relative likelihood of entering into a formal disciplinary process)

1.10 In 2022, the relative likelihood was 3.75, which indicates that BME staff are more likely to enter formal disciplinary processes than white staff (this has been the highest since the standard started). HR and EDI worked together to identify the key causes of the increase in cases involving BME staff. In 2023, the likelihood reduced to 0.68, which indicates that white staff are more likely to enter disciplinary processes than BME. Out 14 cases reported, 6 are BME staff and 8 are white staff.

Indicator 4 (Relative take-up of non-mandatory training)

1.11 In 2019 and 2020, BME staff were marginally more likely to access non-mandatory training than white staff. The performance for indicator 4 declined in 2021, with white staff being 1.26 times more likely to undertake development opportunities than ethnic staff; in 2022, this improved to a relative likelihood of 1.01. In 2023, the relative likelihood improved further to 0.93, indicating that BME staff are marginally more likely to access non-mandatory training than white staff.

Indicator 5 (Relative likelihood of experiencing harassment and bullying from the public)

1.12 Performance for this indicator had seen improvement from 2019-2022 but reduced in 2023 for BME (+0.7%) and white (+2.5%) staff. From 2019 to 2022, the percentage scores for experiencing bullying were reduced for both BME and white staff, and the gap in experiencing was slowly closing. However, in 2023 the gap in experience between BME and white staff had increased from -0.7% to +1.1% (proportionally, more white staff reported experiencing bullying and harassment from the public compared to BME staff). The Trust score of 29.3% of BME staff reporting experiencing harassment and bullying from the public is lower (1.5%) than the national average for acute and acute & community trusts (for BME staff), which also increased compared to last year.

Indicator 6 (Relative likelihood of experiencing harassment and bullying from colleagues)

1.13 The results show an improvement in BME staff (-2.3%) and white staff (-1.4%) experiencing bullying from colleagues. The gap between BME and white staff experience has also improved by reducing by 0.9% from 2.0% to 1.1%. Notably, 25.4% of the Trust's BME staff reported harassment and bullying; this is lower than the national acute and acute & community average (28.8%) for BME staff, which saw a slight increase compared to last year.

1.14 **Indicator 7** (Relative opportunities for career development). The experience of the Trust's BME staff has been relatively consistent between 2019 to 2022, whilst white staff experience has been reduced by circa 2% per annum in the same period. In 2023, both staff groups saw an improvement in this indicator, with BME staff by 1.3% and white staff by 3.1% so that 41.2% of BME and 57.5% of white respondents stated that the Trust acted fairly regarding career opportunities/career development. The gap in experience between BME and white staff increased from 14.5% in 2022 to 16.3% in 2023. At the same time, the gap in experience between the Trust's BME staff and the national acute and acute & community average (for BME staff) has increased from 4.7% in 2022 to 5.8% in 2023.

NB: there has been a change in the staff survey's central reporting for this question. Previous years' surveys excluded staff that responded, 'don't know'. In the latest staff survey, this was changed to reflect all staff who answered the question.

Indicator 8 (Relative experience of discrimination from staff)

1.15 The results for BME staff experience of discrimination have slightly improved from 15.2% in 2022 to 15.0% in 2023. For white staff, it degraded with an increase from 8.3% to 9.4%, decreasing the gap by 1.3% points to 5.6%. Notably, 2.3% fewer Trust BME staff reported experiencing discrimination from other staff compared to the national average for BME staff in acute and acute & community services.

Indicator 9 (Relative level of Board representation)

1.16 The minus 14.8% shows an under-representation on the Board compared to the organisational profile, which represents a decrease in under-representation compared to 2022.

2. Workforce Disability Equality Standard (WDES)

2.1 The first report submitted at the end of July 2019 was based on 2018/19 data. The 2023 submission provides data for 2022/23. The ten indicators for WDES are taken from ESR and other systems for indicators 1, 2, 3, and 10; and from the annual staff survey for indicators 4, 5, 6, 7, 8, and 9.

Indicator 1 (Trust profile for staff with and without disabilities at different bands)

2.2 With only 3.0% (an increase of 0.5% from 2022) of staff represented in ESR and 18.6% of the staff who responded to the staff survey, the following analysis can only apply to those specific respondents. It is therefore a key priority that we engage staff in the benefits of uploading demographic data into ESR to enable the Trust to target resources and activities in support of those with disabilities. This has been promoted in all training including leadership, equalities, and appraisal training we well as the various staff networks, including BAME, 'LGBTQ+' and 'Whittability'. From the data available, compared to last year, the non-clinical representation is either in line or higher than compared to the overall workforce, and each cluster has increased. Compared to last year, the representation in clinical roles is lower in almost all clusters except in indicators 2 and 5, and nearly all clusters saw an increase except indicators 4 and 5.

Indicator 2 (Relative likelihood of being appointed)

2.3 In 2022, the relative likelihood was 0.84; this means that disabled candidates were slightly more likely than non-disabled candidates to be appointed from shortlisting. In 2023, this rose to 1.18, meaning non-disabled candidates are slightly more likely to be appointed, increasing the overall gap in experience between the two groups. However, using the rule of 4/5ths does not suggest that there is an overall statistically adverse impact.

Indicator 3 (Relative likelihood of entering formal capability process)

2.4 In 2022, the relative amount for this indicator was 2.44; this means that disabled staff are more likely to enter a formal capability process than non-disabled staff (it should be noted over a 2-year rolling period, this relates to one case involving one disabled member of staff). In 2023, the relative likelihood rose to 5.37 (over a two-year rolling average period, this relates to two cases involving disabled staff out of 8 cases). The relative likelihood is impacted by the low levels of declaration and the low number of cases of capability.

Indicator 4a (i) (Relative percentage of staff experiencing bullying from patients)

2.5 In 2023, there the performance for this indicator declined with an increase of 4% in staff with disabilities facing bullying from patients, their relatives, and the public, now at 37.4%. There is a slight increase in non-disabled staff experience (+0.6%) now at 28.0%. This increases

the gap in experience between the two groups from 6% to 9.4%. It is worth noting 4.4% more Trust staff with disabilities reported experiencing bullying and harassment from patients than the national acute and acute & community average for disabled staff.

Indicator 4a (ii) (Relative percentage of staff experiencing bullying from managers)

2.6 There has been a slight improvement with a reduction of 0.4% of staff with disabilities experiencing bullying from managers, now at 22.3%. The comparable figure for non-disabled staff is 11.2% cent which is a decrease of 2.6% from 2022. This has increased the gap in experience between the two groups by 2.2%. It is worth noting 5.2% more staff with disabilities in the Trust reported experiencing bullying and harassment from their managers than the national acute and acute & community average for disabled staff.

Indicator 4a (iii) (Relative percentage of staff experiencing bullying from colleagues)

2.7 This indicator has seen improvement with a decrease of 1.2% of staff with disabilities experiencing bullying from colleagues, now at 26.5%. There has been a decrease of 2.6% in non-disabled staff experiencing bullying from colleagues, which is now 17.3%. This increased the gap in experience of both staff groups experiencing bullying from colleagues from 7.8% to 9.2%. It is worth noting 0.4 percentage points fewer staff with disabilities in the Trust report experiencing bullying from their managers than the national acute and acute & community average for disabled staff.

Indicator 4b (Reporting bullying and harassment when experienced it)

2.8 This indicator has seen an improvement with a 2.4% increase of staff with disabilities reporting incidents, this is now 47.1% of this staff group. There has been a 0.3% increase of staff without disabilities reporting such incidents, which is now 48.9%. This has reduced the gap in experience between the groups from -3.9% to -1.8%. It is worth noting that 1.3% fewer Trust staff with disabilities report incidents compared to the national acute and acute & community average for staff with disabilities.

Indicator 5 (Relative percentage of staff believe there are equal opportunities for career development)

2.9 In 2023, 40.1% of staff with disabilities reported that they believed there were equal opportunities for career development, which represents an improvement with a 1.6% increase from 2022. There has been an increase of 2.6% for non-disabled, bringing the 2023 score to 51.8%, and increasing the gap from 10.7% to 11.7%. The national average for disabled staff in acute and acute & community services is 51.4%, and there is a gap in experience with Trust staff with disabilities of 11.3%, which has decreased since 2022 by 1.6%.

NB: * there has been a change in the central reporting for this question in the staff survey: previous years' surveys excluded staff who responded, 'don't know' and in the latest staff survey, this was changed to reflect all those that have answered the question.

Indicator 6 (Relative experience of feeling pressure from manager to work when not well)

2.10 Compared to 2022, the performance of this indicator has degraded with a 1.0% increase in disabled staff that reported feeling pressure from their manager, the overall score in 2023 is 29.5%. For non-disabled staff there has been a small reduction (improvement) compared to 2022 of 1.3%, which gives an overall score of 20.7%; this has increased the gap in experience between the two groups from 6.5% in 2022 to 8.8% in 2023. 0.5 percentage points fewer Trust staff with disabilities report experiencing pressure from their manager to attend work compared to the national average for acute and acute & community services for staff with disabilities.

Indicator 7 (Relative percentage saying they are satisfied with how the extent to which the Trust valued their work)

2.11 In 2023, 34.7% of staff with disabilities reported being satisfied – this represents an improvement with an increase of 0.9%. In comparison, 45.6% of non-disabled staff reported satisfaction with the extent to which the organisation valued their work, a decrease of 1% compared to 2022. The gap in experience between the groups has decreased from -12.7% in 2022, to -10.9% in 2023. 2.2% more Trust staff with disabilities compared to the national average for acute and acute & community services for staff with disabilities report experiencing satisfaction with how the Trust values their work.

Indicator 8 (Percentage saying employer made reasonable adjustments)

2.12 There is an increase of 2.4% of staff with disabilities reporting that the Trust made reasonable adjustments from last year (2022 62.3% compared to 64.7% in 2023); this represents an improvement. Overall, 7.1% fewer Trust staff reported that their employers made reasonable adjustments compared to the acute and acute & community services average.

Indicator 9 (Relative engagement scores)

2.13 The 2022 staff engagement scores decreased by 0.3 (this is a score and not a percentage) for staff with disabilities. This represents a degradation in performance and no change for non-disabled staff. The gap in engagement marginally increased to 0.7 and this has been broadly constant since 2019. The Trust's engagement score for staff with disabilities is 0.1 less compared to the national average for acute and acute & community services for staff with disabilities.

Indicator 10 (Relative level of board representation)

2.14 This metric relates to the representation of Board members in comparison to the Trust's overall workforce profile. Given the level of staff disclosure throughout the Trust, the results have limited meaning. The 2023 results show that there is a 3.7% (overall Board), 8.1% (voting members) and 8.1% (executives) over-representation of people with disclosed disabilities. There is an under-representation of 14.3% (overall Board) and an over-representation of 8.0% (voting members) and 8.0% (executives) for non-disabled members.

Table 3: Summary of performance on each WDES indicator

WDES Indicator		2020 Results			2021 Results			2022 Results			2023 Results		
1	Profile – disability at different bands	ESR shows 2% of staff disclosed having a disability; just under 50% having no disability; and 48% did not disclose. Of the responses to the annual staff survey approximately 5% of staff disclosed having a disability.			ESR shows 2.09% of staff recorded having a disability; 49.38% having no disability; and 48.53% did not share that information. Staff survey results show 14.2% of staff have a disability.			ESR shows 2.5% of staff recorded having a disability; 48.1% having no disability; and 49.4% did not share that information. Staff survey results show 17.0% of staff have a disability.			ESR shows 3.0% of staff recorded having a disability; 47.6% having no disability; and 49.5% did not share that information. Staff survey results show 18.6% of staff have a disability.		
2	Likelihood of being appointed (non-disabled vs disabled applicants)	0.96			1.02			0.84			1.18		
3	Likelihood of entering formal capability process	Zero: (no staff with disclosed disabilities have entered into formal capability)			Zero: (no staff with disclosed disabilities have entered into formal capability)			2.44			5.37		
4a (i)	Percentage of staff experiencing harassment and bullying from ***patients & public***	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**
		33.4%	31.3%	2.1%	33.0%	29.0%	4.0%	33.4%	27.4%	6.0%	37.4%	28.0%	9.4%
4a (ii)	Percentage of staff experiencing harassment and bullying from ***their managers***	24.1%	16.3%	7.8%	30.0%	13.0%	17.0%	22.7%	13.8%	8.9%	22.3%	11.2%	11.1%
4a (iii)	Percentage of staff experiencing harassment and bullying from ***other colleagues***	32.9%	23.5%	9.4%	30.0%	19.0%	11.0%	27.7%	19.9%	7.8%	26.5%	17.3%	9.2%
4b	Percentage of staff that reported harassment and bullying when they experienced it	48.7%	45.3%	3.4%	43.8%	47.1%	-3.3%	44.7%	48.6%	-3.9%	47.1%	48.9%	-1.8%

WDES Indicator		2020 Results			2021 Results			2022 Results			2023 Results		
5	Percentage of staff believing there are equal opportunities for career development	46.6%	50.2%	-3.6%	41.8%	49.7%	-7.9%	38.5%	49.2%	-10.7%	40.1%	51.8%	-11.7%
6	Experience of feeling pressure from manager to work when not well	33.5%	22.0%	11.5%	37.4%	21.6%	15.8%	28.5%	22.0%	6.5%	29.5%	20.7%	8.8%
7	Percentage saying they are satisfied with how the extent to which the Trust values their work	39.3%	51.6%	-12.3%	37.1%	53.7%	-16.6%	33.8%	46.5%	-12.7%	34.7%	45.6%	-10.9%
8	Percentage saying employer made reasonable adjustments	68.1%			67.0%			62.3%			64.7%		
9	(9a) Relative engagement scores	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**	**Disabled**	**Non-Disabled**	**Gap**
		6.7	7.2	-0.5	6.7	7.3	-0.6	6.5	7.0	-0.5	6.3	7.0	-0.7
	9(b) Enabling disabled staff to have a voice in the organisation.	There is now a 'Whittability' Network which has 'met' online several times during the pandemic in support of shielders and redeployed staff.			'Whittability' Network has an executive sponsor and governance structure.			'Whittability' Network has an executive sponsor and governance structure.			'Whittability' Network has an executive sponsor and governance structure.		
10	Relative level of board representation (Executives)	There is an apparent 11% over-representation of people with disclosed disabilities and an over-representation of 38% for non-disabled members resulting from the almost complete disclosure in Board and only 2% Trust disclosure			There appears to be an 18% over-representation of people with disabilities, a 31% over-representation for non-disabled members resulting from the almost complete disclosure in Board and 2% Trust disclosure			There appears to be an 17.5% over-representation of people with disabilities, a 11.9% over-representation for non-disabled members.			There appears to be an 8.1% over-representation of people with disabilities and an 8.0% over-representation of non-disabled members.		

3. Priorities and next steps

3.1 The high priority areas for improvement for our Trust remain around improving outcomes for key WRES indicators and by completing equality impact analyses of the key policies and outcomes in recruitment and selection, access to training and development opportunities, formal employee relations cases. The table below sets out some of the interventions planned.

WRES indicator	Action areas
1 - Percentage of BME staff	• Improving our information and coverage of the workforce to reduce the level of unknown ethnicity in the workforce • Secure places on national and sectoral talent management programmes for BME staff at band 8A and above • Continue will rollout of cohorts 2/3 of Band 2-7 Development Programme and monitor take-up • Individual development schemes in ICSUs and corporate departments to diversify their senior leadership positions • Continue with the offer of external mentoring and coaching
2 – Recruitment outcomes	• Continue work to build on data access and quality • Complete review of recruitment and selection policy to ensure alignment to guidance on inclusive and diverse panels • Rollout training for inclusive and diverse panels
8 – Disciplinary processes	• Continue with the implementation of the Restorative and Just Culture programme. • Building on the Trust pilot of reverse mentoring by rolling out the Reciprocal Mentoring for Inclusion Programme • Continue promotion of the national Leadership Academy Inclusive Leadership for Health and Social Care Programme to all staff, in particular, line managers to help increase confidence and capability in managing diversity and diverse teams • Complete an audit as part of the equality impact analysis to provide assurance on cases, and consistency of approach and outcomes and for inclusion in our public sector equality duty report •
4 – Training and development	• Improving data coverage and quality by including monitoring of all non-mandatory activity completed at the Trust along with development activities for trainee doctors, nurses, allied health professionals and within integrated clinical service units and corporate departments to identify any potential inequalities
5 – Bullying & Harrassment	• Monitor incidents quarterly and with targeted action plans for areas reporting a high incident
9 – Board membership	• Identify and support senior leaders from ethnic minority backgrounds to move beyond leadership within their area of expertise to executive roles through Leadership programmes such as the Nye Bevan • Develop proposals to help increase diversity on the Board through the NExT Director programme with NHS England's Non-Executive Director Appointments team.

3.2 As with the 2022 report, there is a limit to how meaningful and transferable the outcomes of the WDES data can be when the NHS National Staff Survey indicates that 18.6 per cent of staff who have a disability, and ESR indicates that only 3.0 per cent of staff have disclosed their disability. A concerted effort has been made to request disclosure at staff network events and through emails since the 2019 results were known and this will continue. The low disclosure rates means that there is limited meaning to the analysis provided.

3.3 The most important priority for WDES improvement continues to be the disclosure rate. This is being encouraged through the WhitAbility Staff Network, line management, equality and inclusion modules of leadership, appraisal, and other training programmes. In addition, work is also focussed on implementing health passports and Whittington Health's first policy on reasonable adjustments, including clear guidance for staff and their managers on the access to work scheme. It is envisaged that implementing the reasonable adjustment policy will add to the current efforts to improve the disclosure rates.

3.4 Adopting a 'Just and Learning Culture' is being advanced through collaborative exploration of relevant processes and procedures throughout the Trust and is at the early stages of implementation. This is a key priority in bringing together different aspects of the culture improvement work, including reducing bullying and for increasing inclusion with staff engagement and programmes such as reciprocal mentoring.

4. Recommendations

4.1 The Executive team, Trust Management Group, Workforce Assurance Committee and Trust Board are asked to:

i. note the outcomes from this year's WRES and WDES which will be submitted to NHS England and publicised on our external webpages; and
ii. continue to support the ongoing work arising from these results.

APPENDIX 1 – SUMMARY OF WRES INDICATORS FOR FROM 2017 TO 2023, INCLUDING THE GAP BETWEEN WHITE AND BME STAFF
(Colour coding is based on movement from the previous year: pink is a fall in performance; green is an improvement)

WRES Indicator	2017		2018		2019		2020		2021		2022		2023	
	White	BME	White	BME	White	BME	White	BME	White	BME	White	BME	White	BME
1. Ethnic Profile		45.0%		43.0%	42.6%	41.6%	37.8%	40.2%	37.5%	39.7%	37.7%	38.2%	41.5%	37.4%
2. Likelihood of being appointed	2.17		2.14		1.65		1.55		1.64		1.42		1.51	
3. Likelihood of entering a formal process for disciplinary	2.41		1.18		1.44		0.85		1.57		3.75		0.68	
4. Take-up of non-mandatory training	-		-		0.94		0.91		1.26		1.01		0.93	
5. Experience of bullying from public	30.3%	28.6%	28.0%	29.0%	31.0%	36.0%	31.0%	33.0%	28.9%	30.3%	27.9%	28.6%	30.4%	29.3%
Gap	-1.7%		1.0%		5.0%		2.0%		1.4%		0.7%		-1.1%	
6. Experience of bullying from colleagues	24.6%	31.9%	27.0%	33.0%	31.0%	36.0%	30.0%	32.0%	24.2%	29.7%	25.7%	27.7%	24.3%	25.4%
Gap	7.3%		6.0%		5.0%		2.0%		5.5%		2.0%		1.1%	
7. Career development	86.6%	70.0%	59.5%	39.8%	56.2%	35.8%	58.2%	39.7%	56.4%	39.7%	54.4%	39.9%	57.5%	41.2%
Gap	-16.6%		-19.7%		-20.4%		-18.5%		-16.7%		-14.5%		-16.3%	
8. Experience of discrimination	6.6%	16.6%	8.0%	17.0%	9.0%	20.0%	8.0%	16.0%	8.2%	16.9%	8.3%	15.2%	9.4%	15.0%
Gap	10.0%		9.0%		11.0%		8.0%		8.7%		6.9%		5.6%	
9. Board / Trust comparative representation	- 45.0%	- 23.0%	-21.8%		-23.0%		-16.5%		-20.6		-27.2%		-14.8%	
Basic % of Total	13.3%		12.0%		20.0%		16.7%		12.5%		17.6%		26.7%	

Meeting title	**People Committee**	**Date: 11th March 2023**
Report title	Gender Pay Gap Reporting	**Agenda item: 23/10**
Executive director lead	Norma French, Director of Workforce	
Report author	Amelia Barajas-Villaluenga, Head of Workforce Systems & Analytics	
Executive summary	Annual snapshot reporting of the gender pay gap has been a requirement of public sector organisations since 2017. There are six core statistics to be reported as percentage gaps**. A positive percentage indicates that men earn more than women, and a negative percentage indicates that women earn more than men for the specific measure in question**. The measures are as follows together with the 2022 summary: (i) Mean average: 6.33 % (ii) Median average: 1.65% (iii) Bonus mean average: -28.66% (iv) Bonus median average: 35.67% (v) Percentage of men and women receiving bonus pay: summarised in Appendix 1 (vi) Proportion of four quartiles: summarised in Appendix 1. The mean average hourly pay gap has closed by 1.2% from March 2021, from 7.6% in March 2021 to 6.3% in March 2022. The average gender pay gap as a median average has also closed when compared to March 2021, by 4.9%, from 6.5% in March 2021 to 1.7% in March 2022. The results are required to be publicly reported and are available for the public to view on the Government website at https://gender-pay-gap.service.gov.uk/Employer/VnMLXxqF.	
Purpose:	This paper is for information	
Recommendation(s)		
Risk Register or BAF		
Appendices	1. The Published Whittington Health Gender Pay Gap Report	

Gender Pay Gap at Whittington Health NHS Trust

1.0 Introduction

1.1 Gender pay gap obligations were introduced in 2017 alongside requirements for specified public bodies, including publishing annual information to demonstrate compliance under the Public Sector Equality Duty (PSED) and publishing equality objectives every four years. This is the fifth year of the extended duty, allowing a more comprehensive action plan to be created where necessary, provides an opportunity to benchmark against other Trusts, and learn from work undertaken in previous years, in both the NHS and the private sector in reducing the gender pay gap. The data reflects 2022 workforce structure, and so does not take into current changes.

1.2 This report provides a summary of the gender pay gap findings, prior to general publication, and recommends next initial steps.

2.0 What is the Gender Pay Gap?

2.1 The Equality and Human Rights Commission defines the difference between equal pay and the gender pay gap as follows:

- Equal pay means that men and women in the same employment performing equal work must receive equal pay, as set out in the Equality Act 2010.
- The NHS has a national pay structure and job evaluation system for staff on Agenda for Pay grades and Medical and Dental grades to ensure that men and women who carry out the same jobs, similar jobs or work of equal value are paid the same. We regularly review pay awards to allow for pay and grading reviews of new roles in a process managed with the active involvement of trade union representatives of our staff. It makes no reference to gender or any other personal characteristics of existing or potential job holders.
- The gender pay gap is a measure of the difference between men's and women's average earnings across an organisation or the labour market. It is expressed as a percentage of men's earnings. A positive result denotes higher male earnings; a negative result denotes higher female earnings.

2.2 An example could be that on average men earn 10% more pay per hour than women, that men earn 5% more in bonuses per year than women, or that the lowest paid quarter of the workforce is mostly female. These results must be published on the employer's own website and the Government portal. This means that the gender pay gap will be publicly available to stakeholders, employees, and potential future recruits. As a result, employers should consider taking new or faster actions to reduce or eliminate their gender pay gaps.

2.3 The gender pay gap is different to equal pay. This means that intricate research and analysis is needed to understand why a pay gap exists, and therefore what can be done to address it. National research has shown, for example, that women are less likely to negotiate higher starting salaries on a particular grade than men. There are also particular influencing factors in the NHS. For example, some professions are more likely to attract females than males.

3.0 What do we report?

3.1 The legislation requires an employer to publish six calculations:

- Average gender pay gap as a mean average;
- Average gender pay gap as a median average;
- Average bonus gender pay gap as a mean average;
- Average bonus gender pay gap as a median average;
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment;
- Proportion of males and females when divided into four groups ordered from lowest to highest pay.

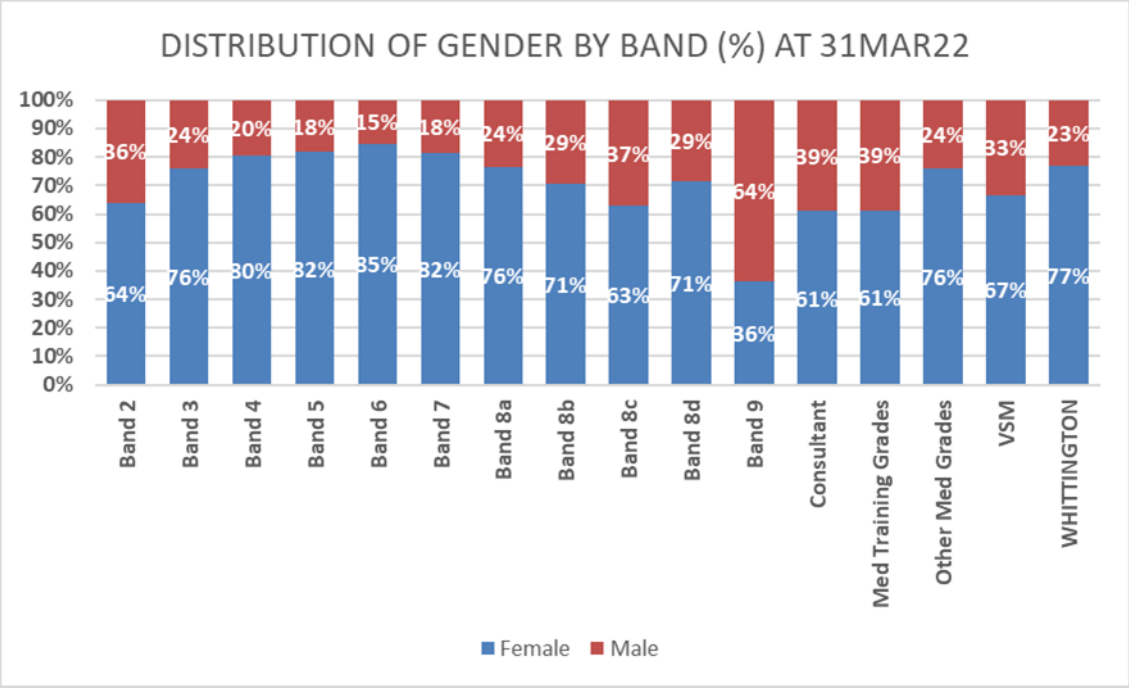
4.0 Summary of Whittington Health Gender Pay Gap Analysis.

4.1 Gender pay analysis for 2022 shows that at Whittington Health, women employed by our Trust earn an average of 6.3 less than men, per hour. This is a 1.2% improvement when compared to the figure reported for end of March 2021 (7.6%). Our full gender pay gap report is attached at Appendix one. 2017 was the first gender pay gap analysis we had run but data from the last three years is being reflected on this paper for comparative purposes.

5.0 Whittington Health Gender Profile

5.1 Table one, below, shows that on 31st March 2022 the Trust workforce comprised 77% female and 23% male across all roles at all levels of pay.

Table 1: The Breakdown of Headcount by Pay-Band and Gender



5.2 Table 1 shows that males are over-represented at higher bands (AFC Band 8A to VSM) and females under-represented, in comparison to the whole Trust gender profile (23% male and 77% female).

5.3 The representation for medical and dental staff at consultant level is 61% female and 39% male. In comparison to the whole Trust profile, there is a 16% under-representation of females at consultant level, and a 16% over-representation of males.

6.0 The Gender Pay Gap – hourly rate of pay

6.1 Table 2, below, shows the overall pay gap based on the basic hourly rate for all employees across three years (2020-2022) for both the mean rate and the median rate for men and women.

Table 2: Mean and Median Hourly Rates for Men and Women

	Mar-20				Mar-21				Mar-22			
	Male	Female	Difference	Pay Gap Percentage	Male	Female	Difference	Pay Gap Percentage	Male	Female	Difference	Pay Gap Percentage
Mean hourly rate for all employees	£22.80	£20.46	£2.34	10.26%	£23.23	£21.48	£1.76	7.57%	£23.85	£22.34	£1.51	6.33%
Median hourly rate for all employees	£19.97	£18.65	£1.31	6.58%	£20.98	£19.61	£1.37	6.51%	£21.23	£20.88	£0.35	1.65%

6.2 Table two shows a gradual decrease in the average hourly pay rate gap for men and women from March 2020 to March 2022. The median hourly rate in 2022 shows a gap reduction of 4.9%, from 6.6% to 1.7%.

7.0 Gender Pay Gap by Staff Group

Table 3, below, shows the gender pay gap for different staff groups. All the negative figures demonstrate negative pay gaps (in which women earn more than men). Each group is discussed separately below.

Table 3: Three Year Figures for Pay Gaps for Specific Staff Groups

	Mar-20				Mar-21				Mar-22			
Staff Group	Male	Female	Difference	Mean Pay Gap Percentage	Male	Female	Difference	Mean Pay Gap Percentage	Male	Female	Difference	Mean Pay Gap Percentage
ADD PROF SCIE&TECH	£22.57	£22.73	-£0.16	-0.71%	£23.88	£23.11	£0.77	3.22%	£25.66	£24.70	£0.96	3.74%
ADD CLIN SERVS	£13.15	£13.48	-£0.33	-2.51%	£13.40	£13.82	-£0.42	-3.13%	£14.42	£14.74	-£0.32	-2.22%
A&C	£20.39	£16.64	£3.75	18.39%	£20.27	£17.47	£2.80	13.81%	£24.05	£20.87	£3.18	13.22%
AHP	£20.93	£21.72	-£0.79	-3.77%	£22.26	£22.86	-£0.97	-4.37%	£22.94	£24.47	-£1.53	-6.67%
E&A	£13.94	£12.91	£1.03	7.39%	£14.91	£13.70	£1.21	8.12%	£15.64	£14.60	£1.04	6.65%
HEALTHCARE SCIE	£23.09	£21.86	£1.23	5.33%	£23.98	£22.74	£1.24	5.17%	£24.38	£24.04	£0.34	1.39%
M&D	£35.51	£34.90	£0.61	1.72%	£35.71	£36.22	-£0.51	-1.43%	£38.00	£39.44	-£1.44	-3.79%
N&M REG	£21.71	£21.54	£0.17	0.78%	£23.42	£22.93	£0.49	2.09%	£23.41	£23.33	£0.08	0.34%

7.1 Additional Professional Scientific and Technical staff group show an average pay gap of 3.74%, showing a deterioration of 0.5% from March 2021. This group is made up of support to AHP and support to Scientific and Technical Staff. Males represent 19% of the group and females 81%.

7.2 Additional Clinical Services staff group show in March 2022 a negative average pay gap, as in previous years, of -2.22%. Males represent 15% and female 85% of the staff group.

7.3 Administrative and Clerical staff group still show a consistently high pay gap in Mar22 (13.22%) but a gap reduction of 0.6%% from Mar2021 (13.81%). The male/female headcount split on the A&C group is 35% male and 65% female.

7.4 Allied Health Professionals show consistently negative gender pay gaps from Mar2020, -6.67% in Mar22. In this staff group 15% of staff are male and 85% female.

7.5 Estates and Ancillary staff show a reduced pay gap in March 2022 (6.65%) compared to 2021 (8.12%). 56% of staff are male and 44% female.

7.6 Healthcare Scientists reduced the average pay gap by 3.8% between March 2021 and March 2022, from 5.17% to 1.39%. The gender split in the Healthcare Scientist group is 33% male and 67% female.

7.7 Medical and Dental staff group continue to show a negative pay gap from March 2020, -3.79 in March 2022, from -1.43% in March 2021. 38% of medical and dental staff are male and 62% female.

7.8 Registered Nurses and Midwives closed the pay gap by 1.8% from March 2021 and March 2022, from 2.09% to 0.34% . In this group male staff represent 13% of this staff group and females 87%

7.9 Table Four, overleaf, provides more detail for medical and dental staff

Within the medical staff group the average hourly rates in March 2022 were lower for females than for males in the 'Consultants and GPs' (0.24% pay gap) and 'Trust Grade and other Doctors' (6.25% pay gap) roles. The pay gap in the 'Doctors in Training Grades' show a negative value, -1.34%, indicating that the average hourly rate for female trainee grade doctors is higher than the rate for male trainees.

Table 4: Medical and Dental Hourly Pay Rates

	Mar-20				Mar-21				Mar-22			
Staff Group	**Male**	**Female**	**Difference**	**Mean Pay Gap Percentage**	**Male**	**Female**	**Difference**	**Mean Pay Gap Percentage**	**Male**	**Female**	**Difference**	**Mean Pay Gap Percentage**
Consultants and GPs	£48.29	£47.59	£0.70	1.45%	£48.66	£48.96	-£0.30	**-0.62%**	£50.65	£50.53	£0.12	**0.24%**
Doctors in Training Grades	£28.76	£28.54	£0.22	0.76%	£25.15	£25.40	-£0.25	**-0.99%**	£26.84	£27.20	-£0.36	**-1.34%**
Trust Grade and Other doctors	£30.41	£31.82	-£1.41	**-4.64%**	£32.23	£31.66	£0.57	**1.77%**	£39.82	£37.33	£2.49	**6.25%**

8.0 The Gender Pay Gap – bonus payments

8.1 At Whittington Health, the only bonuses that are paid are Clinical Excellence Awards (CEAs) to consultants. The guidance from NHS Employers and the ESR (Electronic Staff Records) Central Team is that CEAs meet the definition of a "bonus payment" in accordance with the Advice and Conciliation Service (ACAS) guidance relating to the scheme. Local awards are determined and funded locally. National awards are determined nationally and funded by the Department of Health. Table 5, below, provides the breakdown of bonus payments.

Table 5: Breakdown of Bonus Payments

	Male	Female	Pay Gap Percentage
Mean bonus pay per annum	£8,467.85	£10,894.59	-28.66%
Median bonus pay per annum	£7,539.96	£4,850.74	35.67%
Proportion of all employees paid a bonus (of total relevant employees)	2.33%	1.18%	

8.2 CEAs often relate to length of service so it will take many years for newly appointed consultants to progress up the CEA scale. The Mean Pay Gap percentage references a one year period (1st April 2021 to 31st March 2022). It shows a negative value which indicates a higher pay value to female consultants in comparison to male consultants -28.66% gap).

8.3 The proportion of all employees paid a bonus is calculated over the total relevant employee headcount for each gender. The proportion of female consultants is lower (1.18%) compared to the proportion of male consultants (2.33%). That is 25 male consultants out of a total relevant employee male headcount of 1,075 ; and 42 female consultants out of a total relevant employee female headcount of 3,564.

9.0 Next Steps

9.1 These full figures will be published on the Government Website no later than 31st March 2023 as set out by Government guidance.

9.2 The Trust already actively supports women to return to work following maternity and adoption leave and offers shared parental leave and flexible working arrangements. The first WH Women's Network was launched on International Women's Day in March and continues to develop and feedback from this group will help inform subsequent improvement plans.. The Executive Medical Director is the executive sponsor of this Network.

9.3 The Trust will ensure that gender equality continues to be an integral part of our Equality, Diversity and Inclusion Strategy.

Appendix One:

The Published Whittington Health Gender Pay Gap Report (Snapshot as at 31st March 2022)

Standard	Male	Female	Pay Gap Percentage
Mean hourly rate of pay (all employees)	£23.85	£22.34	6.33%
Median hourly rate of pay (all employees)	£21.23	£20.88	1.65%
Mean bonus pay per annum (the only bonuses paid at WH are CEAs to consultants)	£8,467.85	£10,894.59	-28.66%
Median bonus pay per annum (the only bonuses paid at WH are CEAs to consultants)	£7,539.96	£4,850.74	35.67%
The proportion of male and female employees paid a bonus (all employees)	2.33%	1.18%	

Proportion of male and female employees in each pay quartile	Male	Female
Quartile 1 (lower)	25.69%	74.31%
Quartile 2 (lower middle)	20.73%	79.27%
Quartile 3 (upper middle)	19.65%	80.35%
Quartile 4 (upper)	28.74%	71.26%

Meeting title	**Workforce Assurance Committee**	**Date: 26 April 2023**
Report title	**Staff Survey 2022 Results**	**Agenda item:**
Executive director lead	Norma French, Director of Workforce	
Report author	Eliana Chrysostomou, Acting Assistant Director of Learning and Organisational Development	
Executive summary	Every year NHS England commission a national NHS staff survey to be run in every NHS organisation. This is the twelfth year for Whittington Health as an integrated care organisation (ICO), and the fifth in which all staff have been invited to respond. NHS England require external approved companies to manage the process and data to ensure confidentiality, and for this reason no results are provided where the response group is less than 11 responses. Whittington Health uses 'Picker' as the external supplier. This report provides a summary of the results, which must remain under embargo until 9th March 2023. The Trust, along with other ICOs, is benchmarked with 'acute and acute and community' trusts for the third time rather than 'combined' as in previous years. The results are organised into themes aligned to the 'People Promise'. This report provides a detailed summary of the results and compares them under the theme headings with results in previous years where available.	
Purpose:	This paper if for information	
Recommendation(s)	Members of the Trust Board are asked to: • Note the content of this report following the results of the 2022 NHS Staff Survey • Agree the Trust-wide priorities for 2023/24 which will support staff retention and increase morale and engagement across the organisation will be: 1. 'We are recognised and rewarded' particularly level of pay and having adequate material and recourses, and recognition are priorities. 2. 'We are safe and healthy' and particularly negative experiences, and; 3. 'We are compassionate and inclusive' and career progression and providing reasonable adjustments for staff with long-term conditions.	
Risk Register or Board Assurance Framework		
Report history	Staff Survey result reports are provided annually	
Appendices	Respondent background details and Demographics; Templates for (i) Priority areas; (ii) Team Action Plans; (iii) Update Summary for reporting; Communication plans.	

1.0 Introduction

1.1 This is the twelfth year in which Whittington Health as an Integrated Care Organisation (ICO) has conducted the national staff survey and the fifth year in which the Trust opted to invite all eligible staff to complete it. It is the second year Whittington Health has opted to run the survey online only. This paper summarises the results of the survey, draws out key comparative data and provides details of the proposed steps for updating staff and developing action plans.

1.2 The 2022 NHS England-commissioned survey was sent to all staff in 124 NHS organisations. In 2022, 432,292 staff nationally responded with a median response rate of 44%.

1.3 The findings from this NHS survey will be considered in conjunction with the progress made on last year's staff survey action plan, and the analysis of these results will be discussed with the Trust Management Group (TMG) to agree priorities and the overall approach to the development of a staff survey action plans

1.4 The Trust commissions the Picker Institute to run its survey, as do a further 65 other Acute and Acute & Community Trusts. This means that in addition to the national comparisons, we have access to reports at ICSU, directorate and individual service levels for a more detailed and local analysis. Nationally, Whittington Health was benchmarked against a total 124 similar Trusts.

1.5 This is the second year the survey results are aligned to the People Promise. There are seven People Promise elements which replace the old themes in addition to the existing elements of staff engagement and morale. A total of 117 questions were asked in the 2022 survey, of these 97 can be positively scored. Our results include every question where our organisation received at least eleven responses, which is the minimum required.

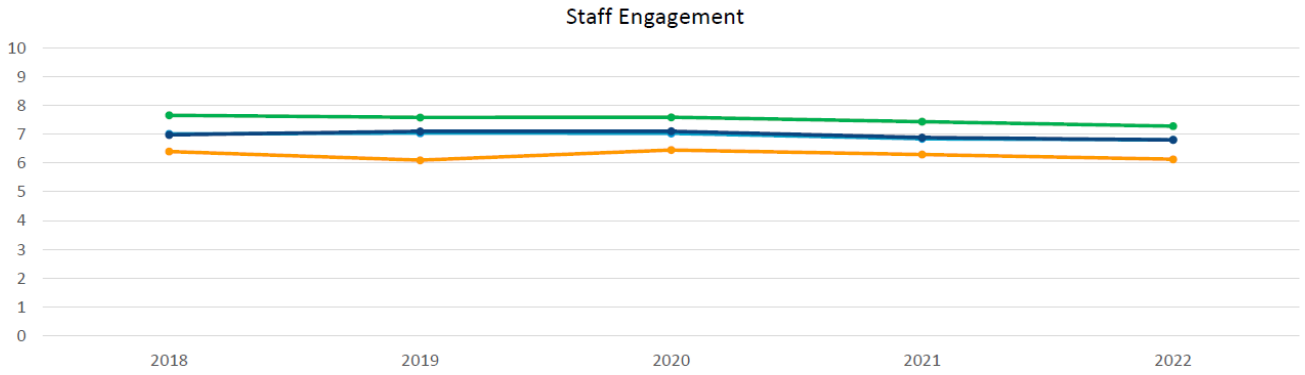
2.0 Response and Respondent Details

2.1 Of Whittington Health's (WH) 4519 eligible staff, 2019 staff took part in this survey, a response rate of 45**%** which is 1% below the average response rate for Acute and Acute & Community trusts using Picker. The Trust's response rate dropped by 7% since 2021. This is first time since 2017 that WH has experienced a response rate below 48%. Details on historic response rate can be found in appendix 1.

2.3 Details about the respondents' demographic background details and occupational groups can be found in appendix two.

3.0 Staff Engagement Indicator

3.1 Whittington Health's theme score of 6.8 for staff engagement is the national average 6.8 score and a reduction from the previous year which was 6.9.



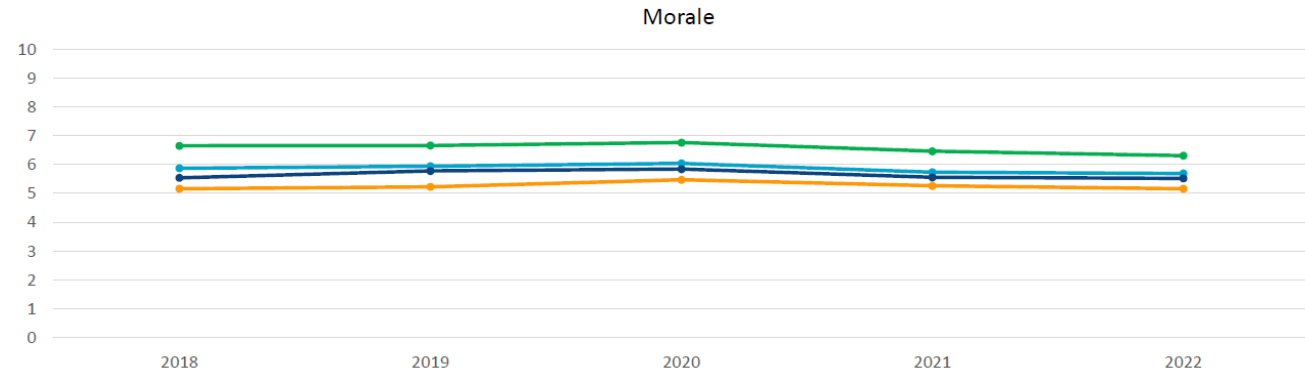
	2018	2019	2020	2021	2022
Your org	7.0	7.1	7.1	6.9	6.8
Best	7.7	7.6	7.6	7.4	7.3
Average	7.0	7.0	7.0	6.8	6.8
Worst	6.4	6.1	6.5	6.3	6.1
Responses	1935	2334	2164	2265	2018

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

- Staff recommendation of the trust as a place to work or receive treatment (Advocacy), scoring slightly above average
- Staff motivation at work – scoring average
- Staff ability to contribute towards improvements at work (Involvement) – scoring average

3.3 Staff Morale Indicator

Whittington Health's theme score of 5.5 for staff morale which is slightly below the national average of 5.7 and a reduction from last year where morale stood at 5.6. The reduction follows a similar trend with other Acute and Acute Community Trusts.



	2018	2019	2020	2021	2022
Your org	5.5	5.8	5.8	5.6	5.5
Best	6.6	6.7	6.8	6.5	6.3
Average	5.9	5.9	6.0	5.7	5.7
Worst	5.2	5.2	5.5	5.3	5.2
Responses	1914	2320	2151	2255	2017

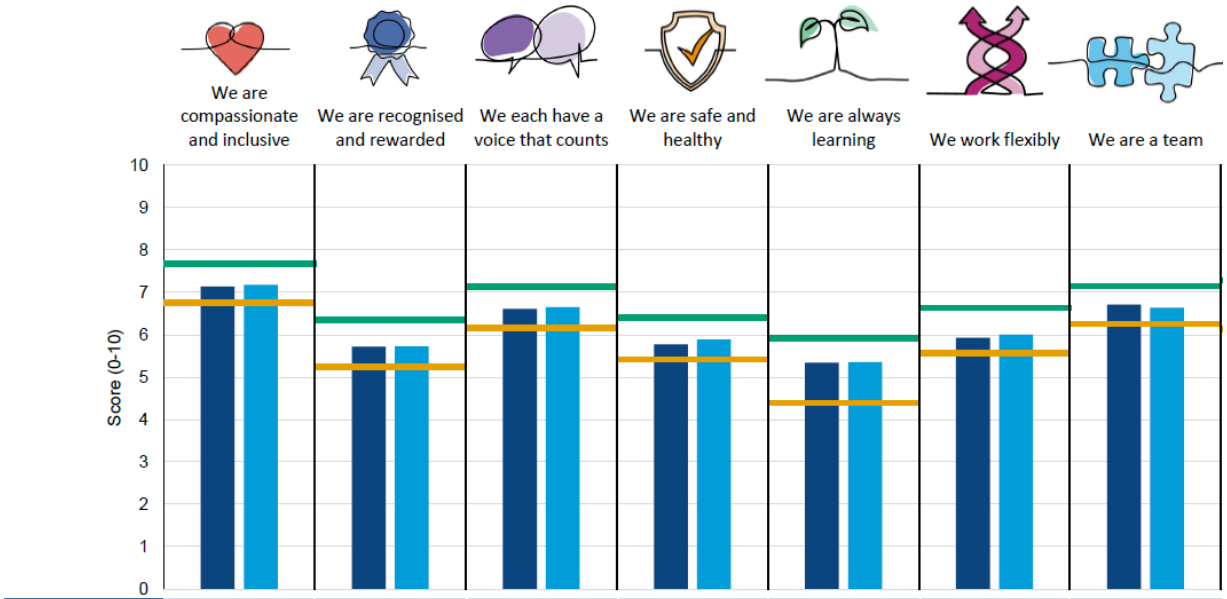
3.4 The key findings that make up the Morale score are:

- Staff retention/turnover – thinking about leaving the organisation where the organisation scored 0.4 below average
- Work pressures where the organisation scored 0.2 below average
- Stressors – where the organisation scored average, and in line with other organisations

3.5 Ranking Scores for Acute and Acute & Community Trusts

The reporting shows Whittington Health results against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). Results are presented in the context of the 'best', 'average' and 'worst' results for the total 124 Acute and Acute & Community Trusts.

3.6 Whittington Health – 2022 overall People Promise results



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team
Your org	7.1	5.7	6.6	5.8	5.3	5.9	6.7
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3
Responses	2016	2017	2006	2004	1927	2014	2016

3.7 In 2022 Whittington Health is not ranked as 'worst' or 'best' in any of the themes. The Trust is slightly above average for one of the themes: We are a team; Average for two themes: We are recognised and rewarded, and We each have a voice that counts. The Trust has scored slightly below average in We are compassionate and inclusive, We are safe and healthy, We are always learning, We work flexibly.

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

4.1 Areas with significant change (improved or declined scores)

4.2 Most declined scores

The below table indicates the most declined areas in comparison to 2021 and shows the overall NHS average in 2022. Note that despite the decline in these five areas since 2021, apart from the level of pay satisfaction, the Trust remains above NHS average. 0802

People Promise element or theme	Question	2021	2022	NHS Average
We are recognised and rewarded	q4c. Satisfied with level of pay	25.7%	20%	25.1%
Staff Engagement/Advocacy	q23d. If friend/relative needed treatment would be happy with standard of care provided by organisation	67%	62.2%	61.9%
We are compassionate and inclusive: Compassionate Culture	q23b. Organisation acts on concerns raised by patients/service users	74.7%	70.7%	68.3%
We are safe and healthy: Health and safety climate	q11a. Organisation takes positive action on health and well-being	76.5%	70.6%	68.3%
We are safe and healthy: Health and safety climate	q13d. The last time you experienced physical violence at work, did you or a colleague report it?	76.5%	70.6%	68.3%

4.3 Most improved scores

The table below shows the top five most improved scores for 2022 in comparison to 2021. Note that in the areas of Development and Reasonable Adjustments the organisation is still below the NHS average, with making reasonable adjustments to enable staff with disabilities to carry out their work 8.3% below average.

People Promise element or theme	Question	2021	2022	NHS average
We are safe and healthy: Negative experiences	q11b. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	36.6%	33.2%	30.6%
Morale: Stressors	q5c. Relationships at work are unstrained	46.4%	48.4%	44.0%
We are always learning: Development	q22e. Able to access the right learning and development opportunities when I need to	52.6%	54.8%	56.4%
We are compassionate and inclusive: Inclusion	q8b. Colleagues are understanding and kind to one another	68.7%	70.7%	69.6%
Not linked to People Promise elements or themes	q30b. Has your employer made reasonable adjustment(s) to enable you to carry out your work?	61.8%	63.4%	71.7%

4.4 Highest and lowest scores in comparison to the NHS average

4.5 The below table shows the highest scores for WH in comparison to the NHS average scores. The organisation has scored highly on quality of relationships at work and in two domains around line manager's asking staff opinions before implementing changes and providing clear feedback. The organisation has also scored positively around witnessing errors or near misses that could hurt the patients or service users.

Despite the organisation scoring positively (10% below NHS average) on staff not working additional paid hours, the trust is still 7.4% above NHS average where staff are working additional unpaid hours.

People Promise element or theme	Question	2021	2022	NHS average
Not themed	q10b. On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?	30.5%	30.5%	40.4%
Morale: Stressors	q5c. Relationships at work are unstrained	46.4%	48.4%	44.0%
We are a team: Line management	q9c. My immediate manager asks for my opinion before making decisions that affect my work.	60.9%	62.1%	56.9%
Not themed	q17. In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?	N/A	31.8%	35.2%
We are a team: Line management	q9b. My immediate manager gives me clear feedback on my work	64.7%	66.0%	62.1%

4.6 The table below shows the bottom five scores for WH in comparison to the NHS average.

The organisation has seen an improvement in some of the bottom scores since 2021, such as the organisation making reasonable adjustments for staff with long term conditions or disabilities, but it is still one of our lowest scored compared to the NHS average. The same applies to career progression, where the organisation has made an improvement of 2% but it is still below NHS average by 7.3%. The organisation has seen a decline and remains in the bottom scores in the areas of working additional unpaid hours, having adequate material to do my work and thinking about leaving.

People Promise element or theme	Question	2021	2022	NHS Overall
Not themed	q10c. On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?	62.5%	63.7%	56.3%
We are safe and healthy: Health and safety climate	q3h. I have adequate materials, supplies and equipment to do my work	47.0%	46.5%	53.5%
Not themed	q.30b Has your employer made reasonable adjustment(s) to enable you to carry out your work?	61.8%	63.4%	71.7%
We are compassionate and inclusive: Diversity and equality	q15. Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	46.3%	48.3%	55.6%
Morale: Thinking about leaving	q24b. I will probably look for a job at a new organisation in the next 12 months.	27.5%	30.5%	23.0%

5 People promise elements and theme results Covid-19 Classification

5.1 Since 2020 the NSS includes a Covid-19 Classification which is aligned to the People Promise elements and the themes of 'Morale' and 'Engagement'. This section shows the

breakdown of themed scores for staff in the following subgroups and the average across Acute and Acute Community Trusts:

- Staff who worked on a Covid-19 specific ward or area at any time
- Staff who have been redeployed at any time due to the Covid-19 pandemic
- Staff who have been required to work remotely/from home due to the pandemic

5.2 Theme scores by COVID-19 subgroup

**Where the organisation has scored average, it is marked as '😐', above average as '☺' and below average as '☹'.*

Theme	All staff	Worked on COVID-19 specific ward or area	Redeployed	Required to work remotely or from home
We are compassionate and inclusive	7.1 ☹	6.9 ☹	7.0 ☺	7.4 😐
We are recognised and rewarded	5.7 😐	5.3 ☹	5.5 ☺	6.1 😐
We each have a voice that counts	6.6 😐	6.4 ☹	6.6 ☺	6.9 ☺
We are safe and healthy	5.8 ☹	5.3 ☹	5.4 😐	5.9 ☹
We are always learning	5.3 ☹	5.3 ☹	5.4 ☺	5.6 ☺
We work flexibly	5.9 ☹	5.4 ☹	5.7 ☺	6.5 😐
We are a team	6.7 ☺	6.5 😐	6.6 ☺	7.0 ☺
Staff Engagement	6.8 😐	6.6 😐	6.7 ☺	7.0 😐
Morale	5.5 ☹	5.1 ☹	5.3 😐	5.6 ☹

6 Equalities Indicators from the Staff Survey

In its fifth year, Workforce Disability Equality Standards (WDES) breakdowns are based on the responses to questions *Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?* In 2020, this question was shortened and the word '*disabilities*' removed to align with the standard question used by ONS. The question and related WDES results remain historically comparable since 2019, but the WDES labels have been updated to better reflect the new wording of the question. The word disability has now been replaced by 'long-term condition (LTC) or illness'

6.1 WDES (Workforce Disability Equality Standards) indicators reported in the Staff Survey for Whittington Health

The table overleaf, shows improvement in 6 out of 9 WDES indicators with areas such as experiencing abuse form managers and colleagues improving and where staff are experiencing bullying or abuse, reporting has improved. There is also an increase in staff with disabilities or long-term conditions believing the organisation provides equal opportunities and a positive shift towards the organisation making reasonable adjustments. There is an increase in staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months – an increase not mirrored in staff without a long-term condition. There is also a 1% increase in staff feeling pressure from their managers to come in to work despite feeling unwell – this may be because of the end of the government's guidance on protecting vulnerable people during the Covid-19 pandemic in 2020/21. There is also a decrease in engagement for staff with LTC of 0.2 since 2021.

Table to show WDES Indicators	2019		2020		2021		2022	
Question	**LTC or illness**	**WITHOUT LTC or illness**	**LTC or illness**	**WITHOUT LTC or illness**	**LTC or illness**	**WITHOUT LTC or illness**	**LTC or illness**	**WITHOUT LTC or illness**
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	33.4%	31.3%	32.8%	28.8%	33.4%	27.4%	**37.5%**	28.0%
Percentage of staff experiencing harassment bullying or abuse from a manager in the last 12 months	24.1%	16.3%	29.5%	13.4%	22.7%	13.8%	**22.3%**	11.2%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	32.9%	23.5%	30.1%	19.0%	27.7%	19.9%	**26.5%**	17.3%
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or colleague reported it	48.7%	45.3%	43.8%	47.1%	44.7%	48.6%	**47.1%**	48.9%
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	46.6%	50.2%	41.8%	49.7%	38.5%	49.2%	**40.1%**	51.8%
Percentage of staff who have felt pressure from their managers to come to work, despite not feeling well enough to perform their duties	33.5%	22%	37.4%	21.6%	28.5%	22.0%	**29.5%**	20.8%
Percentage of staff satisfied with the extent to which their organisation values their work	39.3%	51.6%	37.1%	53.7%	33.8%	46.5%	**34.7%**	45.6%
Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	68.1%	73.4%	67%	75.5%	62.3%	N/A	**64.7%**	N/A
Staff engagement score (0-10)	6.7	7.2	6.7	7.3	6.5	7.0	**6.3**	7.0

**Each 2022 response is graded in green if there has been a positive improvement for staff with a LTC or illness and red if a decline from the previous year.*

6.2 WRES indicators reported in the Staff Survey for Whittington Health

In its fifth year of reporting there are four indicators comparing the experience of B.A.M.E and white staff. NHS England report the findings under 'BME' staff whilst Whittington Health uses the acronym B.A.M.E.

**Each 2022 response is graded in green if there has been a positive improvement for B.A.M.E staff or red if a decline from the previous year*

Table to show WRES Indicators	2018		2019		2020		2021		2022	
Question	**BME staff**	**White staff**	**BME staff**	**White staff**	**BME staff**	**White staff**	**BME staff**	**White staff**	**BME staff**	**White staff**
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	35.9%	30.5%	32.5%	30.6%	30.3%	28.9%	28.6%	27.9%	**29.3%**	30.4%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	36.2%	31.4%	31.9%	29.9%	29.7%	24.2%	27.7%	25.7%	**25.4%**	24.3%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	35.8%	56.2%	39.7%	58.2%	39.7%	56.4%	39.9%	54.4%	**41.2%**	57.5%
Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	20.3%	9.5%	16.1%	7.8%	16.9%	8.2%	15.2%	8.3%	**15.0%**	9.4%

6.3 The table above shows a positive decline in three areas around discrimination at work from staff, managers and a positive improvement around career progression. There is a negative increase in staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last twelve months of 0.7%. This mirrors the national increase in bullying, harassment of abuse from patients or the public across the board.

7 Whittington Health Directorate/ICSU Report

7.1 The directorate/ICSU results for Whittington Health contain the results by directorate or ICSU for People Promise elements and theme results from the 2022 NHS Staff Survey. The below directorate results are compared to the unweighted average for the organisation.

**Each 2022 theme score for ICSUs and Directorates is graded in green with a '↑' symbol if the score is above organisational average, and red where the score is below organisational with a '↓' symbol. Where an ICSU or Directorate has scored the same as the organisations averaged it is graded black with a '-' symbol.*

Theme	WH Overall	ACW	ACS	COO	CYP	EIM	Facilities	Finance	IT	Medical Dir.	Nursing & Patient Exp.	Procurement	S&C	Trust Secretariat	Workforce
We are compassionate and inclusive	7.2	6.7 ↓	7.4 ↑	7.4 ↑	7.7 ↑	7.0 ↓	6.4 ↓	7.4 ↑	7.4 ↑	7.8 ↑	7.3 ↑	7.2 -	6.9 ↓	7.6 ↑	8.1 ↑
We are recognised and rewarded	5.8	5.1 ↓	5.9 ↑	6.0 ↑	6.3 ↑	5.6 ↓	5.1 ↓	6.3 ↑	5.9 ↑	6.8 ↑	6.2 ↑	5.9 ↑	5.3 ↓	6.6 ↑	7.3 ↑
We each have a voice that counts	6.7	6.0 ↓	6.8 ↑	7.2 ↑	7.1 ↑	6,5 ↓	6.3 ↓	6.8 ↑	6.6 ↓	7.0 ↑	7.1 ↑	6.8 ↑	6.3 ↓	7.2 ↑	7.1 ↑
We are safe and healthy	5.8	5.4 ↓	5.8 -	6.2 ↑	6 ↑	5.4 ↓	6.2 ↑	6.7 ↑	6.4 ↑	6.6 ↑	6.1 ↑	6.3 ↑	5.7 ↓	6.1 ↑	6.9 ↑
We are always learning	5.4	4.5 ↓	5.9 ↑	5.8 ↑	5.8 ↑	5.5 ↑	4.4 ↓	5.4 -	5.0 ↓	6.2 ↑	5.3 ↓	5.3 ↓	5.0 ↓	5.3 ↓	6.2 ↑
We work flexibly	6.0	5.8 ↓	6.1 ↑	6.8 ↑	6.7 ↑	5.6 ↓	5.8 ↓	6.8 ↑	6.3 ↑	6.8 ↑	7.0 ↑	6.4 ↑	5.7 ↓	7.0 ↑	8.0 ↑
We are a team	6.8	6.1 ↓	7.0 ↑	7.0 ↑	7.2 ↑	6.7 ↓	5.7 ↓	7.2 ↑	7.0 ↑	7.5 ↑	7.0 ↑	6.7 ↓	6.4 ↓	7.2 ↑	8.0 ↑
Staff Engagement	6.9	6.3 ↓	6.9 -	7.6 ↑	7.2 ↑	6.8 ↓	6.6 ↓	7.0 ↑	6.7 ↓	7.4 ↑	7.2 ↑	6.7 ↓	6.7 ↓	7.0 ↑	7.6 ↑
Morale	5.6	5.0 ↓	5.6 -	5.7 ↑	5.8 ↑	5.4 ↓	5.5 ↓	6.2 ↑	5.5 ↓	6.6 ↑	6.0 ↑	6.1 ↑	5.5 ↓	5.4 ↓	6.6 ↑

8 Communications, and Developing Action Plans

The Organisational Development Team along with the Communications Team have a proposed timeline for internal and external communications and developing action plans across the ICSUs and Directorates, the Executive Team, and workforce teams: HRBPs, Race, Equality, Diversity, and Inclusion team. For further information please see appendix four.

These plans will continue to be supported by organisational-wide initiatives such as; the ICARE Leadership Programme, Manager's Forum, the Inclusion Steering Group, Career Development programmes and wellbeing support through the 'Caring for Those Who Care' hub.

9 Current developments and future plans

The Trust is slightly above average for one of the themes, **'We are a team'** and has seen improvements in areas of line management and relationships at work improving. This is due to the continued work on the leadership development agenda in line with our ICARE values. In 2022/23 the organisation has successfully commissioned a number of leadership development interventions for all staff, including: Clinical Leadership and Personal Impact with King's Fund, a healthcare leadership programme for senior managers with The Staff College, an internal AHP Leadership Fellowship, and an accredited level 6 management qualification for junior managers with Middlesex University. Additionally the Trust has launched a new internal training on how to give and receive feedback and further expanded the pool of internal mediators in the organisation.

The Organisational Development team has offered team interventions and team coaching to support team working and morale, and has coached a number of managers and leaders in the organisation. We are committed to continuing the work already done in this domain, a further funding has been made available for leadership development and team interventions for 2023.

In order to improve the areas where the organisation has scored below average, We are compassionate and inclusive, We are safe and healthy, We are always learning, We work flexibly, in 2023, we are launching Restorative Culture across the organisation and as part of the programme, a suite of training courses for managers will be available from Spring 2023. After a successful funding bid, a further two cohorts of Bands 2-7 Career Development Programme will launch in 2023 and training for managers and all staff to increase disability awareness will run from Spring 2023 to March 2024.

A new policy on Management of Violence and Aggression at work has been launched in January 2023, to support the People Promise element 'We are safe and healthy' and in particular negative experiences. The policy along with training and supportive material has been piloted in Adult Community Services with positive feedback from colleagues and there is on-going work for the policy to be implemented across all ICSUs.

The organisation has scored average for two themes: We are recognised and rewarded, and We each have a voice that counts. Then Workforce Assurance Committee wil be doing a deep dive on the recognition and reward results, which must be noted are against a backdrop of national industrial action.

In 2022/23 the organisation launched a Financial Well-being Hub and held cost of living events to support staff – this work will continue to support staff's financial wellbeing as well as new interventions around recognition and reward and a new Staff Wellbeing Model will be introduced. As noted above, work will be carried out to improve understanding around the nature of the shortage of equipment, material and resources at work, (where the

organisation has ranked closed to worst) and findings will be presented at the Workforce Assurance Committee in April 2023.

10 Recommendations

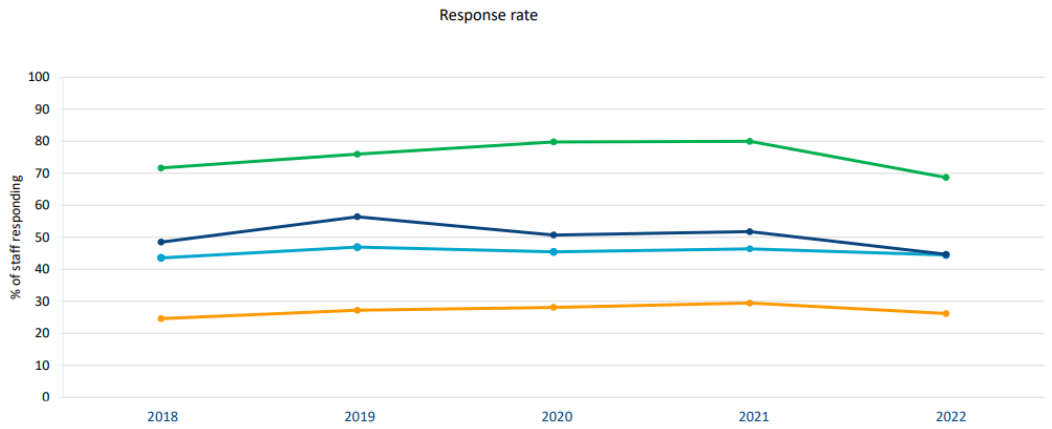
Members of the Trust Board is asked to:

- Note the content of this report following the results of the 2022 NHS Staff Survey

- Agree the Trust-wide priorities for 2023/24 which will support staff retention and increase morale and engagement across the organisation will be:

    4. 'We are recognised and rewarded' particularly level of pay and having adequate material and recourses, and recognition are priorities.
    5. 'We are safe and healthy' and particularly negative experiences, and;
    6. 'We are compassionate and inclusive' and in particular career progression and providing reasonable adjustments for staff with long-term conditions.

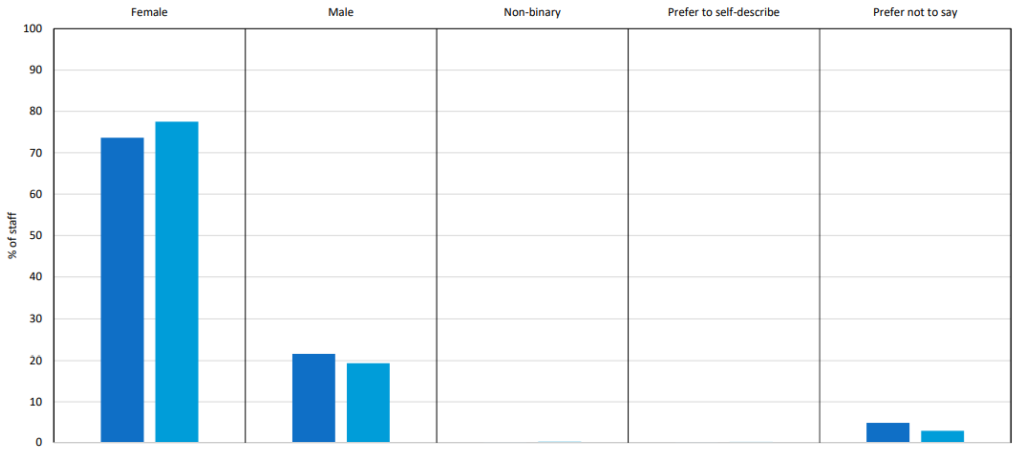
Appendix 1 - Response rate



	2018	2019	2020	2021	2022
Your org	48.5%	56.4%	50.7%	51.8%	44.7%
Highest	71.6%	76.0%	79.8%	79.9%	68.7%
Average	43.6%	46.9%	45.4%	46.4%	44.5%
Lowest	24.6%	27.2%	28.1%	29.5%	26.2%
Responses	1958	2350	2198	2301	2019

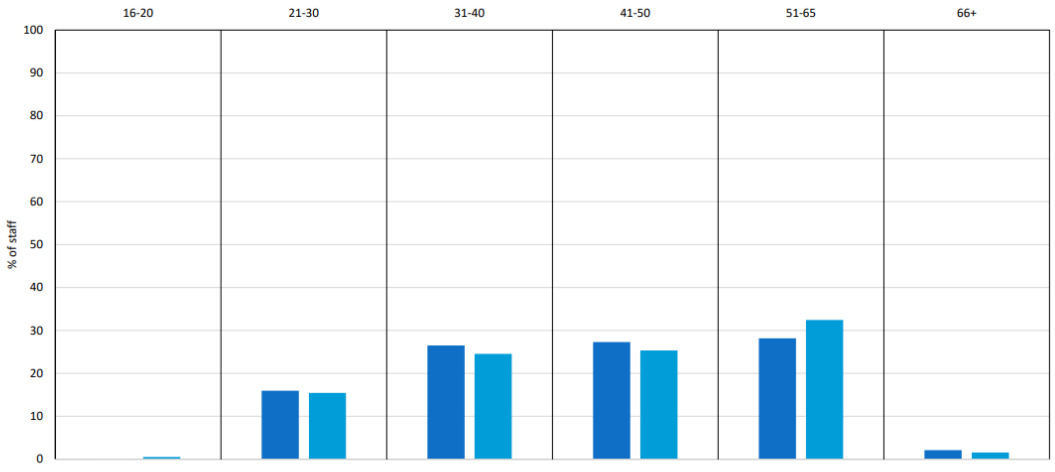
Appendix 2 – Respondent details

Demographics - Gender



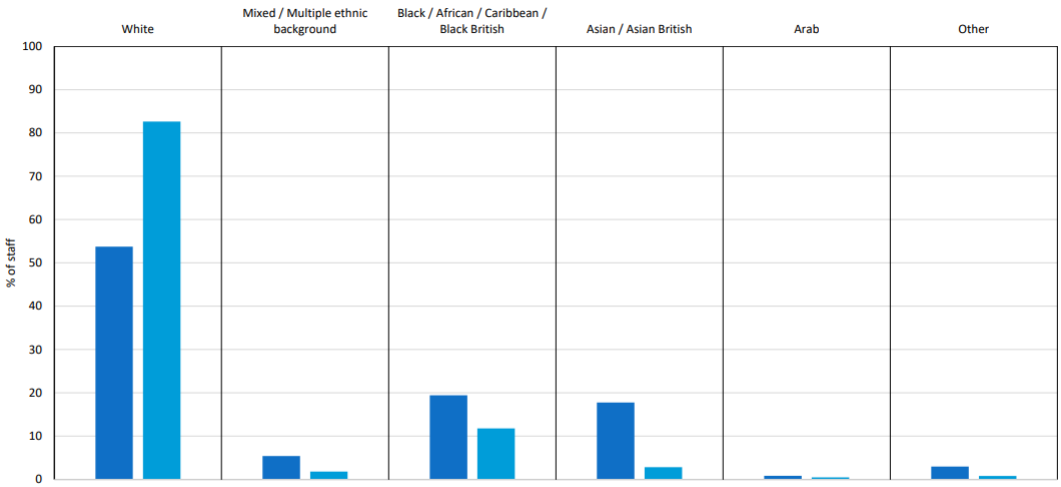
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say
Your org	73.6%	21.4%	0.1%	0.1%	4.7%
Average	77.5%	19.3%	0.2%	0.1%	2.8%
Responses	2003	2003	2003	2003	2003

Demographics – Age



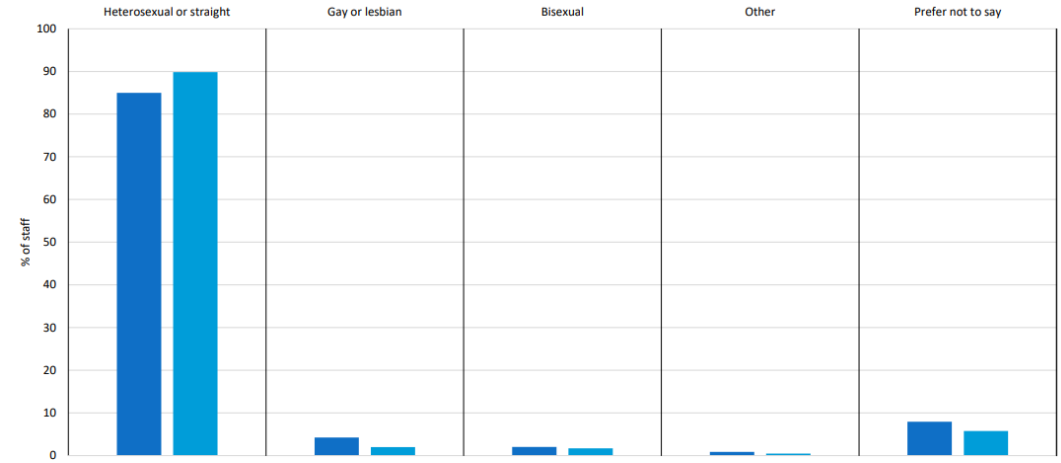
	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.0%	15.9%	26.5%	27.3%	28.1%	2.1%
Average	0.5%	15.4%	24.5%	25.3%	32.4%	1.5%
Responses	2001	2001	2001	2001	2001	2001

Demographics – Ethnicity



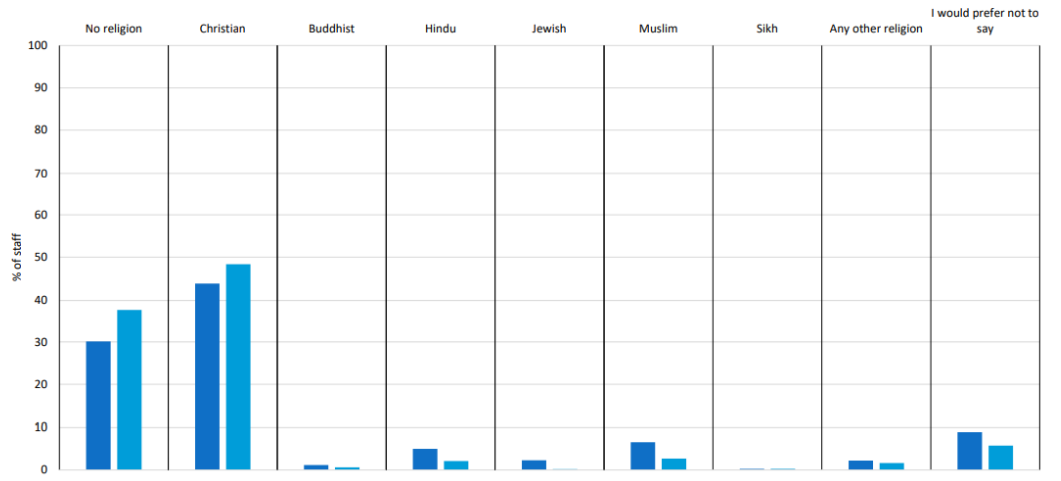
	White	Mixed / Multiple ethnic background	Black / African / Caribbean / Black British	Asian / Asian British	Arab	Other
Your org	53.7%	5.4%	19.4%	17.7%	0.8%	2.9%
Average	82.6%	1.8%	11.8%	2.8%	0.5%	0.8%
Responses	1974	1974	1974	1974	1974	1974

Demographics – Sexual orientation



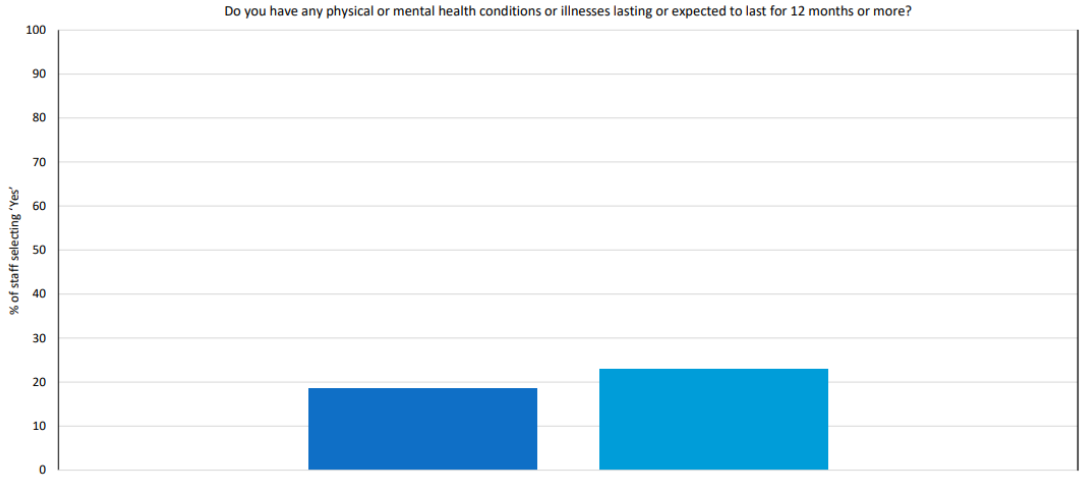
	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Prefer not to say
Your org	85.0%	4.2%	2.0%	0.9%	7.9%
Average	89.8%	2.0%	1.7%	0.5%	5.7%
Responses	1985	1985	1985	1985	1985

Demographics – Religion



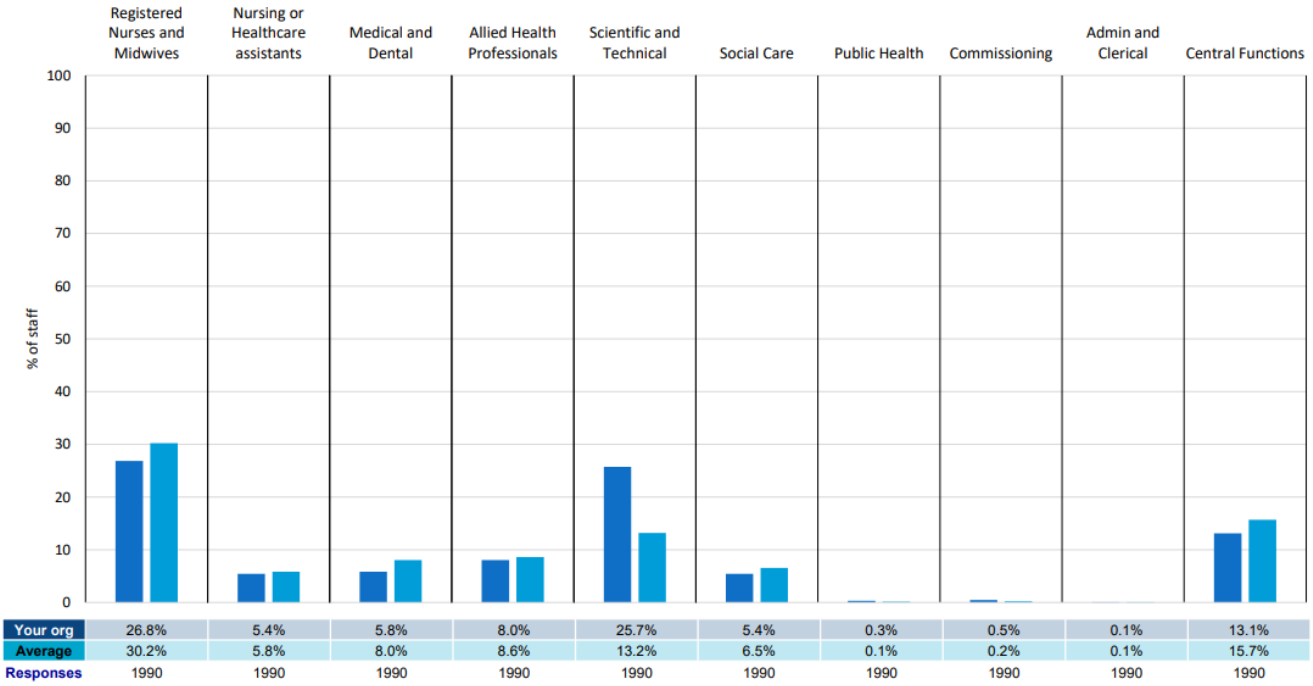
	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	I would prefer not to say
Your org	30.1%	43.8%	1.2%	4.9%	2.3%	6.5%	0.3%	2.2%	8.9%
Average	37.5%	48.3%	0.6%	2.1%	0.2%	2.7%	0.2%	1.6%	5.7%
Responses	1997	1997	1997	1997	1997	1997	1997	1997	1997

Demographics – Long lasting health condition or illness



Your org	18.6%
Average	22.9%
Responses	1999

Occupational group



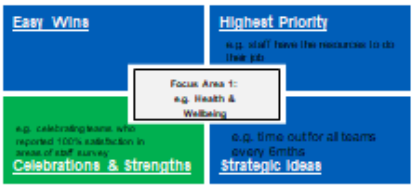
	Registered Nurses and Midwives	Nursing or Healthcare assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical	Social Care	Public Health	Commissioning	Admin and Clerical	Central Functions
Your org	26.8%	5.4%	5.8%	8.0%	25.7%	5.4%	0.3%	0.5%	0.1%	13.1%
Average	30.2%	5.8%	8.0%	8.6%	13.2%	6.5%	0.1%	0.2%	0.1%	15.7%
Responses	1990	1990	1990	1990	1990	1990	1990	1990	1990	1990

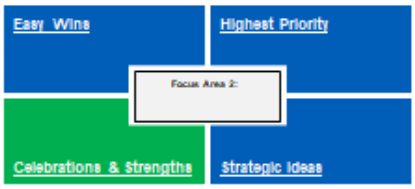
Appendix 3 2022 Templates for ICSU/Directorates & Teams

Reminder of template provided

NHS Whittington Health NHS Trust

"We are going to focus on these 3 areas for improvement"





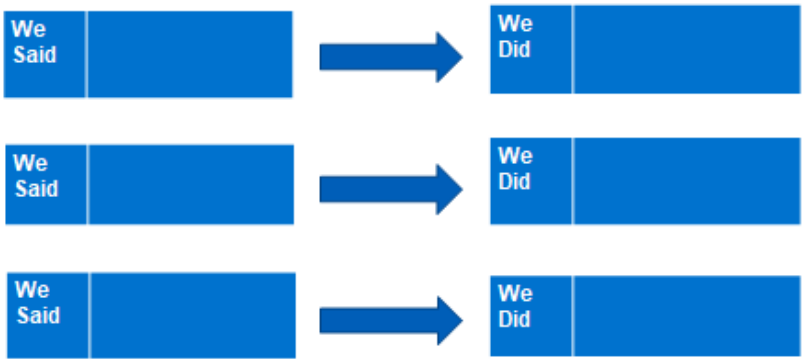
The next page shows how it will be reported for each ICSU/Directorate, based upon Patient Experience updates

Team Action Plans

NHS Whittington Health NHS Trust

For each ICSU and Directorate, the separate Team action plans (as below) will be appended to the main Board Report.

Team:
Theme:



Example Update – for Focus 1
ICSU / Directorate NAME

NHS Whittington Health NHS Trust

Focus Area 1:			
Type	Plan	Update (+ impact)	Indicators of goal met
Easy Wins			
Highest Priority			
Celebrations & Strengths			
Strategic Ideas			

Appendix 4 Communication Plans

Timeline and Activity	Timing	Audience	Lead on content creation
Full & Directorate Whittington Health draft reports sent to all senior leaders prior to TMG – EMBARGO STILL IN PLACE	January 2023	Senior WH leaders	OD
Workforce Assurance Committee – Picker Management report brief – EMBARGO STILL IN PLACE	25th January 2023	WAC	OD
National and Directorate Benchmark Reports (CQC results released to organisations) – EMBARGO STILL IN PLACE	21st February 2023	OD/Dir Workforce	NHS England
Verbal update at EMT 6th March – EMBARGO STILL IN PLACE		EMT	Norma French Director of Workforce
Embargo lifted 9th March 2023	9th March 9:30 am 2023	Public	Comms
CEO All staff briefing overview of results	9th March 12:00pm 2023	All staff	Comms
Noticeboard article with link to intranet blog		All Staff	Comms
Reactive media lines signed off	TBC	Public	Comms
Social media highlighting any positives		Public	Comms
Report submitted to TMG	14th March 2023	TMG	OD
Trust Board report – overall results and next steps agreed	30th March	Trust Board	Dir. of Workforce
WH Managers guide for using staff survey data: sent to all ICSU/ Directorates	15th March 2023	Senior WH leaders	OD & HRBPs
Partnership Group – overall results briefing	TBC	Staff side	OD/ Dir of Workforce
ICSU/Directorate leads to cascade information via relevant Boards including 'We Said We Did' template. HRBPs to support and ensure placed on agendas.	March-April 2023	All staff	Dir of Workforce
ICSU/Directorate leads to present draft staff survey action plan at next Quarterly Performance Review	Tbc	Leads	ICSU/ Directorate leads
Design/deliver/ commission interventions in ICSUs	Mar – Sept 2023	Leads	HRBPs/ Inclusion / OD / OH
ICSU/ Directorate leads to review interventions and report to QPR Boards	August 2023	Leads	ICSU/ Directorate leads
Review of interventions shared with all staff – We Said We Did – month of comms	August ready for Sept 2023	All staff	Comms

Meeting title	**Trust Board – public meeting**	**Date: 24 May 2023**
Report title	**Innovation and Digital Assurance Committee Chair's report**	**Agenda item: 10**
Committee Chair	Junaid Bajwa, Non-Executive Director	
Executive leas	Jonathan Gardner, Director of Strategy and Corporate Affairs	
Report author	Marcia Marrast-Lewis, Assistant Trust Secretary	
Executive summary	The Innovation and Digital Assurance Committee met on 20 April 2023 and took good assurance on the substantive items covered: • The Board Assurance Framework entry, Sustainability 3 • An update on current clinical projects • An update on the progress of the electronic patient record programme's outline business case The Committee also considered: • Revised committee terms of reference • Terms of reference for the Data Quality and Business Intelligence Group.	
Purpose	Noting	
Recommendations	Board members are asked to note the Chair's assurance report for the meeting of the Innovation and Digital Assurance Committee meeting held on 20 April 2023.	
BAF entry	Sustainable 3 - digital strategy and interoperability	
Appendices	None	

Committee Chair's Assurance report

Committee name	Innovation and Digital Assurance Committee
Date of meeting	20 April 2023
Summary of assurance:	

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

Terms of reference of the Digital, Innovation and Performance Committee.
The Committee discussed the revision of the terms of refence of the Innovation and Digital Assurance Committee which were originally agreed by the Board in 2021. Its remit was to provide assurance to the Board primarily on the delivery of Whittington Health's digital strategy and the interoperability of its systems.

The terms of reference had been amended and expanded to include new areas of responsibility which would entail oversight and assurance of:

- performance on data quality and metrics for the delivery of intelligence to support business
- operational performance against local system and national targets
- the Transformation Programme Board which oversees all key transformation projects at Whittington Health
- delivery of the green sustainability strategy and plan.

It was agreed that the committee would be renamed as the Digital, Innovation and Performance Committee which reflects the additional areas of responsibility.

The Committee agreed that the terms of reference should include a focus on performance data quality and targets with a specific angle on operational targets as opposed to quality, finance and workforce targets. It was also agreed that the number of meetings would be increased to six per year.

A final draft of the terms of reference would be approved at the next meeting of the Committee and submitted to the Trust Board for ratification thereafter.

Board Assurance Framework (BAF)
The Committee reviewed BAF entry Sustainable 3 and noted slightly revised assurances in place which reflected the change in the name of Committee. It was confirmed that the Trust's 2023/24 corporate objectives would be submitted to the Trust Board for approval and updates to the BAF would take place thereafter.

The Committee noted the updated BAF.

Current clinical projects
Committee members received an update on clinical informatics projects which were now

mapped to the digital strategy. Highlights included the following:

- A discussion on the Digital Strategy in the context of its digital objectives.
- A review of three pillars of work which were mapped to current projects to track progress.

The Committee noted the Trust governance structure around digital and transformation programmes of work.

D**ata Quality and Business Intelligence Group TOR sign off .**
The Committee reviewed draft terms of reference for the Data Quality and Business Intelligence Group whose primary role was to Provide assurance there is an effective structure, process and system of control for the governance of data quality and business intelligence matters. The Group would report up to the Trust Management Group and the Digital Innovation and Performance Committee.

The Committee approved the draft terms of reference.

Sustainability
The Committee received a presentation on the Trust's draft Green Plan 2023-2026 which outlined the Trust's ambition to reduce its carbon footprint by 80% by 2032 and by 100% by 2040. The Committee noted that NHS carbon footprint data was now available, and the Trust was in a position to track its carbon emissions and benchmark against other NHS organisations. The Trust's carbon footprint was slightly lower than it's partner organisation UCLH but there was a recognition that there were areas of opportunity in which to make progress.

In line with national guidance and under the banner of #GreenerWhitHealth the plan outlined 9 key chapters grouped into 3 themes around care, culture and infrastructure. The Committee noted opportunities to make the greatest impact around the prevention of wastage of nitrous oxide and participation in the reduction of the medicine's wastage programme.

The Committee was assured that a robust framework was in place which would ensure delivery of the Plan through, staff engagement, the creation of a Green Champions Network, a task and finish group, a Sustainability Steering Group with oversight by the Transformation Committee and the Digital Performance & Innovation Committee.

The Committee welcomed the development of a roadmap with estimated costs aimed at the decarbonisation of the estate over the next three years. The Trust had secured £2.5m of funding which would need to be matched to facilitate the next steps.

The final draft of the Green Plan was scheduled for approval by the Committee at its next meeting and ratification by the Trust Board thereafter.

2.	**Present:** Junaid Bajwa, Non-Executive Director (Committee Chair) Helen Brown, Chief Executive Naomi Fulop, Non-Executive Director Jonathan Gardner, Director of Strategy & Corporate Affairs **In attendance:** Sam Barclay, Clinical Chief Information Officer Mark Livingstone, Director of Allied Health Professionals Hugo Mathias, Chief Information Officer Hugh Montgomery, Professor of Intensive Care Medicine, University College London Iolanda Pedrosa, Chief Nursing, Midwifery and Allied Health Professionals Information Officer Marcia Marrast-Lewis, Assistant Trust Secretary